“The Weight of Perhaps Ten or a Dozen Human Lives”: Suicide, Accountability, and the Life-Saving Technologies of the Asylum

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SUMMARY: By accounting for the law’s productive capacity to structure asylum physicians’ encounters with suicide, this essay argues that the antebellum asylum was a technology for the preservation of life. The essay first shows how suicide’s history as a crime encouraged popular attributions of suicide to insanity. What began as a tactic to protect survivors, however, ended by bolstering the professional claims of asylum medicine. Initially it appeared there was much to gain from claiming suicide as their own, but dominion over prevention in fact rendered asylum physicians and their staffs vulnerable in unanticipated ways: for while agents of suicide were effectively evacuated of legal responsibility, a variety of laws made physicians more accountable than ever. Focusing on medical superintendent Amariah Brigham and his staff at the New York State Lunatic Asylum shows how the anxiety of assuming guardianship over the suicidal created networks of accountability that profoundly affected daily life.

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Once each week, Connecticut physician Ebenezer Hunt searched for suicide. Using the Mercury, and Weekly Journal of Commerce, he tabulated 184 cases that occurred between October 1843 and October 1844.1 After

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organizing the dead according to age, residence, civil condition, and remote and proximate causes, Hunt then sent his analysis by post to Amariah Brigham, medical superintendent of the New York State Lunatic Asylum at Utica and inaugural editor of the newly minted *American Journal of Insanity*. The note that accompanied his findings expressed hope that the synoptic sketch of popular death notices would reveal patterns that could, in turn, inform more effective measures for prevention. Suicide, after all, was “the occasion of much painful solicitude to those to whom the immediate guardianship of the insane is entrusted”: the staff of insane asylums across the nation.² Brigham agreed—and then took action. Over the next five years, he and his medical assistants thumbed through dozens of New York papers to create suicide studies of their own.³

More immediately, however, he published his own article alongside Hunt’s in the third number of the *Journal*. Brigham’s article began with the sad tale of one Mr. ____, whose death by suicide Brigham had discovered in the *New York Commercial Advertiser*. At the coroner’s inquest, the brother of the deceased admitted that Mr. ____ had indeed seemed sometimes despondent, but not so despondent as to “call for particular attention.”⁴ Brigham expressed surprise that this brother, like so many others, chose not to “interpose and secure these unfortunate individuals from the too often fatal consequences of their disease.”⁵ Finally, he juxtaposed the brother’s negligence with case studies describing how several suicidal individuals had been saved by residence at Brigham’s asylum. Some had been admitted to the asylum by family, others by officers of the state. In all cases, however, the implication was clear: Brigham and his staff, buttressed by the life-saving power of the asylum, were uniquely situated to prevent suicide.

The exchange between Brigham and Hunt highlights revealing convergences of popular culture, medicine, and the law that are worth exploring. As Jan Goldstein hypothesized two decades ago, psychiatry has been a particularly apt case study for uncovering the historically specific ways in which the disciplines have interacted with the law.⁶ Subsequent

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². Ibid., 232.


⁵. Ibid.

scholarship has gone far toward documenting this complex relationship as it developed in the courtroom: the development of the medical jurisprudence of insanity, the increasingly common deployment of the insanity defense in the criminal realm, and the growing emphasis on mental competence in the civil realm are all examples of the ubiquitous effects of this alliance. As Susannah Blumenthal has persuasively shown, the symbiotic relationship between jurists and mental disease specialists in the early American republic created a distinct legal universe in which mental capacity became the defining characteristic of accountability. Work in the history of suicide has shown that debates over how, whether, and to what extent the state should govern an individual’s right to die served as a powerful precedent for grounding legal irresponsibility in adjudged mental incapacity. A surprising array of historical actors strategically mobilized medical knowledge to resist, alter, or infiltrate the juridical.

One of the more important contributions of this scholarship has been to demonstrate the many paths along which psychiatry interacted with the juridical across the long nineteenth century. At the same time, however, allopathic physicians in particular faced what Ted Porter has called “rising standards of accountability.” Medical practitioners did not just contribute to the creation of a new legal universe based in mental competency through expert testimony and works of medical jurisprudence. As revealed


8. Blumenthal, “Default Legal Person” (n. 7), 1141.


by the history of tort law—the ways in which courts determine responsibility for harm in civil proceedings—they also populated this universe as accountable legal persons. The coexistence of a legally sanctioned medical model of suicide and the fact of physicians newly responsible to the law opens the question of how these phenomena may have interacted beyond the space of the courtroom. That is, what did it mean to be a “default legal person” who assumed guardianship over a legally irresponsible, yet potentially suicidal individual? What did it mean to be accountable for another’s suicide? This essay focuses on the ways that asylum physicians accommodated and integrated this increased burden of responsibility, because many were legally compelled to do so. How might this accountability have circumscribed possibilities for this particular class of practitioners, or habituated them to certain ideas and practices?

