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"WHERE ARE YOUR PENNILESS MANIACS?"

MEDICINE, ECONOMICS, AND CLASS
AT HARTFORD’S RETREAT FOR THE INSANE

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In 1869, the Retreat for the Insane at Hartford severed the purse strings that had tied it to the Connecticut state treasury for more than twenty-five years. By late the following year, the state had removed the last of the “indigent and pauper insane” from their rooms at the Retreat, settling them into a new, state institution in Middletown. Though the relationship forged between the Retreat and the state had initially benefited all, pressures from many sides led both parties, in the end, to choose divergent institutional paths. From the point of view of the Retreat, enduring concerns about the incurability of chronic mental illness merged, by the 1860s, with new worries about overcrowding, the insufficiency of state funding, and competition from newer institutions in other states. Commitments to serving all people of the state, without regard to means, yielded dramatically to partisan discussions of class. While, at the outset of its relationship with the state, the Retreat found honor in providing service to those who could not afford to pay for it, by 1870 its directors were celebrating its new, narrow commitment to the wealthy, “a class whose sufferings from mental disease were most
acute... and whose restoration to health and usefulness, were most important. At all points, medical and scientific ideas became intertwined with social and economic concerns, as physicians and directors at the Retreat first attempted to define the goals of its hospital and then struggled to breathe new life into the dinosaur that had once been a model institution.

This paper traces the history of the relationship between the Retreat for the Insane and the state of Connecticut, focusing on the ideas that led the directors of the Retreat to turn their backs on poor patients and rededicate the institution to the exclusive care of the wealthy and educated. It begins with a brief review of the early history of the Retreat; continues with a discussion of the medical, social, and economic ideas that developed during the years of Retreat / state cooperation; and provides analysis of the complex reasons for the final schism. Throughout, it weaves from medicine and science to economics and social concerns, providing a context for the decisions made by the Retreat and evaluating the ways in which physicians and institutional leaders used scientific arguments to justify changes that grew from non-scientific concerns.

EARLY HISTORY

The drive that led to the founding of the Connecticut Retreat for the Insane began in 1820, when a committee of the Connecticut Medical Society circulated a questionnaire...
inquiring as to “the number and condition of insane persons in this state.” The effort produced responses from seventy municipalities, whose officials reported 510 insane people living in their communities. With 54 towns not reporting and the committee expressing “the strongest reason to believe, that at least one half have been overlooked,” the group extrapolated from this known figure, projecting that at least one thousand mentally ill individuals lived within the borders of Connecticut.

The remedy for this problem, the committee suggested, was the immediate endowment of a new hospital “established on humane principles, and presenting to the unfortunate sufferers who enter its portals, all that ingenuity can suggest or benevolence bestow for the cure of their disorder.” The Connecticut Medical Society emptied its coffers of $600 to provide seed money and, in 1822, the General Assembly chartered the Retreat for the Insane as a private institution, contributing $5000 to the cause.” By 1824, after a subscription drive had collected $20,000 in private donations, the Retreat had opened its doors to the first 44 patients.

At the time of its founding, the concept of a psychiatric hospital was unfamiliar in the United States. Though Doctors Tuke, in England, and Pinel, in France, had begun to boast of extraordinary success in curing the mentally ill at their respective asylums, only three American institutions predate the Retreat. Indeed, the first report of the CMS committee that conducted the census took pains to lay the groundwork for the

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3 Report . . . . 1821, p. 6.
justification of such a concept. With a dramatic flourish, they summoned the image of
“the poor maniac, doomed to confinement in the lonely dungeon, and often to wear the
chains which should be reserved for guilt alone;” evoking empathy for the hundreds of
mentally ill effectively imprisoned in town almshouses throughout the state. They
continued by drawing attention to “the wretchedness of those families upon whom
devolve the care and maintenance of the insane,” families whose “peace is interrupted,
their cares... multiplied, their time... engrossed.” The commissioners further expanded
their emphasis, noting that “the misery which (families) suffer, is communicated to an
extensive circle of friends, and the whole neighbourhood is indirectly disturbed by the
malady of one.”

The commissioners countered this image of an expanding spiral of misery with a
general discussion of the European model. In the United States, the insane “rove from
house to house, alternately the objects of merriment and or dread” and, without adequate
treatment, end their lives in “confirmed derangement.” In England, by contrast, the
insane “are sequestered from public view, and being subjected to the most judicious
treatment, they usually regain their reason.” The only possible solution, then, to the
problem of insanity—for the community as well as for the mentally ill themselves—is the
founding of a hospital. Such a hospital, they claimed, “will diminish the number of the

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6 Annual Report, 1824, p. 1. The 1823 report of the Society for the Relief of the Insane lists each donor. A
few individuals gave between $50 and $300 each, but the great majority donated $5 or less. Twenty-five
patrons donated $50 each, and one woman, Susan Tracy of Franklin, donated $.12.
7 Report... 1821, p. 6.
8 Report... 1821, p. 6. The commissioners also suggested that insanity could be a contagious conditions,
citing its preponderance in certain villages along the Connecticut River: “... when an individual becomes
insane, unless he is removed from his family and associates, it is probably that some of them will become
the subjects of the same disorder. In different sections of the state, we find examples of insanity,
apparently produced in this manner, and hence it becomes endemic in particular villages and at particular
seasons.” (p. 7, emphasis in original)
"Report... 1821, p. 8."
insane” by a “restoration to health” gained through prompt treatment, and “will also diminish the expense of their maintenance” by centralizing services and allowing the friends of the insane “to pursue their customary avocations without molestation and without fear.”

From the beginning, then, the founders of the Retreat for the Insane were concerned not only with the medical treatment of the insane but also with the broader social and economic benefits of asylum care. From the beginning, these men described a facility that would serve not only the patients housed within its walls, but also struggling families and entire communities whose energy and resources were sapped by the mentally ill. Accepting the model developed in Europe, they proposed to found an institution that would not only shelter the mentally ill in order to provide them with treatment but also shelter the wider community from the inconveniences of living with the mentally ill.

The issue of class appears in these founding documents only tangentially, and in their pages, the authors stressed the universality of insanity as an affliction that strikes members of all classes. Though these men showed sympathy for the poor, especially those confined to town ahnshouses, they reserved detailed empathy for those whose economic means and emotional stability were depleted in caring for an ill relative. They expressed concern for such families, “their fortunes reduced or entirely dissipated, in attempting to restore to reason one unfortunate member,” families who suffered “when all their ‘worldly goods’ are wasted.” They also noted the special challenges presented

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10 *Report...*, 1821, pp. 10 and 11; emphasis in original.
11 *Report...*, 1821, p. 11.
12 *Report...*, 1821, pp. 6-7.
by “the character and rank of the patient”\textsuperscript{13} of means, one whose family would be unlikely to seek treatment in a public institution.

The commissioners underscored the universality of insanity by connecting it with the shared English ancestry of New Englanders. “The people of New-England,” they wrote, “inherit the constitution of their ancestors, and partake to a greater or less extent of their hereditary disorders-One of these, and by no means the least considerable, is insanity.” In addition to this biological heritage, the commissioners also saw in the social circumstances of American life additional dangers that led some to insanity. “The easy transition from one rank of society to another, and the facility with which wealth is accumulated,” they warn, “serve to cherish even in humble life, those hopes, which in other countries are repressed or entirely subdued. Expectations high raised, are the usual precursors of disappointment.”\textsuperscript{14} Far from distinguishing one class from another, the commissioners here stressed both a shared genetic heritage and shared social circumstances that unite Connecticut citizens under the threat of insanity.

The modern historiography of the asylum begins with an evaluation of this social context of insanity. Early analyses of the significance of the asylum stressed reform and the progress of medical knowledge. Proponents of this school lauded the new groups of physicians who replaced chains and cages with humane care and, though they doubted

\textsuperscript{13}Report . . . . 1821, p. 8.
\textsuperscript{14}Report . . . . 1821, p. 7. Variations on this theme of the specific dangers of American life appeared in psychiatry textbooks as well as the annual reports of asylums. Dr. Henry Stearns, who would later become the superintendent of the Hartford Retreat, expanded this theme, writing, “in the former conditions of life, persons were, to a much large degree, governed, and their requirements provided for, by legal, or arbitrary, enactments, so that there existed less care on their part, as to obtaining those things necessary for self and family, while in the present, the larger degree of personal liberty enjoyed, and the multiplied artificial wants created, bring increased care and individual responsibility.” Though Stearns was responding to the specific circumstances of American urbanization in the 1880s, his theory derives from that conceived during the era in which the Retreat was founded. Henry Putnam Stearns, M.D. \textit{Insanity: Its Causes and Prevention. New York: G.P. Putnam's Sons, 1883, p. 14.}
the high cure rates claimed by superintendents, these theorists greeted the development of the asylum as a sign of medical progress.\footnote{For a example of this type of analysis, see Henry M. Hurd, \textit{et al.}, \textit{The institutional Care of the Insane in the United States and Canada (4 vols.)}} Challenges to this unexamined acceptance of the rhetoric of the time began to appear in the 1960s, with the most thoroughly conceived revision appearing in 1971, in David Rothman’s work, \textit{The Discovery of the Asylum}. In this volume, \textit{Rothman} challenges the progress-and-reform theory, suggesting instead that social and economic concerns of the new republic influenced the development of the asylum, guiding rather than following the medical “progress” that favored the segregation of the mentally ill. “Psychiatrists,” he suggests, “\textit{were} more American than they were scientific, and the \textit{nature} of their response to insanity cannot be comprehended unless one recognizes that they defined mental illness as a social problem, not just a medical \textit{one}.\footnote{Rothman, p. xviii.}” Rather than see \textit{pure} science as the motivating force, \textit{Rothman} identifies a collective fear of social disorder in post-colonial, Jacksonian society and sees, in the asylum, “\textit{an} effort to insure the cohesion of the community in new and changing circumstances.” In the asylum, he identifies a utopian impulse. “The institution,” he writes,

would arrange and administer a disciplined routine that would curb uncontrolled impulses without cruelty or unnecessary punishment. It would re-create \textit{fixity} and stability to compensate for the irregularities of the society. \textit{Thus,} it would rehabilitate the casualties of the system.\footnote{Rothman, p. 133.}
Like the penitentiary and the poorhouse, the insane asylum "represented and attempt to compensate for public disorder in a particular setting and to demonstrate the correct rules of social organization."\(^{19}\)