Answering these questions requires that we consider the law as something both more and less than a repressive, monolithic leviathan that is diametrically opposed to the productive power of discipline. Traditionally, these have been understood as “two great paradigms of power,” the coexistence of which presents a significant problem for historians of medicine and of the human sciences more broadly. In this schema, the law becomes illustrative of a repressive, prohibitory power—it sets out that which individuals must not do. The disciplines, on the other hand, become illustrative of a creative, productive power that works by generating self-regulating individuals—they establish that which individuals must do. A focus on the subtler mechanisms of disciplinary power has produced a remarkable yield for historians of the asylum. It has, most importantly, allowed them to move beyond an inveterate debate between the social control model, on the one hand, and the humanitarian model, on the other. The first of these, perhaps most identified with David Rothman, framed the precipitous rise of the asylum in the Jacksonian and antebellum periods as a desperate play for power among a handful of professional elites made anxious by a shifting political and sociocultural landscape. Revisionist historians such as Gerald Grob and Nancy Tomes,
noting that the consolidation of professional power in many ways relied upon the existence of the asylum, argued for a more textured consideration of historical processes. They emphasized that many failures of the moral treatment movement could be explained by the unrealistic, utopian expectations of the first generation of superintendents. These and similarly nuanced institutional accounts opened the way for a third and more recent wave of historians who, armed with a critical eye toward the capacious work of disciplinary power, underscored the ways that asylum physicians solidified their authority through the performative benevolence of humanitarian work.


18. I use the term “technology” to emphasize the interrelatedness of knowledge, methods of inquiry, and their practical application.
the popular press’s tendency to ascribe suicide to insanity. They did so largely in response to suicide’s long history as a crime at British common law, the legal system derived from centuries of custom and judicial precedent and that ruled the United States in the absence of statute law. Thus conditioned, editors and reporters unwittingly provided Hunt, Brigham, and Brigham’s cohort with the raw data they needed to scientifically “prove” the connection between suicide and insanity. At least initially, it seemed that practitioners of asylum medicine had much to gain from “fixing” suicide in this way—a term with which I mean to indicate, first, the mapping and containment of individual corpses in place and time so as to constitute suicide as an object; and, second, the technologies with which asylum physicians sought to identify, restrain, and cure the suicidal individuals under their care.19

Yet having monopolized this behavior to the point that attempted suicide could—and often did—authorize involuntary commitment to an asylum, asylum physicians and their staffs found themselves vulnerable in perhaps unanticipated ways. The anxiety of assuming legal guardianship over the suicidal generated knowledge, influenced therapeutics, and affected architectural style. Fear of suicide was by no means the sole contributor to such decisions. Yet by attending primarily to the role of the dramatically noisy, the aggressively homicidal, and the violently psychotic, historians miss the significant ways in which the quiet, the melancholic, and the suicidal contributed to asylum life. Moving beyond the spectacular forms of insanity, we see that even the most unobtrusive and docile patients informed every moment of every day. As one physician phrased it, the burden of the suicidal was one that “only those can fully comprehend and appreciate, who have had the weight of perhaps ten or a dozen human lives hanging at the same time upon their responsibility.”20 Even as it contributed to an institution’s social and physical environments, this burden also disciplined all individuals who, at one time or another, inhabited them. It created networks of accountability that included not only medical practitioners and ward attendants, but also carriage drivers, cooks, and even the patients themselves. Particularly in the context of new ideas about legal accountability, suicide had a profound impact on asylum life.

This essay pays particular attention to the network of accountability constructed at the New York State Lunatic Asylum at Utica, which Brigham

superintended from its opening in 1843 until his death in 1849. Though I also attend to broader developments in asylum medicine, there are several arguments to be made in favor of focusing our gaze in this way. First, Brigham showed greater interest in suicide than many of his fellow superintendents. It was also under Brigham’s editorship that the *American Journal of Insanity* contained the first medical enumerations of suicide in the United States. More broadly, however, New York was the first state to write assisted suicide into statute law as a crime, and it was in the western part of New York that the early malpractice “crisis” of the 1840s was most acute. Taken together, these peculiarities make Brigham an exemplary case study for thinking about suicide, accountability, and the life-saving technologies of the asylum.

“A Singular Verdict”: Suicide and Common Law

The popular tendency to ascribe suicide to insanity reflected not ontological concerns but, rather, a long history of practical negotiations with the law that had been under way for at least two centuries. Before the 1600s, Western Europeans largely conceptualized suicide as both a religious and a secular crime. As representing a transgression against God, the corpse of a suicide was often subjected to posthumous acts of desecration and ignominious burial. Suicide was also a felony at law, and the property of suicides determined to be “felons unto themselves” (*felo de se*) was vulnerable to confiscation by the state. Such property forfeiture, however, fell out of favor during the seventeenth and eighteenth centuries. Contemporaries noted that it did nothing to punish the dead; rather, it simply left surviving family members destitute. To shield the latter from the pecuniary difficulties attendant upon forfeiture, coroner’s juries drew on a newly developed medical model of suicide. In England, for example, juries increasingly returned verdicts of *non compos mentis* (“not in sound mind”) rather than *felo de se*. Although this “privilege of legal irresponsibility” was experienced unevenly across social classes, historians have suggested that the medical model’s ascendance led to more tolerant societies in which suicides and their families were treated with increasing compassion.

21. The quotation in the heading is from “Suicide,” *Daily Cleveland Herald*, June 24, 1856.  
Yet suicide remained a crime according to British common law, the legal custom that ruled the colonies and the newly formed United States. Traditional punishments migrated unevenly to the North American colonies, so, too, the traditional protective strategy of coroners and their juries. Burial rights were often governed separately from property forfeiture, which reflected the distinction between punishment for suicide as a religious crime and punishment for suicide as a secular crime. The colony that would become Massachusetts, for example, abolished property forfeiture in 1641 and 1701, respectively, though Massachusetts also instituted a 1661 statute requiring ignominious burial for those who committed suicide while in sound mind. During the Revolutionary era, however, official lenience toward suicide became one way for colonial governments to distinguish themselves from their British counterparts. By 1792, seven states had prohibited forfeiture, though they remained silent on the question of ignominious burial and posthumous desecration.