During the last thirty years, historians have challenged Rothman's thesis, William Muraskin challenges Rothman's failure to evaluate the concept of "American" concerns about instability, claiming that the anxiety Rothman describes "is not a general American malaise, but a specific class uneasiness... contemporary self-interest made into self-serving ideology."\(^{20}\) Muraskin challenges Rothman's implied notion that Americans widely shared fears of instability, claiming that those who supported the proliferation of asylums were members of the ruling class whose basic aim was "to stabilize society in their own class interest."\(^{21}\) Dismissing Rothman's work as "an intellectual tour de force, more stimulating than convincing,"\(^{22}\) he suggests that the social-control school of analysis would go further to explain the rise of the asylum.\(^{23}\)

Andrew Scull also challenges Rothman's thesis, charging that "while Rothman persuasively describes this anxiety (about the destabilization of American society), he almost entirely neglects to explain it-to give us any understanding of why these persons

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19 Rothman, p. 154.
20 William A. Muraskin. "The Social-Control Theory in American History: A Critique." *Journal of Social History*, 1976 9(4), p. 561. Unfortunately, I was unable to find many critical articles written more recently than this one. Where attention was paid to the question of class in the 1970s and 1980s, perhaps in the wake of Rothman's book, interest in that question seems to have faded by the 1990s, yielding especially to analyses of treatment programs and, for some reason, numerous evaluations of the case of Mary Todd Lincoln. One article, published in 1995 in the *Tennessee Historical Quarterly*, concerned the history of the Tennessee Lunatic Asylum from 1837-1865, but I was unable to obtain a copy.
21 Muraskin, p. 563.
22 Muraskin, p. 563.
23 Muraskin acknowledges the limitations of this school, faulting its “underdeveloped and crude conceptualizations” (p. 563) and warning that pure social-control analysis fails to investigate the possibility that "what reformers claimed as humanitarianism was indeed just that." (p. 566) Ultimately, for Muraskin, social-control theorists fail to acknowledge the complexity of philanthropic action. Nevertheless, he uses this theory to challenge Rothman “ultimately," he concludes, through the application of social-control theory, "we found that Rothman’s interpretation was unacceptable." (p. 568)
became anxious about these things at this time." Looking to England, Scull charges that the rise of the asylum was not a uniquely American phenomenon; therefore, it could not have risen in response to specific American circumstances. Drawing from the work of sociologist David Mechanic, Scull reads into Rothman’s work a cause that himself did not identify: a pervasive American fear that “the increased mobility of the population and the anonymity of existence in the urban slums were combined with the destruction of the old paternal relationships that went with a stable, hierarchically organized rural society.” Looking again to the English model, Scull faults this imputed analysis for its assumption that American circumstances yielded these concerns. In England, he explains, people were expressing similar fears about instability and developing institutional responses. Where in America the problem was urban instability, in England the fear derived from the rise of a new, rural working class. For Scull, the key to rising anxiety in both nations grew from the rise of the capitalist market system. “Prior to the emergence of a capitalist system,” he writes,

economic relationships did not manifest themselves as purely market relationships. Economic domination or subordination was overlaid and fused with personal ties between individuals. But the market destroyed the traditional connections between rich and poor, the reciprocal notions of paternalism, deference, and dependence characterizing the old order, producing profound shifts in the relationships between superordinate and subordinate classes, and of upper class perceptions of responsibilities toward the less fortunate.

In the breakdown of the old order, Scull charges, traditional notions of community responsibility crumbled, the insane came to be classified as deviants incapable of contributing to the new economy, and there developed, in the asylum, a “system... .

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26 Scull, p. 340.
(directed) toward an economical restraint of those posing a direct threat to the social order."^{27}

Despite considerable disagreements, Rothman, Muraskin, and Scull all concur that the asylum proliferated not only in response to "progress" in medical thought. Instead, new enthusiasm for such hospitals reflected both changes in the structures of American life and anxiety about how best to control such changes. Certainly, the founders of the Retreat for the Insane shared these concerns. In their explicit discussion of the peripheral social and economic benefits of the segregation of the mentally ill, they reveal an awareness of the broader implications of this new institution. Even in the composition of the commission — six doctors, four lawyers, three ministers, six judges, and the governor of Connecticut^{28} — they reveal a tacit understanding that the implications of their work lie beyond the purely medical. This composition lends credence to Muraskin's assertion that the anxiety expressed by Rothman's "Americans" was really the anxiety of Connecticut's professional class.

The arguments advanced by these three historians ultimately fail, however, to explain the course taken by the Retreat for the Insane after its founding. Though they identify the cause of anxiety about social disorder in different areas, all underscore the role of the asylum in establishing stability by inculcating discipline and conformity within the structured routine of asylum treatment. All emphasize the centrality of a work regimen in asylum life. As Rothman explains, "steady labor would... train inmates to proper habits, bringing regularity to disordered lives."^{29} Asylums would "teach

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^{27} Scull, p. 344.
^{28} Members of the commission are named in the Report of a Committee of the Connecticut Medical Society... p. 3.
^{29} Rothman, p. 144.
discipline, a sense of limits, and a satisfaction with one’s position, and in this way enable patients to withstand the tension and the fluidity of Jacksonian society. They would reap their greatest benefits in the reeducation of the working class, fitting workers for their rightful place in American society.

The Retreat, however, never committed itself to the rehabilitation of the working class. Though it accepted a few patients unable to pay the costs of their own treatment, it never defined itself as a charity dedicated to the needs of the poor and its treatment program never included the work component central to the argument that the asylum was a tool designed by capitalists to ensure the cooperation of the working class. In this way, the Retreat for the Insane was something of an anomaly in the world of the American asylum. Though the broad outlines of its design conform to the blueprint of the general asylum model, and though the arguments that developed during its early years echo the concerns expressed by other institutions, it remained an anomalous institution whose progress can not adequately be explained in a discussion of the asylum as an institutional form.

THE RETREAT AND THE STATE

Though the founding documents of the Retreat for the Insane emphasize the responsibility of the community to provide treatment and refuge for its insane, that institution itself was slow to provide such services to those citizens whose families could not afford to pay the full cost of care. Instead, it attempted to strictly limit the admission of poorer patients, increasing their numbers only when its directors foresaw economic

\[30\] Rothman, p. 154.
advantage in doing so. Ultimately, finding themselves unable to control the composition of patients in their own hospital and suffering from overcrowding and underfunding, these directors rescinded their offer to serve a broad population, closing the door entirely to those who could not pay.

The 1822 Act of Incorporation specified that “any subscriber paying two hundred dollars, may at all times name one indigent patient, who is to be received into the Asylum upon the most favorable terms.” Towns and associations contributing $250 were accorded the same privilege. Though this passage provided entrance to the Retreat to indigent patients, admission was a right granted not to the patient him/herself but to a benefactor of the institution. In including this language, then, the Retreat was acknowledging the gifts of its most generous supporters-and, not coincidentally, offering a “prize” that might attract other large donations-not opening its doors to the poor. The intent became clearer a few sentences later, when the trustees specified that “no patient of any description can be admitted, until his friends or guardians have deposited with the Treasurer of the Society, adequate security for the payment of the quarterly expenses.” Though in coming years the Retreat would describe itself repeatedly as a charity, it was clearly not the sort of charity that would donate its services to the poor.

In 1830, the Retreat reevaluated its position and proposed, for the first time, that indigent patients be admitted without sponsorship. In light of rising income, the

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32 Act., 1822, p. 6.
33 Unfortunately, the brief financial accountings included with the annual reports do not contain sufficient detail to make it clear whether income was actually rising, as claimed. The Manager’s Report of 1830 makes oblique reference to the necessity of paying off a debt to the state; this situation suggests that
Medical Visitors noted in that year that “we do most anxiously hope that the funds will enable the managers to admit a class of recent cases from amongst the poor at a lower rate.” Aware that such a shift in policy could have dramatic consequences, these Medical Visitors assure their audience that “this class should not be numerous, as it is by no means desirable that admission to the institution should be gratuitous or even fixed for the generality of patients at very low rates.” Should such a drastic redefinition of purpose take place, the visitors warn,

the inevitable consequence of this would be, that towns would crowd into the Institution pauper lunatics in numbers sufficient to fill it and all other classes would be excluded. This would lower the character of the Institution and greatly diminish its usefulness.34

As early as 1830, then, the overseers of the Retreat for the Insane display an awareness of economic class a guiding consideration in managing the clientele of the young hospital. In the passage quoted above, the visitors evince no concern about pure economics, no fear that the income of the Retreat would fall were it to accept many “pauper lunatics.” Instead, their emphasis falls on the social implications of poverty; their fear lodges in the loss of esteem that the Retreat would suffer from such a changing of the patient guard. This explicit link between the economic class of the patients and the social position of the Retreat would not appear again in official reports for another forty years, as the Retreat tried to navigate a middle course between catering to the mental health needs of the wealthy and providing a charitable (and, at most points in time, not unprofitable) service to the poor. The question would, however, lurk below the surface for several years, before finding explicit expression in the late 1860s.

perhaps, rather than reflecting improving financial circumstances, the decision to accept indigent patients reflected either the need for additional income or the payment of a political/economic debt to the state.
In 1831, the Directors of the Retreat decided on a course of action, resolving that the managers of the Retreat be authorized to admit indigent lunatics, whose disease has not exceeded three months, at two dollars per week—provided that the number of such persons in the institution shall at no time exceed the number of ten. And provided also, that no individual shall remain in the institution upon the said terms over six months.\(^{35}\)

In this way, the directors reiterated the right to control the patient population while offering a charitable service to the community, earning a rate that equaled that paid by many private patients, yet still protecting the Retreat from any implication that it was, in the words of the Medical Visitors, “wholly a charitable institution.”\(^{36}\)

While the Retreat grappled with the relative advantages and dangers posed by charity-supported patients, government bodies in Connecticut struggled to determine the most effective ways to provide public relief for the mentally ill. As early as 1654, the colonial records of New Haven record an order that the town provide for Sister Lamson, “so far forth as her husband is not able to do so.”\(^{37}\) In 1699, this specific mandate became general law, as Connecticut’s General Court borrowed, almost verbatim, “An Act for Relieving Idiots and Distracted Persons” from the Massachusetts law book. “Whenever a person should be wanting of understanding so as to become incapable of providing for himself, or should become insane,” the act reads,

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\ldots \text{the selectmen or overseer of the poor of the town} \ldots \text{are empowered and enjoined to take effectual care and make necessary provision for the relief, support and safety of such impotent or distracted person at the charge of the town or place where he or she of right belongs.}\quad^{38}\]


\(^{36}\) *Report of the Medical Visitors, 1830,* p. 5.

\(^{37}\) Hurd, et al., p. 67. All discussion of colonial legislation regarding the insane is taken from this source.

\(^{38}\) Hurd, et al., p.68.
In a colony such as Connecticut, where settlement laws made migration difficult, town responsibility was generally effective in assuring the care of all but “vagrants and tramps.” Only in the mid-nineteenth century, when rising immigration and urbanization began to disrupt traditional patterns would Connecticut begin to reevaluate this policy, and not until the early twentieth century would the state relieve towns of primary financial responsibility and assume the full burden itself.

During the eighteenth century, colonial laws most often made provision for the insane as part of a larger group of undesirable persons. An act of 1727, for example, established a colony workhouse for “rogues, vagabonds and idle persons... all common pipers, fiddlers, runaways, stubborn servants or children, common drunkards, common night-walkers, pilferers, wanton and lascivious persons, common brawlers or railers... [and] persons under distraction, whose friends do not take care for the their safe confinement.” Perhaps concerned about the growing number of mentally ill who were filling both this workhouse and, even more critically, town almshouses, laws of 1715, 1746, and 1784 established and enforced the obligation of solvent relatives to provide care for family members suffering from mental illness.

Despite this mandate, however, town almshouses continued to fill with the insane. In 1793, the new state legislature revoked authority it had earlier granted towns to forcibly confine the insane to workhouses-and, later, to jails—but by that time the practice was already firmly entrenched, providing convenient and inexpensive relief from the disruptive behavior of the unsupervised mentally ill. In 1841, reformer Dorothea Dix would reveal the abominable conditions endured by hundreds of the mentally ill in these almshouses. As late as the 1880s, annual reports of the Retreat for the Insane and, later,
the Connecticut Hospital for the Insane, would include heart-wrenching anecdotes about patients rescued from the filth and cruelty of these poorhouses.

By the turn of the nineteenth century, ideas about the proper treatment of the mentally ill had begun to change. In 1792, French physician Philippe Pinel had “struck the chains from the mentally ill,” replacing whips and shackles with a new regimen of “moral treatment.” Both Pinel and William Tuke, English laymen, established asylums predicated on this new, humane treatment and, by 1800, were proclaiming that not only could the insane be cured, but of those recently stricken, cure rates could exceed 90 percent.

“Moral treatment” was a broad concept that lent itself easily to individual adaptation. Originally described by Tuke in 1802, it remained a vague concept, easily adapted to particular circumstances. In general, it revolved around the creation of a respectful, supportive environment that emphasized the comfort and the encouragement of patients. Warm baths, balanced diets, and a gentle regimen of work, exercise, and structured play replaced the punitive, confining strictures that had previously bound the mentally ill. The combination of kindness and structure, proponents of moral treatment maintained, could help the insane regain the self-control that they had lost and achieve lasting mental health. Historian Gerald Grob explains that “moral treatment, in effect, involved the reeducation of the patient within a proper moral atmosphere,” but, in truth, the term “moral” seems to apply as much to the intentions of physicians as to the program of care they employed. Regardless of the origin of the term, however, most early

39 Hurd, et al., p. 68.
40 Braceland, p. 12.
American asylums, the **Hartford** Retreat included, would be founded upon variations on this moral theme.

In Hartford, patients at the Retreat for the Insane benefited from such moral treatment, but that institution offered little relief to those who could not pay the high fees charged for board and medical care. By 1838, the state had become concerned about the plight of its poor, mentally ill residents and commissioned a census to “ascertain the number...and condition of the Lunatics in this state.” Alluding to ideas held since the founding of Tuke and Pinel’s asylums forty years earlier, the state proclaimed that “until comparatively recently, the insane were considered as lost to themselves and the world.” With the belated realizations that the mentally ill could suffer and that mental illness could be cured, the state acknowledged an obligation to ensure opportunities for treatment to the poor. In addition to completing the census, the committee was charged “to ascertain the best and most effectual means of relief, the amount of money necessary to be expended, for the establishment of such an institution as we might think necessary.” Finding 707 “insane and idiotic...poor living inside state borders, the committee urged “that provision by made by the State for at least one hundred and twenty patients.”

Though the committee praised the Retreat as an “unrivalled” curative institution, it saw little hope for sufficient accommodation of the poor in that facility, as it was governed at the time. The group cited the high cost of treatment at the Retreat, noting that often families **often** must withdraw their relatives **from** treatment before a cure is

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43 *Report...* 1838, p. 3.
achieved, as their funds are exhausted. Though the Retreat opened its doors to “those who are blessed with [economic] competence... to those who have been less favored of heaven, as far as wealth is concerned, its doors are effectually closed.” Added to the question of pure economics was one of governance. “Shall the contemplated institution be connected with the Retreat?” the committee asked, answering in the negative, “The class of patients for whose benefit it is mainly intended, must be supported, in a great degree, at public cost. It should therefore be under the control of the State.” Despite this insistence on direct state governance, the committee acknowledged the possibility that “by placing both establishments under the same medical superintendence (sic), some expense will be saved,” and the state facility would benefit from the expertise and experience of Retreat physicians. By the following year, however, a new committee charged with investigating the question of cooperation had returned a judgment in favor of full independence, asserting that “a separate and distinct institution under the entire control of the State, will possess pre-eminent advantages.”

Crucial to this discussion is the question of class: the State, here, acknowledged an obligation to provide for the poor, claimed a role of authority in dictating the conditions under which they will be supported, and made it clear that it would not intrude upon the proprietary rights of the Retreat to both enforce its own rate structure and dictate the terms of admission. Though the 1838 committee seemed hopeful that a new state institution might draw upon the estimable record of the Retreat, it never considered that

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45 Report... 1838, p. 16.  
46 Report... 1838, p. 16.  
the Retreat could be asked to open its doors to “the most unfortunate of an unhappy race.”

By 1839, the state committee had decided that cooperation would not serve the best interest of the state, and the Senate resolved to offer $5000 to the town of Middletown for the purchase of a site. When the legislature failed to act upon this resolution, the General Assembly considered the question again in 1841, with much melodrama. “A voice breaks in upon our ears,” the document’s author intoned, “inquiring where are your penniless maniacs? Manacled and incarcerated in dungeons, their very ravings admonish us, that until these chains are severed, and the door opened for their restoration, our work in the cause of humanity is not complete.” Their resolution followed immediately: “Resolved. That a committee of one from a county.. shall.. select and establish a site for an Asylum for the indigent and pauper insane of this State,” appoint a building committee, draw necessary funds from the state treasury, and erect an asylum.

The decision to construct an independent state asylum seems firm in this document but, appended to the report, without editorial comment, appeared a letter from the director of the Retreat for the Insane. Addressed to the Connecticut legislature, the letter suggested that the Retreat would accept a share of the burden of caring for the indigent and pauper insane. “The object,” the directors wrote, should be to alleviate the greatest amount of suffering.. at the least expense to the State. With this view, the Directors of the Retreat for the Insane, propose to

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50 Report.... 1838, p. 16.
52 Connecticut General Assembly, 1841, p. 12.
receive all *Insane Poor* belonging to the State... at a less expense than they can be supported at a separate asylum. In a significant shift of attitude, the Retreat had agreed not only to open its doors to the state-supported poor but also, it seems, to admit them at a slightly reduced rate. The final paragraph of this 1841 General Assembly Report accepted the offer by the Retreat, contradicting the resolution that preceded it. “Resolved,” it reads, “that all indigent persons, citizens of the State, and proper subjects for such an institution, shall be received and supported at the Retreat for the Insane, for a sum not exceeding two dollars and fifty cents per week.” The fee, at the time, for private patients was generally three dollars per week.

What had caused this change of heart on the part of the Retreat? As recently as 1840, the directors had written of the inadvisability of offering discounted accommodation to the poor. “It would be... unjust to appropriate any portion of the funds of the Retreat to the charitable maintenance of poor patients,” they had explained, “for in that case it would be necessary to charge others more than is expended for their exclusive benefit. [By] taking such action[,] we should tax misfortune to relieve penury.” Though unwilling to reduce the charges for care, however, the directors did seem willing to take in publicly supported patients. They optimistically suggested that the state should be “looking to the public for that aid, which, in this enlightened age of liberality, the public will cheerfully grant.”

Perhaps this same “enlightened liberality” had struck the souls of the directors of the Retreat. It is also likely, however, that they were attracted by the

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possibility that the state might be induced to fund an expansion of the facilities on their campus. A line, casually slipped into the letter to the legislature, suggests “that said [state] commissioners be further authorized to erect additional accommodations for the insane poor, if found indispensable.”

Though expectations may have been high, money does not seem to have flowed freely from the state treasury. In the report of 1843, the directors reasoned that, by sending the poor to the Retreat, “the State will save the expense of land, and avail itself of the enlarge experience of the physician and other officers of the Institution, without cost. All we ask is buildings, or means to erect them.” By the following year, the Retreat seems to have abandoned the call for building money, refocusing its criticism on the lack of willingness by the State to sufficiently support the patients it sent. Though criticizing this shortsighted state policy, the directors mixed their criticism with optimism: “a spirit is abroad,” they wrote,

...which will break from the public mind the fetters of a false policy [of removing patients before a cure is achieved], and nobly illustrate the far-sighted wisdom of its economy, and the depth and sincerity of its humanity, by furnishing sufficient provision for the restoration or relief of all its insane poor.

In the eyes of the Retreat, then, the state, having failed to fund the construction of new buildings to house the insane poor, was also failing to fund sufficiently the cure of those same patients.