The trend toward decriminalization accelerated across the first decades of the republic’s existence as the act and its agents were increasingly explained as the province of allopathic physicians specializing in mental disease. Thus it was that temporary insanity—or partial mental derangement, or a momentary aberration of mind—came to serve as an important interpretive framework during the antebellum period. This was true to the extent that members of the popular press openly critiqued communities

23. Bell, We Shall Be No More (n. 17), 18–24.
24. Ibid., 18.
26. Kushner argues that punishment fell out of practice before the Revolution. Kushner, American Suicide (n. 22), 30–31. For a nuanced consideration of the laws relating to suicide, see Marzen et al., “Suicide” (n. 25), 63–99, 148–242. Like Kushner, these authors note likely discrepancies between the law and its implementation.
that still enforced forms of punishment traditional to British common law. When a young woman hanged herself in Fish Creek Mills, Virginia, for example, the local community refused to bury her in the churchyard. The New York Herald, reprinting the news from a Wheeling paper, contemptuously added that “the superstitious people” had the body “interred at the cross roads, in accordance with a heathenish custom and an obsolete law.” 27 Even a verdict of felo de se unaccompanied by posthumous desecration or ignominious burial was enough to rouse the surprise of the antebellum press. 28 In these and similar cases, the press both drew upon and contributed to a growing consensus that suicide should no longer be considered either a religious or a secular crime.

Thus antebellum newspapers became a de facto coroner’s office in which the act of suicide and its agents might be adjudged. Analysis of more than 2,300 suicide notices that appeared in 130 English-language newspapers reveals the quotidian yet revealing ways that the law’s legacy structured the subtle narrative work of reporting suicide. More often than not, the tendency to attribute suicide to insanity evidenced a desire to protect survivors. As contemporaries noted in response to sporadic demands to reinstitute traditional forms of punishment, the suicide was beyond the reach of both social and legal judgment. 29 The ramifications of punishment would fall only upon the friends, families, and associates of the dead, regardless of how a community might feel about an individual’s act of suicide. “Pity [the suicide] not,” urged one, “but pity those living, whom he hath made wretched and unhappy by the act.” 30 A designation of monomania or temporary insanity was particularly effective because it simultaneously acquitted both the agent of suicide and the survivors. When a Bostonian cut his throat with a razor, for example, a Lowell paper attributed his suicide to a “species of insanity” brought on by a long journey and the resultant feeble health. 31 The man’s essence—that is, his reason and will—was thus thrice removed from the act of suicide: it resulted

28. “Suicide” (n. 21).
from temporary insanity, which resulted from illness, which resulted from
too-extensive travel. At the same time, however, the temporality of this
model was such that acquaintances, friends, and families could perhaps
be forgiven for not noticing lethal potential in time to prevent it.

When Hunt, Brigham, and Brigham’s medical assistants looked to a
print culture conditioned by common law, then, it is perhaps no surprise
that they found exactly what they had been looking for. They did not
intentionally ignore other data sets; rather, a paucity of official numbers
compelled them to this methodological decision. Despite a long-standing
interest in enumeration, municipal and state processes of death regis-
tration in the United States became regularized synchronically with the
Utica suicide studies. This resulted largely from the efforts of sanitary
reformers, who argued that identifying cause of death was imperative
and should be recorded alongside the traditionally collected identifica-
tory markers. Amassing and analyzing such data would, in turn, allow
sanitarians to more fully comprehend morbidity and patterns of disease
transmission; it might also allow them to develop more effective measures
by which to combat prevalent diseases such as cholera, smallpox, and yel-
low fever. In New York, the state in which Hunt, Brigham, and Brigham’s
staff labored, the legal code did not change until 1847. Even then, it
accomplished very little; official enumerators soon abandoned the new
collection requirements altogether.

The informal networks of newspaper editors and reporters, on the
other hand, were more successful. Reporters regularly trolled the streets
in search of sensational tidbits, and they just as regularly stopped at clerks’
ofices, coroners’ offices, and police stations. This mobility allowed report-
ers to draw upon hearsay and eyewitnessing in addition to official docu-
ments such as police reports, coroners’ findings, or inquest testimony. By
the 1840s suicide notices had become a fundamental element of antebel-
lum print culture. Notices were particularly conspicuous in the dailies

32. Robert Gutman, “Birth and Death Registration in Massachusetts: II. The Inauguration
of a Modern System, 1800–1849,” Milbank Memorial Fund Quart. 36, no. 4 (October 1958):
373–402. On public health developments in New York, see John Duffy, The Sanitarians: A
34. During the period when Hunt, Brigham, and Brigham’s medical assistants worked,
the New York city inspectors continued to rely on physician reporting for mortality statistics.
Sage Foundation, 1968), 307, 310, 312.
and weeklies of the northeasterly states where Hunt—and, in the years to follow, Brigham and his assistant physicians—lived, worked, and tabularized. They ranged from page-one stories to those that occupied nearly a full column, single sentences buried among advertisements, and nothing more than a mere number in a coroner’s weekly summary. Depending on format, a notice might incorporate remarkable biographical detail within a sensationalized account of the days leading up to the death and the act of suicide itself. A notice was just as likely, however, to offer simply the name and death instrument of an agent of suicide. A coroner’s tabulation was typically devoid of even these minimal identifying details, recording only the fact that a suicide had occurred.