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56 Annual Report, 1840, p. 11.
58 Annual Report, 1843, p. 5. A short summary history included in the annual report of 1873 confirms that the state failed to fund a building project, explaining that the Retreat “received a considerable number of the insane poor for a small compensation, [and] other buildings were erected, chiefly by its own funds, but partly from the public treasury.” Forty-Ninth Annual Report of the Officers of the Retreat for the Insane, at Hartford, Conn. Hartford: Case, Lockwood and Brainard, 1873, p. 49.
59 Annual Report, 1844, p. 11.
This question of financial responsibility and the level of state funding would continue to color the relationship between the Retreat and the state until 1870, when the last state patient would be removed to the new Connecticut Hospital for the Insane. Economics concerns alone, however, cannot account for all of the mounting tension in the relationships of the two parties to this marriage of convenience. Throughout the 38 years of state patients at the Retreat, the physicians and directors of that institution would express concern about the threat that state patients posed to the functioning and the reputation of that facility. Questions of medical treatment would merge with concerns about institutional reputation, as Retreat officials merged scientific ideas with social theory to form a pseudo-scientific hybrid that would provide the rationale for eventual separation. In the end, the Retreat would react to concerns about class, choosing a social path the belied its medical ideals and rededicating its efforts to the mental health treatment of the wealthy.

AN UNEASY PEACE

From the beginning, the superintendents and physicians of the Retreat drew attention to the reluctance of Americans to seek early treatment for their mentally ill relatives. Medical theory of the era held that insanity was a progressive disease. “In the early stage of the disease,” explained Hartford Retreat superintendent Dr. Amariah Brigham, in 1842, “there is only disordered action of the brain and this can generally be cured, and the organ suffer no injury.” Early intervention, however, was critical, for “if this disordered action is long continued, it usually causes the disorganization of the brain,
and renders it forever incapable of properly manifesting its functions.

In its early stages, then, mental illness caused disruption of the function of the brain; if untreated, illness would progress, causing changes in the structure of the brain and making a cure impossible. Early treatment, then, was essential.

In the early years, Retreat physicians emphasized the need for early and sufficient treatment for both poor as well as the wealthy but also displayed a willingness to assist “old cases,” those in which mental illness first manifested itself at least one year before hospital admission, as well as “recent cases,” where onset of the disease began more recently. In 1831, superintendent Eli Todd described, in melodramatic terms, the benefits of the Retreat for recent cases. Boasting of a cure rate of nearly 91% in such patients, Todd wrote,

> it becomes the patrons of this Institution to be glad when they see their efforts leading so many fellow mortals from the dark regions of insanity to mental illumination, to happiness and to usefulness. The tree which they have planted has already begun to bring forth fruit, and its vigorous growth gives promise of harvest which will be more and more abundant, so long as the human mind continues subject to those frailties which make shipwreck of reason.

Though he waxed most poetic in that discussion, he did not ignore the benefits that the Retreat provided to old cases. “Even these,” he wrote, “have received no common benefit from the institution. They have been kept from harm-while their friends and relatives have been spared from anxieties which exceed all others...” Not only did members of these two groups of the mentally ill benefit then from treatment at the Retreat, but the Retreat appeared fully committed to caring for both recent and old cases, with its superintendent taking pride in the broad range of the services provided in his institution.

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60 *Annual Report, 1842,* p. 15.
By 1846, four years after the first state-funded patient passed through the gates of the Retreat, that commitment began to waver. The "leading object" of the Retreat, the directors wrote, "should be to cure those insane persons who have not become incurable; to relieve while their malady is yet recent, and to restore them speedily, this preventing their disease from becoming chronic and recovery almost hopeless." The impetus for this statement was public criticism of the high cost of services at the Retreat. "If this were a poor-house," the directors reported, "if the insane could be restored to reason in a poor-house,- the expenses could be reduced." Needing to distinguish the Retreat from a purely custodial institution, the directors chose to underscore their commitment to cure the mentally ill, not merely warehouse them, justifying the increased cost on that basis.

Despite its innocent beginnings, however, this idea of the Retreat as an institution dedicated to cure would come to form the rationale for the exclusion of the poor. Beginning from a reaction to social criticism, officials at the Retreat would develop medical theories that they would use, ultimately, to justify the exclusion of the chronically mentally ill from the facility.

Initially, discussion of the distinction between old and recent cases included no concern, implicit or explicit, about class. In the same report that first suggested a concentration on recent cases, superintendent John Butler reiterated the Retreat's commitment to serving the poor as well as the wealthy. "There are many families whose limited income depends upon the daily united effort of its several members," Butler

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61 Annual Report, 1831, pp. 5 and 4.
62 Annual Report, 1846, pp. 5-6. Twenty five pages later, the directors seem to contradict this statement, with this call: "let ample provision be made [by the state] for the immediate treatment of every case of recent insanity, while those which are hopeless and incurable, may receive that care and kind attention which is necessary to their comfort." Even here, however, emphasis is placed on the cure of recent cases, if not to the exclusion of the housing of old cases.
wrote, “who by patient industry and economy are enabled to meet their current expenditures, but have not the ability of providing, to any great extent, for the emergencies of protracted disease.” To these indigent sufferers, “the State brings timely and paternal aid... . Thus too the self-respect and independence of the patient is preserved.”

Despite this appreciation of the plight of the indigent and the benefit of state aid, Butler’s praise reveals an awareness of class as an element affecting the life of the Retreat. He sympathetically noted the hardships suffered by the indigent, but made no reference of what the state called the “pauper insane,” those whose financial situation was always dire. Such a distinction is not one simply of finances: it implies a moral judgement, as the indigent could be considered poor through no fault of their own, whereas paupers comprised a permanently reduced class whose failure to thrive was often believed to reflect a deficit of character. In 1848, this judgement about who rightly belonged to the “worthy poor” became more explicit, when the annual report applauded the granting of state aid “to those whose frugal industry ensures them an independent competency in health, but who cannot meet the diminished income and increased expenses caused by such sickness without embarrassment.”

Such a distinction proved crucial to the state and the general public, as well as the Retreat, as families applying to the governor seeking aid for ailing relatives emphasized the high character of their relatives. Of Sophia Morgan, “a fit and proper person to be supported at the Retreat,” a sponsor wrote, in 1842, that “her sons are very industrious and worthy young men,” who have supported their mother but who require “all their

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63 Annual Report, 1846, p. 29.
64 Annual Report, 1848, p. 20.
earnings to support themselves and their families. Another young man was described as coming from “a highly respectable family and nothing short of necessity would induce them to consent that John should receive the aid I am about to ask.” The high character of an older man was emphasized as his sponsor wrote that he was, “except at these times [of mania], a sober, industrious, hardworking man and provides well for his numerous family.” And a “Mr. Piper” appears in these collected letters simply as “a man of unexceptionable moral character, industrious and frugal.” Though both the state and the Retreat repeatedly stated their humanitarian commitment to removing the most long-suffering mentally ill from confinement in town almshouses, both seem to have made an effort to discern the worthy poor, indigent but industrious, from the great mass of unworthy pauper poor.

In 1848, a new awareness of the Retreat as an aging institution yielded new concerns about the place of state patients at the institution. Two years earlier, two new wings had been added to the main building of the Retreat, adding 144 new rooms, including six “parlor suites,” to the facility. The inclusion of these parlor suites, providing luxurious accommodation in multi-room apartments for those who “would choose to pay for them,” reveal early suggestions that the Retreat was positioning itself to attract wealthier patients. However, as architecture alone would not raise the quality of Retreat care, the directors noted the need to integrate new therapies, incurring greater

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65 “Letter from RS. Hirman and others de Mrs. Sarah (sic) and Insane Woman.” (no date, filed in 1842 folder) Connecticut State Archives (CSA): Record Group 5 (RG5): Applications for State Aid, Indigent Insane 1842: 1843-45; Box 100A, Folder 1.
66 Lewis Weld to Governor Cleveland, February 8, 1843. CSA: RG5: Box 100A, Folder 1.
67 Oliver S. Wattles and Edward A. Stary to Governor Cleveland, Norwich, June 8, 1843. CSA: RG5: Box 100A, Folder 1.
68 John Howe to Governor Baldwin Birmingham, November 13, 1845. CSA: RG5: Box 100A, Folder 1.
costs. The directors believed, they wrote, “that the time will soon come, if it has not already, when more attention must be given, and expense incurred, in establishing and carrying out systems of moral treatment, than has been done here, hitherto. What is now done elsewhere will demand it.” The Retreat had become aware that mental health care was becoming a competitive business and that, in order to compete in the new market, it must adjust to changing standards.

Already, at this time, there appeared implications that state patients were holding back the Retreat. Though the directors did not suggest any limitations to the admission of state patients, it did emphasize its primary role as a curative institution. “To make the benefits of the Institution accessible to the indigent,” the directors wrote, “should be our aim in all our economical arrangements.” This broad commitment, however, was not the most important consideration. Instead, “the more important object—the recovery of the patient, and his restoration to his friends, and to usefulness in society, should be kept constantly in view.” That these two objectives—the serving of the indigent and the recovery of all patients—are not antithetical makes their juxtaposition all the more significant. By opposing “the indigent” with “the patient,” the directors implied that they consider their private patients their primary constituency. Though they were unwilling to disinherit the poor, they revealed a preference for the wealthy. Through the explicit discussion concerns improving the quality of the Retreat through the incorporation of more expensive therapies, the subtext suggests movement away from egalitarianism. Within a few years, the disapproval of state patients would become more explicit.

71 Annual Report, 1848, p. 6.
72 Annual Report, 1848, p. 7.
73 Annual Report, 1848, p. 7.
The next year, the directors for the first time connected class, economics, and medical theory, faulting the state for filling the halls of the Retreat with old cases. Though in the annual report of that year the directors congratulated the public health commitment exhibited by the state in “the increasing number of admissions,” they warned that there are also “some considerations... which excite other, and less grateful reflections,” namely, the commitment of large numbers of old cases. The directors laid blame with the state—not for funding the care of old cases, but for failing to provide aid to those sufferers before their ailments became incurable, citing a “false economy” that saves short-term dollars but incurs great long-term costs, both human and financial.74

Though, here, explicit criticism of state policy charges ignorance of state-of-the-art medical theory and shortsighted, miserly economics, it introduces an opportunity to link class and medical theory more directly. Over the next several years, this argument would fester below the surface of the discussion of medicine and economics. Soon, the directors of the Retreat would begin to equate state patients with chronic patients, laying the groundwork for the decision to eventually exclude state patients entirely.

First, however, the Retreat would turn its attention to developments in institutional design, comparing its aging facility with that of new hospitals sprouting across the country. “In these days,” the directors warn,

it will not answer to trust to past success. A few years have made great changes... The plainest accommodation of any well ordered Hospital at the present day, is far more comfortable and efficient than the wealthiest could procure for their insane friends a little more than a quarter of a century since. Within a few years a number of new Lunatic Hospitals have been constructed in the United States... with... all those improvements which the experience of the past has produced, and these for the convenience, comfort and efficiency, are not surpassed in the world.75

74 Annual Report, 1849, p. 15.
75 Annual Report, 1851, p. 22.
The world of mental health treatment was changing, and the primacy of Hartford’s Retreat for the Insane was challenged. Founded as a model institution, having enjoyed (or, more accurately, claimed) the highest cure rates in the world, and having earned the admiration of physicians throughout the country, the reputation of the Retreat was slipping as new institutions outshone its brilliance. The Retreat required renovation and improvement, but first, it needed the funds to make such changes possible. Improvements, the directors wrote, “implicate an increased expenditure which this Institution does not at present possess the means of meeting.” As they could not look to the state for such funding, the directors announced that they “must look abroad for such means to the liberality of that community to whose beneficence the Retreat owes its existence.” In differentiating “that community” from the state, the Retreat drew upon its legal status as a self-governing institution and began to redefine its definition of its constituent population. With a compelling need for increased income and an intransigent state apparatus refusing to fund improvements, the directors of the Retreat felt free to redefine their commitments. In time, those commitments would no longer include an obligation to serve those without independent means.

BREAKING WITH THE STATE

The year 1852 proved pivotal in the reevaluation of the relationship between Retreat and state. In that year, the physicians and directors of the Retreat combined mounting concerns about overcrowding caused by a buildup of old cases with

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76 Annual Report, 1851, p. 23.
the previously acknowledged awareness of growing market competition, forging a new framework of analysis that moved considerations of class to the center of discussion.

For the first time, in 1852, the medical visitors included an element of criticism in their annual report. Though generally satisfied with life at the Retreat, this group explained,

we could not fail to observe, that while their (the “inmates”') numbers were considerably increased... the character of the class of patients admitted, was not altogether unexceptionable. Not a few of them are, in our opinion, incurable; and of these a considerable proportion belong to the class who are supported from the State appropriation.”

Though context suggests that the first use of the term “class” implies a distinction between curable and incurable patients, its second use clearly refers to socio-economic status. To remedy this, the visitors suggested that “early provision be made, to accommodate a larger number of the hopelessly insane, by erecting a building, every way suited to their wants.”* Though the visitors were directly suggesting the segregation of curable patients from the incurable, the theoretical linkage of incurable patients with state aid suggests that such a new facility would, in large part, isolate the poor from the wealthy as well.

Though few mental health professionals in the United States questioned the need to segregate the mentally ill in asylums, the question of whether to segregate incurable cases in separate facilities remained contentious within the psychiatric community at least through the 1850s and 60s. In 1854, Thomas Kirkbride, the unchallenged American authority on the design of asylums, questioned the practice, warning that “the first grand

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78 Report of the Medical Visitors, Annual Report, 1852, p. 7
uncurable; and to condemn any one to an institution for this particular class is like doomizing him to utter hopelessness.” Kirkbride worried, as well, that lower standards would reign at such custodial institutions. “Once resigned to receptacles specially provided for them,” he argued,

all experience leads us to believe that but little time will elapse before they will be found gradually sinking, mentally and physically, their care entrusted to persons actuated only by selfish motives-the grand object being to ascertain at how little cost per week soul and body can be kept together... 79

The great majority of other physicians and medical theorists concurred with Kirkbride’s assessment, with one superintendent calling the idea of creating separate asylums for incurables a “mere pretense of philanthropy-the base coin of benevolence.”* In its increasing efforts to exclude incurable patients, the Hartford Retreat would prove to be out of step with most mental health professionals. Responding to social concerns about the social implications of caring for poor patients, the Retreat lost step with the mainstream of medical theory.

In the same report of 1848, the medical visitors of the Retreat revealed an awareness of class as significant not just to the population of the Retreat, but to its reputation as well. “The importance of securing increased accommodations for patients of a more cultivated, refined and wealthy class, has been considered by us,” they wrote. “We think it not difficult to perceive, what position our Retreat must take in public estimation, unless provision suited also to the wants of this class, their habits of living, their tastes, and means of support, is also made by the Directors.”81 In the eyes of the

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80 Letter by Dr. Hanbury Smith, Ohio Lunatic Asylum, published in the periodical Mental Hospitals, 1855, p. 22.
medical visitors, the future success of the Retreat could best be served by the segregation of state-aided, incurable patients from wealthy, private patients. Such a solution would not only reduce crowding at the institution but would “maintain the character of our own, as a first class institution for the insane.”

Dr. John Butler, superintendent of the Retreat, seems not to have shared these sentiments. In the Superintendent’s Report, he did not contradict the medical visitors’ statement of overcrowding; indeed, he included population statistics that chart a steady rise from 1843 to 1852, with the number of patients doubling during that time. Rather than link overcrowding with an excess number of incurable or state-supported patients, and rather than suggest that the Retreat consider renovations that would attract wealthy, educated patients, Butler expressed pride in the Retreat’s role in rescuing two “pauper cases” from the despicable treatment they had suffered in almshouses. Though years of chaining had caused both to lose the use of their legs, Butler wrote, “they swing themselves about on their hands!” Though both were considered incurable, he continued, “both are cleanly and as regular in all their habits as any of that class (of incurables) in the institution!”

Though he did not address the recommendations of the medical visitors directly, Butler implied greater sympathy for the plight of the “pauper insane” and demonstrated a continued willingness to devote some of the resources of the Retreat to their humane treatment.

Analysis of an early account book from the Retreat reveals that the institution was, indeed, beginning to fill with state-supported patients. By 1844, two years after the Retreat first began to accept state-supported patients, one third of the patients were

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already receiving aid from the state treasury. By 1851, the last year to include complete and clear data, the state-supported population had risen to 47%. However, even in 1851, less than 10% of the Retreat’s residents were funded totally by state money; for the great majority, families paid one half the cost of board and treatment. In addition, though state-supported patients paid $3.00 per week, private patients rarely paid significantly more. The great majority paid between $3 and $4, though two paid $10 per week and one woman, inexplicably, paid $39. Though overcrowding may have been becoming a problem, the account book suggests that the finances of the Retreat were not adversely impacted by this state of affairs.

While officials at the Hartford Retreat struggled to control the population of their facility, administrators of asylums in other states faced the same challenges. Studying the Brattleboro Retreat, historian Constance McGovern discovered similar concerns about overcrowding at an institution that shared the Hartford Retreat’s private status but public responsibility. McGovern chronicles a decline in the quality of care at the Brattleboro Retreat during the first fifty years of its operation, during which time “the hospital had moved from routinely curing the insane to merely incarcerating them.”84 Rather than fault the hospital, McGovern blames the state of Vermont for warehousing incurable patients and failing to fund their care sufficiently, reserving criticism, as well, for the public, who “increasingly viewed the asylum as a ‘convenient place for inconvenient people.’”85 Overcrowding, underfunding, and the subsequent decline in the quality of care nearly destroyed the Brattleboro Retreat, which was able to rebuild its reputation only after the state constructed a new asylum for incurable patients. Though McGovern

finds honor in the resurrection of the Brattleboro Retreat after the removal of state patients, she seems to have conducted no research into the quality of care offered to the chronically mentally ill at the new state institution. Like the directors of the Hartford Retreat, McGovern is concerned only with the status and reputation of a private institution, not the overall care of New England’s mentally ill.86

In 1853, the medical visitors of the Retreat for the Insane at Hartford devoted almost half of their lengthy report to the theme of class, repeating their call that the Retreat re-orient itself in an effort to attract the wealthy. This time, they called for the erection of suitable buildings, with such apartments and appurtenances, as will meet the wants of that class of patients, who at home have been accustomed to all the comforts and luxuries which wealth could command, and the appliances which ingenuity and refinement could suggest.87 That the Retreat had few such wealthy or refined patients at the time caused little concern, as ‘Pet such apartments be furnished...in buildings erected with the express object of accommodating this class of patients, and in our opinion they will soon be filled’.88 And, by attracting and serving this new class, they claim, “not only will the taste and wishes of the most fastidious friends be gratified, but the resources of the institution will be increased, and thereby the field of her usefulness extended, far beyond

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85 McGovern, p. 215.
86 The Brattleboro Retreat has an outstanding collection of nineteenth-century annual reports from across the country. They are shelved in the office of the CEO and, while they are ostensibly available to researchers, access seems limited by the territoriality of this official. I spent a few hours reading 19C annual reports from the Brattleboro Retreat, but the CEO was disapproving of the unsightliness of this researcher climbing ladders in his antechamber. The situation of the Brattleboro Retreat in the 1860s stands in stark contrast to that of the Hartford Retreat, with the former institution expressing pride in its commitment to provide comfort to all comers, even the most incurable old cases and detailing its program of physical labor. Considerations of length and scope prevent further discussion of the differences.
the present limits. They did not specify how such an increase of fortune and influence would occur.

This time, the medical visitors enjoyed the support of the Board of Directors, whose members shared their concerns about the reputation of the institution. “If not the first,” they wrote, “ours was one of the first Institutions in this country, . . . for many years, it had few, if any rivals, and no superior in any particular.” Times, however, had changed. “Everywhere [asylums] have been constructed with the utmost care,” the directors wrote,

and no pains have been spared to make each successive effort exceed all preceding ones. . . . It is not to be disguised, that many of these Institutions are perfect palaces—erected and furnished also, with the most careful reference to the minutest wants of their occupants.90

In the eyes of the directors, the impetus for such changes had grown not from advances in medical theory, but from the changing circumstances of American life. “Communities are growing rapidly in wealth and refinement,” they wrote.

they are becoming increasingly exacting and fastidious. The habits of our citizens are, many of them expensive and luxurious; their mode of life, rendering them more and more exposed to diseases of a nervous character, which jeopardize reason, and even life itself. They are constantly requiring the accommodations of our Institutions for the Insane; and what, I ask, will friends of this class be most likely to do with a relative who becomes insane?