The structure of suicide notices varied widely, but the sheer volume in the antebellum press made it a useful source for enumerative investigation—and so it was that the makers of the Utica suicide studies turned to the popular press. Their reliance on the popular to create scientific knowledge was innovative indeed. Though historians have suggested that these studies were largely recapitulations of municipal and state death records, this could not be further from the truth. While they did not ignore official data completely, the men who produced the studies recognized the incompleteness of official mortality counts. Furthermore, suicide stories were also just that: stories. While state, municipal, and federal enumerators focused on tangible and immediate causes of death—a gunshot, for example, or arsenic poisoning—the popular press often added the ultimate causal attributions that official enumerators jettisoned. Reporters’ tendency to ascribe suicide to temporary insanity dovetailed neatly with the professional goals of asylum medicine. This is not to say that the medical enumerators were not also tentative. Hunt in particular showed a keen awareness of the unique difficulties attendant upon his method.


36. Kushner, American Suicide (n. 22), 42–45. Kushner approaches the studies primarily as an early iteration of the urbanization thesis later immortalized in Durkheim’s On Suicide (1897). He suggests that the findings were reflective of census data, refers to the authors as simply “the editors,” and suggests that popular reports “confirmed” the studies. Similarly descriptive accounts also appear in James H. Cassedy, American Medicine and Statistical Thinking, 1800–1860 (Cambridge, Mass.: Harvard University Press, 1984), 159, which addresses the causes to which asylums attributed suicide; and Liah Greenfeld, Mind, Modernity, Madness: The Impact of Culture on Human Experiences (Cambridge, Mass.: Harvard University Press, 2013), 554–59, whose approach is epidemiological.
He cautiously acknowledged his discomfort with the tacit influence of
ewsgathering and reading practices; indeed, he devoted a full paragraph
to various equivocations. The common practice of reprinting, he acknowl-
vedged, would require enumerators to account for “the number copied
from one into the other.” Furthermore, it was likely that more systematic
attention to the popular press would reveal infinitely more suicides. “We
certainly have no right to infer that because one weekly newspaper has
furnished a record of 184 suicides, that every other contains an equal
number,” he wrote.

Ultimately, further studies relied upon institutional resources that
were, in turn, reliant upon the financial support of New York state and
the generosity of newspaper editors. Within a month of receiving Hunt’s
letter, Brigham mobilized the resources of his institution to begin a
count of his own. The asylum offered, first, an overwhelming amount
of reading material. This meant, on the one hand, that the medical staff
had constant access to the printed works of their European contempo-
raries. On the other, editors regularly mailed fresh copies of newspapers
and periodicals to Utica. Year after year, the asylum received an eclectic
mix of material that provided the Utica studies with a remarkably broad
sample from across the state. The titles range from the expected to the
more surprising: the New York Sun and Utica Gazette appear, of course, but
so, too, the Knickerbocker Magazine and the Missionary Herald.

38. Ibid., 231.
39. The annual reports from this period, which can be found in Box 1 of record group
1479-96 at the New York State Archives in Albany (NYS A), are the best source for this. The
asylum’s accounts record, also at NYS A, list only the amount spent on newspapers, rather
than specific titles. Amariah Brigham, “First Annual Report of the Superintendent of the
New York State Lunatic Asylum at Utica (February 1, 1844),” in Annual Report of the Managers
of the State Lunatic Asylum (Utica, N.Y.: Reprinted at the Asylum, 1861), 55; Amariah Brigham,
“Second Annual Report of the Superintendent of the New York State Lunatic Asylum at Utica
(November 30, 1844),” in Annual Report of the Managers of the State Lunatic Asylum (Utica,
N.Y.: Reprinted at the Asylum, 1861), 52–53; Amariah Brigham, “Third Annual Report of the
Superintendent of the New York State Lunatic Asylum at Utica (November 30, 1845),” in
Annual Report of the Managers of the State Lunatic Asylum (Utica, N.Y.: Reprinted at the Asylum,
1861), 60–61; Amariah Brigham, “Fourth Annual Report of the Superintendent of the New
York State Lunatic Asylum at Utica (November 30, 1846),” in Annual Report of the Managers
of the State Lunatic Asylum (Utica, N.Y.: Reprinted at the Asylum, 1861), 75–77; Amariah
Brigham, “Fifth Annual Report of the Superintendent of the New York State Lunatic Asylum
at Utica (November 30, 1847),” in Annual Report of the Managers of the State Lunatic Asylum
(Utica, N.Y.: Reprinted at the Asylum, 1861), 68–70; and Amariah Brigham, “Sixth Annual
Report of the Superintendent of the New York State Lunatic Asylum at Utica (November
30, 1847 [sic—1848]),” in Annual Report of the Managers of the State Lunatic Asylum (Utica,
N.Y.: Reprinted at the Asylum, 1861), 34–35.
of the subsequent studies drew on approximately fifty of “the principal and most widely circulated journals of the State,” to which the physicians “had constant access.” The asylum also proved invaluable by providing Brigham with (somewhat) eager enumerators. The labor necessary to scour hundreds of pages each week would have been remarkable, indeed. Certainly it would have been impossible for the superintendent to undertake on his own. As the staff shifted and grew, the task of tabulation continued to be relegated to the most junior assistant physician at the asylum: first to associated practitioner J. Edwards Lee, then to Charles Nichols, and, finally, to George Cook. The asylum provided the time, labor, and raw data necessary for continued inquiry.

From their unique data set, the makers of the Utica suicide studies drew a number of conclusions. By tabularizing the time of year in which the deaths had occurred, as well as the more common methods used to achieve it, the enumerators sought to answer the questions of how and when. They concluded that suicide was likeliest to result from hanging, throat cutting, or poison, and that the spring and summer months were deadlier than those in the autumn or winter seasons. In addition to tables that illuminated suicide as an act or behavior, each also sought to answer the more novel question of who by taking the agents of suicide as another—and, for our purposes, more crucial—unit of analysis. The subtle distinction between the act of suicide and the agents of suicide as object of study marked an important break: if an attribution of suicide to various temporalities such as day and month placed the root cause with the weather or the airs, a preoccupation with individuals shifted it to the very essence of persons—what we might call, after Michel Foucault, the “internal architecture” of an elusive suicidal object that was still embryonic in the antebellum period. Creating a type of person who was likeliest to die by suicide meant addressing such questions as mental state, age, gender, and residence. Hunt, Lee, Nichols, and Cook each confidently sketched the contours of a similar object: the likeliest candidate for suicide was male, not female, and he could be expected to die between the ages of twenty and fifty; it was also most common among married city dwellers.

Perhaps most telling, each also lent scientific credence to the popular affinity for ascribing suicide to insanity.\(^4^4\) Crucially, it was not the mere collection of ostensibly objective numbers that achieved this, but rather the wedding of data to particular interpretive commitments. The data fully realized suggested that the majority of suicides were, in the end, inexplicable. Of the 184 cases that Hunt analyzed, a full 101 had no cause assigned. The studies published in 1847, 1848, and 1849 produced similar results: in each case, unattributed suicides were comparable in number to, or outstripped, those attributed to insanity. The “obvious” connection that the enumerators cultivated had much more to do with the ordering of tabularized data—in which the unknowns were shifted to the bottom of the table despite numerical primacy—and the selective interpretation of the accompanying summaries. Despite their data, and in the interest of making suicide their own, the enumerators agreed that “suicide is generally one of the accidents of insanity.”\(^4^5\) They also, unsurprisingly, suggested that residence at an asylum was the best—perhaps only—way to guarantee the prevention of suicide. This small cohort of enumerators thus jettisoned the fundamental unknowability of suicide in order to make a case for their own therapeutic significance. What began as a tactical maneuver designed to protect survivors of suicide ended by protecting the professional claims of asylum medicine.

“Obliged to Receive All”: Civil Commitment Laws

Though the studies appeared under the authorship of Lee (1847), Nichols (1848), and Cook (1849), it was Brigham’s steady commitment that led to the enumeration, not theirs: the count continued for five years despite changes in staff, and their disappearance also coincided with Brigham’s death in 1849.\(^4^6\) Brigham’s abiding interest in the project was by no means inevitable, but he saw the project as a unique way to contribute to the study of mental disease and asylum medicine more broadly. When in 1846 he introduced the results of his medical assistant’s first study, he framed it with the reminder that “the conductors of such institutions should

\(^4^4\) Each included tables of causation, at the top of which was either mental derangement or insanity and melancholy. Hunt, “Statistics of Suicides” (n. 1), 227; Lee, “Statistics of the Suicides” (n. 3), 352; Nichols, “Statistics of Suicide” (n. 3), 250; Cook, “Statistics of Suicide” (n. 3), 307.

\(^4^5\) Nichols, “Statistics of Suicide” (n. 3), 252, emphasis original.

\(^4^6\) The quotation in the heading is from “Mortality in Lunatic Asylums,” Amer. J. Insan. 4, no. 3 (January 1848): 253–58, quotation on 253–54.
endeavor to contribute to the advancement of science,” not only to satisfy personal interest, “but for the benefit of our successors.” His earnest belief that suicide was a necessary and proper object of study had also been borne out two years earlier during the first, formative meeting of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII). Having just received Hunt’s study in the mail, Brigham arrived at the Jones Hotel with suicide on his mind and supported the formation of a special Committee on the Prevention of Suicide. Yet the association’s emphasis on prevention as a crucial function of the asylum also compelled Brigham to look elsewhere for the raw data necessary for his suicide studies. The tension between a desire to understand suicide, on the one hand, and a desire to claim professional expertise in thwarting it obliged him to follow Hunt’s methodological example and seize upon a sensationalized print culture for the corpses with which to develop a coherent, authoritative body of knowledge on death by suicide.

There was also, however, a more functional consideration that structured Brigham’s intellectual pursuit of suicide and his practical interest in its prevention—namely, the history of civil commitment law that helped to determine which patients arrived at his door. Because the authority to confine those deemed insane was rooted in British poor law and was codified in several states prior to the advent of a functional asylum system, jails and poorhouses were the primary site of detention well into the nineteenth century. New York’s first law, enacted in 1788, specified only that those who “by lunacy” were deemed too “dangerous to be permitted to go abroad” were to be “apprehended” and “safely locked up in some secure place.” This remained in place until an 1827 statute distinguished between insane and criminal subjects and specified that those deemed insane were to be either confined at home under the auspices of the overseer of the poor or confined via a contract system at the Bloomingdale Asylum in New York City. This changed yet again with the opening of the New York State Lunatic Asylum at Utica, which was fully under the auspices

51. Ibid., 420.
of the state and thus compelled to receive all individuals deemed simultaneously insane and a public charge. The 1842 commitment law—the law in operation while Brigham superintended the Utica asylum—specified that anyone deemed “furiously mad (or so far disordered in his senses) as to endanger his own person or the person or property of others, and that it is dangerous to permit such lunatic to go at large” should be sent to an asylum, preferably the State Lunatic Asylum, within ten days.52