The answer seems obvious: they will send their friends to “one of our modern magnificent hospitals,” rather than to one like the Retreat, “one of far less pretension, which may cure indeed their suffering friend, as well, but which can not minister to any. . . of his luxurious habits.”

89 Report of the Medical Visitors, Annual Report, 1853, p. 12
By 1853, the managers of the Retreat also shared concerns about the place of their hospital in the increasingly competitive world of mental health care. However, because this group held responsibility for the financial viability of the institution, its members refused to endorse a proposal for an extensive building campaign. The managers boasted of accommodating “all suitable patients for whom application has been made,” save “many incurables whom the towns... have sent us.” Looking back to the founding documents, the managers found justification of such a course in the dedication of the Retreat “for the relief and recovery of the insane.” As incurable patients could not, by definition, benefit from “relief and recovery,” they could not justifiably be refused treatment, the managers argued. Hence, though the managers plotted a more conservative course, refusing to endorse the construction of new buildings until money could be laid aside and a formal study of the needs of the wealthy completed, they expressed sympathy with the cause proposed by the medical visitors and participated in the decision to exclude publicly funded, incurable patients.

It is significant to note that the report of 1853 was conceived and written while superintendent John Butler conducted a six-month tour of “many of the most prominent Lunatic Hospitals in England and Scotland.” In Butler’s absence, Dr. E.K. Hunt, Though the evidence suggests that Hunt was the architect of plan to disengage the Retreat from the state, research into his background reveals a man with broad, and seemingly sincere, philanthropic commitments. He served for 25 years as physician for the Asylum for the Deaf and Dumb, president of the Young Men’s Institute, master of the Industrial School for Girls at Middletown, and a member of various Hartford school committees. Though he reveals a preference for involvement in organizations that enforce the imposition of middle-class values on those who might otherwise resist them, broader involvement with the schools (his
chairman of the Medical Visitors, took the role of acting superintendent, and it is in his 
name that the report of the Board of Directors appears. It is likely that this shifting of 
roles and this repositioning of influence account for the broad enthusiasm expressed in 
the annual report of 1853. Upon his return Butler again seized the reigns of power, 
rededicating himself to significant improvements in the facilities of the Retreat but 
remaining committed to serving the poor as well as the wealthy.

Butler returned from Europe bursting with enthusiasm for the quality of 
institutions on that continent. “In the new Institutions,” he wrote,

. . . I found a beauty of structure with a thoroughness and perfection of 
arrangement, which I have never seen equaled elsewhere. . . . It was evident that in 
these new Asylums no pains or needful expense had been spared to obtain, in the 
first place, the most unexceptionable plans.96

Citing the beauty and utility of spacious grounds, the generous appointment of social 
rooms, and the variety of opportunities for “manual employment.”97 He quickly secured 
an appropriation of $8000 from the Legislature and began what would become an 
extensive series of improvements to the buildings and grounds. Butler appeared to echo 
the sentiments of Hunt and others when he called for improvements to the Retreat, 
finding justification in the charitable nature of Americans. “In this ready recognition of 
the wants of the insane,” Butler writes,

society is rendering to them (hospitals for the insane) a duty demanded both by 
humanity as well as policy. This will not be satisfied by the mere erection of

daughter graduated from Hartford Public High School), city sanitary commissions (fighting a cholera 
epidemic) and Hartford Hospital suggests at least some sincerity of purpose. For information on Hum, see: 
Russell W, Gurdon, “Draft of Address delivered at dedication of the Hum Memorial Building, Hartford.” 
1898? Also see: “Obituary of Ebenezer K, Hunt, M.D., Hartford, CT by Gurdon Russell, MD.” Reprinted 
from Proceedings of the Connecticut Medical Society, (no date, no publisher).
97 Here, Butler is referring not to purposeful, physical labor but to such hobby-related activities as 
embroidery and woodworking.
buildings, however extensively it may be done, but will also demand a liberal provision for those internal equipments and appliances of treatment.\textsuperscript{98} However, where Hunt and his supporters suggested that such improvements were necessary primarily for their utility in attracting the wealthy, Butler emphasized his dedication to the mental health needs of all people, regardless of class. Even the poor and violent, he writes, "\textit{are none the less observant of any deficiencies in the comforts or convenience of their accommodation, or of the attention and courtesies of their attendants.}" Laying to rest the question of whether the Retreat should concentrate its attentions on the wealthy, Butler offers a blunt conclusion: "In our arrangements for the most unfortunate of all our classes, nothing therefore should be \textit{wanting.}\textsuperscript{99}

For the next five years, the question of class would remain invisible in the annual reports of the Retreat, Hunt and his fellow elitists silenced by Butler’s firm hand. The report of 1855 joyfully describes the beautification of the grounds and praises the new female lodge as "\textit{perfectly simple, plain, and rigidly economical in its finish.}\textsuperscript{100} The report of 1857 emphasizes the "\textit{cheerful} and homelike” atmosphere in the Retreat as a whole. Though many of the improvements could be described as raising the level of luxury at the retreat—a greenhouse, a museum, a bowling alley—never does any writer suggest a narrowing of the patient population or an emphasis on attracting the wealthy. Indeed, in 1856, Butler again expressed his commitment to a broad range of patients, contradicting the managers’ earlier insistence that the Retreat offer preferential admission to recent cases, noting the “great duty of improving... the condition of that large class, which, thought beyond the hope of cure, is nevertheless capable of very great

\textsuperscript{100} \textit{Annual Report,} 1855, p. 32.
improvement." Where Hunt and others had minimized the claim that the incurably mentally ill placed on the Retreat and dismissed that population by equating it with the poor, Butler here insists that the officers of the Retreat have an obligation to all the mentally ill, incurable as well as curable, poor as well as wealthy.

While Dr. Butler stood back from questions of class during these years, the subject played a central role in studies conducted by other states. In 1855, the Massachusetts house ordered a study of “insanity and idiocy” in the state, with special attention to the status indigent and pauper populations. The commission produced an exhaustive report that filled over 200 pages and became the benchmark by which all other studies would be measured.

In Hartford, the Retreat for the Insane complained about the special challenges posed by state patients, but it never published statistics on their numbers. The Massachusetts commission, by contrast, placed considerations of class and ethnicity at the forefront of their study. Extensive charts classify “lunatics in Massachusetts” by both “pecuniary condition—Independent and pauper,” and “nativity-American and foreign,” a category which they subdivided into “Irish” and “other.” Not surprisingly, given the anti-Irish climate that predominated in the industrial northeast, the commissioners discovered a preponderance of “pauper lunatics,” largely Irish, in the state’s institutions. Also not surprisingly, they found these Irish most likely to be classified as “excitable—troublesome” or “furious-dangerous” than their American counterparts. To the Massachusetts commissioners, the implications were clear. “Poverty,” they explained,

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101 Annual Report, 1856, p. 22.
102 Report on Insanity and Idiocy in Massachusetts by the Commission on Lunacy. Boston: William White, 1855, “Table V; Pauper Lunatics in Hospital, &c.” p. 47.
is an inward principle, enrooted deeply within the man, and running through all his elements; it reaches his body, his health, his intellect, and his moral powers, as well as his estate... Hence, we find that, among those whom the world calls poor, there is less vital force, a lower tone of life... There is also less self-respect, ambition and hope, more idocy (sic) and insanity, more crime than among the independent. 103

Poverty, it seems, was as much a result of flawed genetic inheritance and character as of circumstance. The commission took special exception to the Irish, who “form many impracticable purposes, and endeavor to accomplish them by unfitting means, “thereby suffering doubt and harrowing anxiety,”104 that led, ultimately, insanity. Though officials of the Retreat never suggested that the poor were morally responsible for their own insanity, they were developing their analysis of class and mental illness at a time when such beliefs were enjoying wide publicity.

The Massachusetts commission was especially disturbed by the cost of funding the treatment of such foreign sufferers, who enjoy “the blessings of our hospitals to a greater degree than has been allowed to our own children,”105 and proposed novel solution. Where others had suggested the segregation of the wealthy from the poor, this group suggested, instead, segregating the “native lunatic” from “lunatic strangers.”106 Where the Retreat constructed an argument that successful treatment of the rich required catering to their whims, the Massachusetts commission looked at segregation as a social mandate, calling the rich and poor “unfitting and unacceptable to each other... instinctively separate.”107 More deeply significant than pure economic distinctions, however, lay differences of nativity. Where native Americans, regardless of

103 Report on Insanity... p. 52.
104 Report on Insanity ... p. 62.
105 Report on Insanity... p. 65.
106 Report on Insanity... pp. 66 and 68.
107 Report on Insanity... p. 146.
wealth, shared a moral heritage, recent immigrants “never, even in health, had sufficient ambition, or energy, or command of circumstances” to integrate themselves into American culture. These foreigners could survive in “plainer and cheaper accommodations... than would be proper for the average of the other patients—the members of the families of the farmers and mechanics of Massachusetts.”

Though the ideas of the Massachusetts commission differ greatly from those expressed by officials of Hartford’s Retreat for the Insane, the two groups hold common beliefs. Most significant is their agreement that segregation is necessary. Though the two parties disagree on which classes to separate from each other, given the wide distribution and strong influence of the Massachusetts report, it is likely that forceful expression of ideas about segregation by nativity created a psychological space in which Retreat officials could more freely explore theories about segregation by class. Also important is a shared belief that low economic status and incurable insanity were linked. Here, again, the Retreat adopted a more cautious path, linking the two primarily by implication. For the Massachusetts commission, incurability was caused not only by delayed treatment but by the “imperfectly organized brain and feeble mental constitution” endemic to those recently arrived on American shores. Though no one at the Retreat ever embraced such an overtly racist theory, it is again possible that such

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108 Report on Insanity..., p. 150. Other significant studies were conducted in New York and California; in both instances, class played a central role. Also, psychiatric texts of the era discussed the link between poverty and insanity, most positing a dialectical relationship between the two. Considerations of length and focus prevent a full discussion of these sources. For the New York and California reports, see: Wilkins, E.T., M.D. Insanity and Insane Asylums. Report of E. T. Wilkins, MD., Commissioner in (sic) Lunacy for the State of California, Made to His Excellency H. H. Haight, Governor. 1871, and Willard, Sylvester D., M.D. Report on the Condition of the Insane Poor in the County Poor Houses of New York. Albany: Chas. Van Benthuysen, 1865. For a medical discussion of the link between poverty and insanity, see: Henry Putnam Stearns. Insanity: Its Causes and Prevention, NY: G.P. Putnam’s Sons, 1883, especially chapter XIII: “Poverty,” pp. 199-208.
extreme expression in the Massachusetts report allowed the Retreat to advance its milder theories without fear of contradiction.

While theorists across the country discussed the link between class and insanity, new concerns faced Hartford’s Retreat for the Insane. In 1859, despite recent state appropriations totaling $14,000, the Hartford Retreat found itself on unstable economic ground. Chartered by the legislature as an independent corporation, it suffered doubly from the confusing status of its financial status. In other states, new public institutions enjoyed generous government support, with Massachusetts contributing $729,000 for the establishment of three state hospitals and New York investing over $650,000 in a single facility at Utica. In Connecticut, such handsome support was not forthcoming, as the state viewed the Retreat as a private entity. Because of the original charter, however, members of the potentially philanthropic public viewed the Retreat as a state hospital, assuming that it was amply supported with tax dollars. As a result, donations were scarce and “the blessings of Divine Providence upon the spirit of Christian philanthropy” proved insufficient to support the Retreat through the inflationary cycle of the 1850s.

Responding to these financial pressures, the directors of the Retreat complained in 1859 about the insufficiency of state rates, linking them implicitly to overcrowding and the challenges of old cases and calling again for the dedication of the Retreat to a wealthy population. “In the state institutions around us,” they write,

... the indigent insane have properly the precedence. The Retreat, on the contrary, takes a different position. While it extends to this class every accommodation in its power... with an unrivaled liberality, it also recognizes the great duty of making ample and suitable arrangements for the treatment of that large class

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10 Report on Insanity... p. 56.
11 Annual Report, 1859, p. 28.
whose previous habits of life lead them to require a more luxurious and abundant accommodation.  

Though the directors claimed to celebrate the idea that state support enables the Retreat to “extend its sphere of usefulness”  

By 1861, John Butler and the directors of the Retreat had inaugurated a private fund-raising campaign, attracting over $11,000 in donations in its inaugural year, as well as the contribution of numerous books, paintings, and elegant furnishings. The annual report of that year detailed the gifts and their owners, providing reinforcement for those whose philanthropy might be increased by publicity, and requested an additional $12,000 in donations for a conservatory, a melodion, and new libraries. To emphasize the utility of donations to the Retreat, Butler looked back to rhetoric that appeared in the earliest editions of the annual reports. “Insanity,” he warned,  

Though emphasizing the universality of the threat of mental illness, Butler focused that threat on the fears of the wealthy, suggesting that donations to the Retreat could, in the future, benefit them directly.

At the same time, Butler drew attention to overcrowding at the Retreat, revealing that the Retreat felt overwhelmed by the number of old cases attempting to enter its program. “The first great object of the Institution,” Butler stated for the first time, “is the

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113 Annual Report, 1859, p. 22.
114 Annual Report, 1861, p. 32.
restoration of the Insane to health. The recent and curable cases have the first claim for admission, be they rich or poor, from the state or from abroad. Though his final phrases suggest an egalitarian outlook, Butler soon equated old cases with state-funded patients. "There are old and incurable cases enough in the State," Butler writes, probably enough in its alms-houses alone, absolutely needing the care of the Institution, to fill the Retreat to its utmost capacity. Should these be admitted, the Retreat must become a simple Receptacle, and all recoveries cease. Though Butler leaves room for the inference that some incurable cases are not supported by the meager state appropriation, he sees no reason to detail their situation relative to the Retreat. Butler, too, had come to equate old cases with state patients.

By 1861, then, the Retreat had begun to position itself for change. In its fund-raising campaign it began to attract the support of independent benefactors. In its suggestions that overcrowding was the result of the warehousing of incurable patients, it laid the foundation for a justification of their exclusion. In its implicit equation of incurable patients with those receiving state support, it began to develop the argument that preserving the Retreat as a curative institution required disentanglement from the state. And, in 1861, John Butler began to hint that such a separation represented the best course, for the state as well as for the Retreat. Commenting on the seemingly endless number of mentally ill still living in almshouses, he stated, the remedy for this state of things is evidently not within our reach. We have not the means either to enlarge the Institution or erect a new one. It remains for the State of Connecticut to decide whether she will be content with the insufficient accommodations we are enabled to afford, or, imitating the example of her sister States around her, furnish from her ample means, proper accommodations for all the Insane within her borders."

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117 Annual Report, 1861, p. 15.
Though Butler was not specific about what he envisioned such “proper accommodations” to entail, he wrote from frustration with the growing number of incurable, state-supported patients filling the Retreat, and at a time when other states were committing significant resources to the establishment of state hospitals for the mentally ill. Here, then, Butler was not calling for an expansion of the Retreat; rather, he was hinting that the state consider building its own facility.

**FINAL SEPARATIONS**

In 1865, Butler’s implicit suggestion found explicit expression, and separation became the official policy of the Retreat. “What shall be done with the chronic and incurable insane, especially of the indigent class?” asked Butler. Finding the Retreat both full and incapable of “providing suitable care” for such people, he insisted that “both humanity and economy.. .demand some prompt and sufficient action.” Butler praised the states of Massachusetts and New York for founding public institutions and suggested that Connecticut follow their example: “The propriety of establishing an institution for incurables.. .should be considered.” 18

This decision to take a stand in favor of separation grew from the fact that, by 1865, the financial situation of the Retreat had become dire. Economic dislocations caused by the war had lead to increased costs for supplies and salaries, as well as late

18 Annual Report, 1865, pp. 16-17. Emphasis in original.
payment by the state.\textsuperscript{119} The state had continued to send patients to the Retreat, but had ceased paying for their treatment.

Butler did not stop at the simple recommendation that the state build a hospital. Instead, he developed a complex and creative analysis of the economics of mental health treatment, offering it as justification for this new course. Though costs had risen and payments fallen the public, it seems, continued to be critical of the perceived high cost of care at the Retreat. Rather than defend its rates, Butler used this criticism to support his recommendation. “The question naturally arises,” he explained, whether such a class of patients (as the incurable and indigent) should pay as much as those who require more care as well as more expensive treatment.” He answered in the negative, defending the high rates charged to private patients expecting luxury at the Retreat, but suggesting that “neither justice nor humanity requires the state to expend large sums of money upon persons who can not be benefited \textit{thereby}.”\textsuperscript{120}

In Butler's view, this new state institution, by virtue of serving a different population, could embrace a new form of therapy. Through a program of manual labor, Butler suggested,

\begin{quote}
those dull and dormant minds, dozing for years in silence and stupidity, may be aroused, may be woke up to new life and energy. Those torpid, unused, and consequently feeble muscles, may be gradually brought into use, be limbered \textit{first} and strengthened. \textsuperscript{121}
\end{quote}

Where future patients at the Retreat would require luxury and elegance, state patients would benefit \textit{from} physical labor, as befit their class. Conveniently, such a program would offer even greater rewards, Butler explained, as “the labor of such patients may be

\begin{footnotes}
\item[119] The situation was more critical in other states, where states paid their bills to hospitals not in cash but in scrip.
\item[120] Annual Report, 1865, pp. 20 and 21.
\end{footnotes}
so employed as not only greatly to benefit them but to seriously diminish the cost of their
support.”122 Not only would a state institution be inherently less expensive to construct
and run, but its patients could be counted on to subsidize their own care.

The following year, the directors of the Retreat began to denounce state-supported
patients with unprecedented vigor. Citing overcrowding, the directors again blamed the
state. “The class of patients, the chronic and the indigent, from which this excess mainly
comes, makes it still more objectionable, and still more pernicious in its effects.”123 They
note the difficulty faced by towns in “keeping one or more filthy, noisy or dangerous
pauper lunatics,” implying that the Retreat could accept no obligation to serve such a
distasteful population. Finally, they call upon “that better class who with higher motives,
accept the universal obligations of that ‘pure religion and undefiled,’” to bestow “the best
gifts of a wise christian (sic) benevolence” upon a new state institution.

Historian Gerald Grob has analyzed shifting understandings of class in
discussions of mental health care throughout the United States, identifying the source of
that shift in the changing patient demographic. In the early days of asylum care, Grob
claims, “superintendents and patients for the most part shared a common cultural and
religious heritage.”124 As immigration increased, however, and the American population
became more heterogeneous, the ideologies that developed among the upper classes
necessarily sifted into considerations of proper asylum management. Before long,
systems of classification that had separated patients into groups on the basis of symptoms
and behavior had, without conscious consideration, yielded to “a system partly based on

121 Annual Report, 1865, p. 23.
122 Annual Report, 1865, p. 22.
123 Annual Report, 1866, p. 20.
socioeconomic characteristics, for they often employed social, educational, cultural, and religious criteria for classifying patients. Where earlier emphasis had been placed on segregating, for example, violent and noisy patients from the more cooperative, by the 1860s, the crucial distinction seemed to lay in class.

Though little evidence on the socioeconomic status of Retreat patients survives, applications for state aid for the insane suggest that the demographic shift in Hartford might be less dramatic than that experienced elsewhere. Though, by the 1860s, Connecticut cities had experienced a great influx of recent immigrants, applications for aid written in 1866 show little variation among potential patients from the Yankee stock that had filled its wards from the beginning. Of the fifty-one surviving letters of application, only five potential patients have names that can immediately be identified as foreign. In addition, the great majority, with surnames like Talcott, Hoskins, and Scribner, came from small towns, rather than the cities that had experienced the greatest influx of immigrants. In addition, most letters were written by town selectmen, rather than relatives, implying that these people had established sufficient residency to incur the sympathy of town officials who, if their petitions were successful, would share the cost of care at the Retreat. These records, then, suggest that Grob’s thesis does not explain new ideas about class as they developed at the Hartford Retreat, where the population seems to have remained stable despite demographic changes in the outside world.