So it came to be that Brigham, unlike his counterparts at privately funded institutions, was, as he himself complained, “obliged to receive all.”53 Though many were admitted by overseers of the poor or by family and friends as private patients, Brigham’s annual reports show a preoccupation with the legal compulsion under which he lived and worked by repeatedly arguing for “the uselessness of comparing results of treatment.”54 This statement evinces Brigham’s frustration with the annual reports of other superintendents who, as historians have shown, ritualistically evoked rates of recovery and discharge to assuage the concerns of state legislatures and the public more generally. So elemental for legitimation were these numbers that most annual reports led with them. Superintendents also often combined the quantification of cure with descriptions of the asylum that emphasized its domestic tranquility or opportunities for recreation, thereby eschewing an institution’s carceral function in order to avoid association with jails, prisons, and poorhouses.55 But, as Brigham argued again and again, private institutions were not compelled to receive “many of the very worst and most hopeless” with which he and his staff were forced to contend. Superintendents at privately funded asylums also could require that friends or family of a suicidal patient make special provisions to ease the burden of increased attention and care. In such cases, they might ask

52. “Form of Warrant of Commitment,” in Rules and Regulations Adopted by the Managers of the New York State Lunatic Asylum, at Utica (Utica, N.Y.: R. W. Roberts, 1842), 19; Dwyer, “Civil Commitment Laws” (n. 49), 83.
53. “Mortality in Lunatic Asylums” (n. 46), 254.
54. Brigham, “Fifth Annual Report” (n. 39), 26, emphasis original.
55. The most recent example is Porter, “Funny Numbers” (n. 10). Nancy Tomes discusses cure rates as part of a broader argument that annual reports were meant to engender confidence among the family and friends of patients, thereby encouraging them to patronize the new system. Nancy Tomes, “A Generous Confidence: Thomas Story Kirkbride’s Philosophy of Asylum Construction and Management,” in Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 121–43. For earlier interpretations, see Norman Dain, Concepts of Insanity in the United States, 1789–1865 (New Brunswick, N.J.: Rutgers University Press, 1964), 141; Deutsch, Mentally Ill in America (n. 50), 207–12; and Rothman, Discovery of the Asylum (n. 15), 130–33.
for extra monetary compensation to support an arrangement in which “the whole services of an attendant are devoted to a single person.” This class of superintendent also had the legal right to refuse admission to men and women deemed particularly dangerous. Brigham had no such luxury. As long as the institution had the spatial capacity to accommodate, he had no authority to turn away a patient who arrived with a warrant of commitment—regardless of how hopeless or dangerous the case appeared.

His cure rates, Brigham knew, reflected the power of the law and the power of therapeutics to an obnoxiously equal extent. In contradistinction to his general helplessness in the face of New York’s commitment law, the prevention of suicide proved to be a site at which, quite simply, his and his staff’s agency mattered: if they could not miraculously cure the incurable, surely they could keep the suicidal from achieving their designs. In this regard, suicide was as meaningful a litmus test as cure. He did not jettison entirely the themes of cure and domesticity, but alongside these more well-known tactics for achieving legitimation he also strategically highlighted the repressive, carceral functions of the asylum. In his first annual report, Brigham did indeed describe the “delightful promenades” made possible by the asylum’s elevated verandas, but he also hurriedly assured patrons that they were outfitted with iron bars so that patients could “enjoy all the benefits of the open air” safely. He happily detailed the minutiae of surveillance strategies. He used his annual reports not only to highlight Utica’s carceral function, but also to publicize the results of the studies conducted under his tutelage. Successful suicides were far from unknown at Utica—one patient died in 1845, one in 1846, and two each in 1847 and 1848—but the number of successful suicides found in the papers dwarfed these numbers. For Brigham, this juxtaposition highlighted two observations: first, that suicide rates were on the rise, and, second, that early admission to an asylum was the only effective means by which to stay that unsettling increase. Too often, he remonstrated, the suicidal “are known to be melancholy and a little insane by their nearest friends, who, however, often conceal the fact until after the catastrophe.”

While other superintendents sketched a future of recovery and hope to allay families’ fears, Brigham busily cultivated that fear by sketching an alternative future of death, grief, and guilt.

56. “Report of the Trustees of the State Lunatic Asylum” (Albany, 1841), 90, History of Medicine Division, National Library of Medicine, Bethesda, Md.
“The Sleepless Watchfulness of the Guardian”: Newly Accountable Persons

In the case of suicide, then, it appeared that medicine’s infiltration of the law was complete—even to the extent that the law literally deposited the suicidal at the door of the asylum.60 But just as the judicial system had effectively evacuated suicidal agents of responsibility, medical practitioners also faced “rising standards of accountability.”61 The public’s mounting expectations for health outcomes, in conjunction with an emergent marketplace professionalism, reframed allopathic physicians as contractual agents rather than as simply beneficent healers.62 These processes contributed to the proliferation of civil suits during this period of malpractice “crisis,” in which one contemporary estimated that 90 percent of practicing physicians in New York faced a charge of malpractice at one time or another.63 Moving from the civil to the criminal realm, it becomes apparent that changing ideas of accountability had other impacts relevant to our purposes: even as individual suicide was decriminalized, state legislatures increasingly moved to codify common law statutes against assisted suicide that targeted druggists and dispensaries especially. New York led the way in 1828, but the middle third of the century witnessed a rash of legislation that officially equated the deliberate provision of an instrumentality of suicide with either manslaughter or murder. Missouri was the first to follow New York’s example (1835), but Arkansas (1838), Mississippi (1839), Wisconsin (1849), Minnesota (1851), Washington (1854), Kansas (1855), Oregon (1865), and Florida (1868) soon followed.64

Asylum physicians did not encounter a slew of malpractice suits or manslaughter charges in this period. Still, having been granted dominion over suicide, asylum physicians and their staffs found themselves vulnerable in perhaps unanticipated ways. This became painfully evident in April 1846 as the Massachusetts state legislature debated whether or not to approve the request of Samuel B. Woodward, superintendent at the Worcester State Lunatic Hospital and president of the AMSAII. The hospital needed an additional wing, Woodward submitted, and won-

60. The quotation in the heading is from Hunt, “Statistics of Suicides” (n. 1), 231, emphasis original.
61. Porter, “Funny Numbers” (n. 10), 587.
62. De Ville, Medical Malpractice in Nineteenth-Century America (n. 11); Mohr, Doctors and the Law (n. 7), esp. 109–21.
63. Mohr, Doctors and the Law (n. 7), 117.
ordered if the legislators would be so kind as to appropriate the necessary additional funds for its construction. Opinions varied: several spoke in support of Woodward’s request, while others denounced it. More interesting than the fact of disagreement, however, is the strategy adopted by Amherst physician Timothy J. Gridley, who appeared late in the day to accuse Woodward of negligence. He relied on suicide to drive home the significance of his allegations: Woodward and his staff allowed patients to sleep alone, Gridley charged, and were directly responsible for several successful suicides that had taken place at the asylum. Gridley also told the story of one man in particular. “Although he was sent there with a written statement of his case,” Gridley recounted, “so carelessly was he attended to, that he committed suicide within a week.” Gridley finished his comments with a rather startling statistic. “More than one quarter of all the suicides in the State,” he reported, “took place at the Worcester hospital.” Woodward soon resigned.

This confrontation proved to be a flash point that galvanized asylum superintendents in at least two directions. First, when members of AMSAII gathered for their second annual meeting just a month after the incident, they resolved to conduct the type of research that would allow them to answer Gridley’s accusations. In language akin to Brigham’s reports on his own tabulations, they collectively determined to enumerate suicide:

Resolved. That each member of this Association be requested to ascertain the facts and circumstances (such as sex, age, civil state, vocation, mode and other matters susceptible of being tabularized) of each case of suicide, occurring in his respective State, between the first day of January and the last day of December 1847, and forward an abstract of the same, as soon after the latter date as convenient, to the Chairman of the Committee on Suicide;—it being understood that in States having more than one member, they be requested to divide their State by certain territorial limits.

Though a complete accounting of the resolution’s implementation is beyond the scope of this essay, its adoption makes clear that the enumerat-

65. Gridley and Woodward confronted one another again the following year when each offered expert testimony regarding mental competence. They arrived at opposing conclusions. “The Case of Oliver Smith’s Will,” Law Reporter 10, no. 8 (November 1847), 289–300, esp. 294.
67. Ibid. The extent to which Gridley’s accusations influenced the legislature is unclear; all that can be said is that they refused Woodward’s request in this particular case.
tion of suicide held promise not just as a means by which to monopolize suicide. In the context of professional attack, it also became a wide-reaching maneuver of defense intended to safeguard the profession and its practitioners.

But how would statistics of successful suicides achieve this end? Well, quite simply, by redistributing responsibility through contextualization. Superintendents understood that even a single death by suicide held remarkable significance. As such, when compelled to report an inpatient suicide, they often took particular pains to explain it. From Massachusetts, Luther Bell wrote, “A single person only has fallen a victim to a suicidal attempt, made almost in the presence of a vigilant attendant, and resulting in death from the previously entirely exhausted state of the patient, rather than from the severity of the attempt itself.” Francis Stribling equivocated similarly from Virginia: “There has been but one case of suspected suicide,” he reported. “Not certain that death in that instance was not the result of accident instead of design.”

When duty required a superintendent to report an unambiguous case of suicide, he might take yet another tack. Suicide by hanging, wrote John Parker from South Carolina, “cannot be prevented by any police, when the patients determine upon self-destruction.” He followed this claim by admitting, “The cases with us during the existence of the asylum, number 6 or 8.”70 Such numbers taken alone might prove startling; framed by the entirety of suicides successfully undertaken in a particular year, however, they seemed less so. The two suicides at Utica in 1847, for example, paled in comparison to the 106 accomplished across New York in the same year.71

New ideas about accountability also contributed to a more dramatic—and, indeed, longer lasting—overhaul of the more practical problem of prevention in the asylum. Woodward, influenced by French practitioners Phillipe Pinel and his student Jean-Étienne Dominique Esquirol, had long advocated what came to be known as the “pledge system,” a ritual undertaking in which a patient would be released from mechanical restraints or confinement only after having solemnly promised to refrain from suicidal behavior.72 Even those “who have been detected in making preparation