Nevertheless, the Retreat remained committed to the exclusion of state patients from its halls and, by 1867, its officials were overjoyed, celebrating the recent charter of

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125 Grob, p. 226.
the Connecticut Hospital for the Insane. “I congratulate the State,” wrote John Butler, “upon its decision to discharge this duty to these, its suffering children, by the immediate erection of a State Lunatic Hospital” for “the large class of indigent insane who look to the State for succor.”127 Serving a population with lower expectations, this new institution could afford to charge lower rates than the Retreat, as its “larger wards admit of a less number of attendants and a diminished expense.”128 Meanwhile, the Retreat could dedicate itself to serving a clientele of a higher class, ushering in “a new era in the life of the Retreat, freeing it from its embarrassments.”129

Contained within this report is the most highly developed class-based argument to date. With state patients resettled in a state institution all their own, the Retreat would reveal the philosophy that would guide its future. Its directors looked to “hotels, [and] watering places,” rather than hospitals, for a model, noting that each of these private facilities was dedicated to serving only one class of clientele. Similarly, they argued, hospitals for the mentally ill should specialize. Successful treatment, they explained, required that every patient be put at ease by “all those essential, and not injurious or excessively costly indulgences which previous habits, tastes and even prejudices may require.” Fortunately, they continued, such high levels of luxury were not required at a state facility serving the indigent. “Certainly,” they suggested, “it is evident that the more ignorant, unrefined and uncultivated do not require the same surroundings and appliances as the intelligent, cultivated, and refined.”130

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126 These names include three Bridges, a man named Patrick, and a man with the surname of Garraghty. See Applications for Aid, 1866, Box 102.
127 Annual Report, 1867, p. 15.
128 Annual Report, 1867, p. 15.
129 Annual Report, 1867, p. 16.
130 Annual Report, 1867, p. 33.
would provide basic care in a spartan environment, the Retreat would rededicate itself to serving “first, the wealthy; and secondly, indigent persons of superior respectability and refinement.”

By 1870, construction of the Connecticut State Hospital for the Insane was complete and the last state-supported patient had been moved from Hartford to Middletown. Substantial renovations occupied the attentions of officials at the Retreat, and the annual report of 1873 included a foldout engraving of the new main building. “We believe,” the directors boasted, “that no institution in the country is more perfectly and thoroughly ventilated, and if not in every respect a model institution, that there is none other in the country or elsewhere, which possesses so many comforts and conveniences.” The formerly “plain and factory-like-looking building” had been reborn “into a beautiful home-like structure, more resembling a country residence of a private gentleman that a public building or a hospital.” Though for several years officials of the Retreat had displayed a steadily decreasing commitment to serving the poor mentally ill, once the removal of state patients was complete, John Butler felt comfortable enough to express the full measure of his disdain for poverty. “You are opening the doors,” Butler wrote, addressing the board of directors, “to a class whose sufferings from mental disease were most acute, whose necessities of care were most urgent, and whose restoration to health and usefulness were most important.” Not only were the needs of the wealthy more extensive; not only was the cost of their care correspondingly higher; and not only, even, was the suffering of the wealthy more acute.

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132 Annual Report, 1870, p. 5.
133 Annual Report, 1870, p. 20.
134 Annual Report, 1870, p. 27.
The wealthy, in Butler’s judgment, were inherently more important than the poor. In this statement, the rededication of Hartford’s Retreat for the Insane reached its ultimate and most candid expression.

**INDEPENDENCE**

The Connecticut Hospital for the Insane was built to be “a model of strength, durability, and perfect adaptation to its objects.”

Constructed at a total cost of over $347,000 to house 450 patients, its architect claimed never to have seen a building built “with greater economy.” Within two years it was full and, despite the superintendent’s “untiring zeal, watchfulness and exertion in behalf of the great public charity,” its trustees requested additional funds for operating expenses and expansion. Despite the move to an institution designed to be less expensive to operate, the state paid $4.50 per week for the board and treatment of each patient and, by 1870, it was already doubting “whether the labor of the insane [could] be made pecuniarily profitable.” As a model of ideal fiscal management, the Connecticut Hospital for the Insane was not a total success.

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136 Second Annual Report... p. 18.
137 Though the report states that the building would house 450 patients, after two years there were only 250 living at the hospital and the board of trustees was requesting funds for expansion. Nevertheless, when trying to justify the cost of the Connecticut Hospital, it compared its construction costs with those of other state hospitals, calculating a per-patient cost based on a capacity of 450. The annual report of 1870 makes mention of “two wings, according to the original approved plans.” It seems likely that the original architectural plans included a building that could house 450, but only one section of that building was constructed.
138 Second Annual Report... p. 17.
140 Second Annual Report... p. 3 1.
The Retreat, newly emptied of state-supported patients, did not meet with the success it had anticipated, either. Within a few years, its directors were boasting of having transformed the “small, bare, uncomfortable, cheerless, and poorly ventilated rooms and dormitories” into “an institution well nigh perfect in all its appointments.”

Dreams of dramatically raising the cure rate by purging the Retreat of old cases, however, proved illusive. Though the percentage of chronic cases does seem to have declined, the cure rate declined as well. In 1873, new superintendent Reginald Denny noted the admission of 145 patients whose illness had not lasted more than three months, but a recovery rate of only 51 per cent among those patients. According to Denny, this dismal recovery rate reflected not the failure of the Retreat but an unfortunate fact of psychiatric outcomes. “In proportion to the advances in the social and intellectual endowments of those admitted,” Denny explained,

there is a corresponding decrease in the percentage of recoveries, in comparison with that class which is wholly supported at the public expense...one reason is that education is attended with greatly increased activity of the mental faculties, with consequent danger of overstrain or indulgence.

Though Retreat officials had developed an argument that stressed (if speciously) a return to the historic dedication of the Retreat to the cure of the recent insane, and though it had predicated its removal of state patients on the need to rid the institution of chronic patients, Denny claims that the lower cure rate enjoyed by the wealthy was “a fact well understood by those conversant with the subject.” If Denny is correct in his assessment, then the rhetoric used by officials of the Retreat to exclude state patients rests

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142 Annual Report... 1873, p. 5
143 Annual Report... 1873, p. 11.
144 Unfortunately, at this point the Annual Reports cease to provide charts that classify patients by the length of their illness before admission.
145 Annual Report... 1873, p. 20.
at best on ignorance, at worst on a lie. Even if Denny is incorrect, and the “fact” of lower recovery rates for the wealthy was not well known, then the truth remains that the re-dedication of Hartford’s Retreat for the Insane failed to accomplish its principle, acknowledged objective: curing insanity. Despite fancy buildings and a program that catered to the expectations of the wealthy, the Retreat proved less able than ever to cure mental illness. 147

In 1842, the Retreat had made the decision to accept state-supported patients for two reasons. First, knowledge of the cruel conditions of confinement suffered at home and in town almshouses by the mentally ill who could not afford treatment weighed heavily on the hearts of the physicians and directors of the asylum, leading them to transform sincere charitable concern into concrete action. Charity, however, was not their only motivation. Economic self-interest also influenced their decision, as hopes for increased state aid inspired officials whose institutional fortunes were limited by the hybrid status of the Retreat.

Ultimately, from the point of view of the Retreat, the egalitarian experiment proved a failure, and separation seemed the only solution as changing circumstances and ideas merged in muddy confluence. Scientific emphasis on the importance of early treatment, a guiding tenet of asylum care, began to intersect, as early as 1830 with concerns about class, specifically the connection between the class of the patients and the reputation of the Retreat. After 1842, as the state placed more and more of the

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146 Annual Report... 1873, p. 20.
147 It failed, as well, to achieve the financial it had sought. By 1873, 25% of patients could not afford to pay the full cost of their care, and the Retreat was soliciting private contributions to subsidize its work. In this failure, Denny claimed a position of honor, claiming that by accepting not only the very wealthy but also members of “that larger class, refined, educated, sensitive, accustomed to the luxuries of life” but not just then able to part with large sums. Annual Report... 1873, p. 211

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chronically mentally ill in the Retreat, this institution, dedicated to curing mental illness, feared that it was becoming a warehouse for “old cases,” people whose misery could be lessened but who could not be cured. Rather than confront this question of length of illness directly, officials of the Retreat crafted a framework of analysis that combined science with economics, equating chronic mental illness with poverty and suggesting that the only escape from the downward spiral they identified was separation from the state.

As those ideas developed, officials at the Retreat became acutely aware that the construction of new asylums across the United States was introducing new standards for asylum care and increasing competition for private patients. Though, as late as the 1860s, Retreat superintendent John Butler attempted to apply new ideas about mental health treatment to a broad population, even he, in the end, came to identify such a course as ultimately insufficient. Instead, he joined the lead established by the medical visitors, calling for separation from the state and the rededication of the Retreat to the care of the wealthy. Only in that way did they believe that the Retreat could reclaim a position of honor and prestige in the asylum world. Again, social ideas, rather than medical theory, took precedence.

Finally, financial problems arising from the economic dislocations of the 1850s and the Civil War increased tension between the state and the Retreat, as prices for goods and services rose and payments for care fell. Unable to maintain an appropriate standard of care in the absence of adequate payment, the Retreat chose the most drastic course, recommending separation rather than working with the state to solve the problems they shared.
The decision to expel state patients from the Retreat for the Insane did not happen suddenly, and no single circumstance forced this institution to choose an exclusionary course. Though medical thought about the curability of mental illness stressed the importance of early treatment, officials of the Retreat interpreted that scientific idea in social and economic terms, associating chronic mental illness with poverty and using this connection to justify a narrowing of commitment. In addition, social bias on the part of those same officials led them to equate first-class care with an upper-class clientele, defining success at the Retreat as the ability to provide the most luxurious accommodations to the wealthiest patients, rather than the ability to provide the most good to the broadest group. And, finally, financial tensions between the Retreat and the state created the justification for a break.

Though the physicians and directors of the Retreat strove to present their arguments in medical terms, their thinking was, in truth influenced more by their concerns about the social standing of the Retreat-and, by implication, themselves-than by pure scientific thinking. Few clear landmarks marked the course from inclusion to exclusivity. Instead, subtle shifts in emphasis allowed medical, social, and economic arguments to flow together as officials of the Retreat reacted to changing external circumstances and personal prejudices. In the end, science did not lead the Retreat to define a new course. Instead, its directors were driven by social and economic ideas that led them to interpret science to meet their goals. The result was an institution that not only expelled the poor but also congratulated itself for the social contribution of its formal and explicit dedication to the mental health care of the wealthy.
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