69. “Report of the Trustees of the State Lunatic Asylum” (n. 56), 123.
70. Ibid., 149.
72. Hunt, too, was influenced by Esquirol, whose work he was translating at the same time he was conducting his study of suicide. E. Esquirol, Mental Maladies, trans. E. K. Hunt (Philadelphia: Lee and Blanchard, 1845), 253–317. Esquirol first claimed that suicide was an important issue for medical practitioners in an 1821 article, Jean-Étienne Dominique Esquirol, “Suicide,” Dictionnaire des Sciences Médicales 55 (1821): 213. On the Esquirol school’s
for self-destruction, or in secreting instruments for future use,” Woodward remarked, “have never failed to adhere strictly to a pledge given in good faith, with feelings of solemnity.” For Woodward and others who advocated it, the pledge operated symbolically as an embrace of the nonrestraint system and, more significantly, of the human status of the insane. It sought to establish a binding relationship between two individuals, both of whom were understood to be accountable persons. For those who opposed it, however, the pledge system was as irresponsible as it was misguided because it relied upon a conception of the patient as a responsible person. Thus, as Hunt tersely phrased it, “where the propensity to suicide exists, no promises on the part of the person thus afflicted ought to be regarded for a moment.” Asylum physicians of the antebellum period needed more than mere promises. Their resistance to the pledge system as well as its ultimate demise suggest the more quotidian effects of wedding a legally sanctioned medical model of suicide to the reframing of medical practitioners as legally accountable persons.

Thus the burden that the suicidal brought with them to the receiving room imbued them with a disciplinary power far greater than we might expect given the relatively small number of such residents in any given asylum at any given moment. As Brigham himself told it, “The suicidal variety of insanity is the one most dreaded by the officers of Lunatic Asylums, and the one that gives them the most intense anxiety.” The specter of successful suicide began wielding its power even during the earliest phases of ideas relating to suicide, see G. E. Berrios and M. Mohanna, “Durkheim and French Psychiatric Views on Suicide during the 19th Century: A Conceptual History,” Brit. J. Psychiatry 156 (1990): 1–9; Goldstein, Console and Classify (n. 6), esp. chaps. 5–8; Ian Hacking, The Taming of Chance (New York: Cambridge University Press, 1990), 64–77; and Ian Marsh, Suicide: Foucault, History and Truth (New York: Cambridge University Press, 2010), 100–120. Hacking and Marsh are especially keen to suggest that Esquirol’s professional imperialism was total. Berrios and Mohanna, in contrast, argue that Esquirol maintained a “sober view” of suicide that recognized that certain suicides were the result of insanity while others were not. The authors deal with Esquirol—and Durkheim’s re-presentation of Esquirol’s ideas—on pages 5–6. Esquirol’s influence on mental disease specialists in the United States was in keeping with the broader influence of French medical and scientific thought on American medical practice. John Harley Warner, Against the Spirit of System: The French Impulse in Nineteenth-Century American Medicine (Baltimore: Johns Hopkins University Press, 2003).

73. “Report of the Trustees of the State Lunatic Asylum” (n. 56), 100–101, 110.
75. Hunt, “Statistics of Suicides” (n. 1), 231, emphasis original.
of conceptualization, well in advance of receiving residents. Thomas Kirkbride would later codify asylum architecture’s preventative functions in his classic *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* (1854).\(^77\) Certainly the text established an architectural standard, but, more important for our purposes, the text also described practices that were by then well established. Placing this text alongside annual reports and rules and regulations for daily life reveals a (perhaps idealized) world in which the preventative and therapeutic functions of the asylum were carefully and intentionally balanced. The need to prevent suicide touched furniture and sleeping arrangements, sanitation practices and recreation, mealtimes and labor. It impacted the relationships and emotional lives of all individuals who encountered the suicidal. Successful prevention required a great deal of attention, energy, and resources, and was a crucial factor in the shaping of institutional life.

Architecturally speaking, an asylum thus became a balancing act between suicide and the imperatives of prevention and the imperatives of therapeutics. Bars and screens, for example, allowed superintendents to blend effectively the demands of both programs by safeguarding glass while still allowing for the healing properties of sunlight and fresh air to be transmitted.\(^78\) Yet for the “determinedly suicidal,” these were luxuries to be foregone altogether.\(^79\) The ideal asylum would thus include at least a handful of rooms with nothing more than one small window that was too narrow and too high “to be easily accessible.”\(^80\) When pressed, the demands of prevention outweighed the demands of therapy. This was true also with furnishings. In keeping with contemporary emphasis on the restorative power of the domestic, the interior décor ideally would correspond to what one might find in the home of a middle-class family.\(^81\) But though windows might be secured, those bent on suicide might still use furniture as a means to their end. Superintendents and matrons, who at times took charge of furnishings, should select and arrange with suicide in mind. Sharp corners and protrusions were to be avoided at all costs.\(^82\) The spatial arrangement of furniture was equally important.

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\(^79\) Kirkbride, *On the Construction* (n. 77), 18.

\(^80\) Ibid.

\(^81\) Ibid., 57.

\(^82\) Ibid.
table with smooth, rounded edges would accomplish very little if a patient could climb atop it to reach a high window, or a screw, or a ceiling beam.83 Thus bedchambers assigned to suicidal residents were to have headboards securely fastened to the wall.84 And, in some cases, the superintendent and his staff could omit moveable, weapon-ready furniture altogether.85

There seems to have been very little disagreement among superintendents regarding addendums to the edifice itself. It was easy enough to add bars to the windows, or secure furniture in a ward or two. The addition of staff, patrons, and patients, however, brought underlying questions of accountability to the fore in complicated and at times competing ways. Crucially, this work began beyond the asylum walls.86 As Brigham remarked, “a patient cannot commit himself to the Asylum.”87 Rather, each individual had to be brought to Utica by the public authority via the civil commitment law discussed above, or by those whom he called the “friends of the insane”—a turn of phrase that encompassed household members, neighbors, and general practitioners. In either case, commitment was grounded in the basic premise that patients abandoned legal personhood and became instead “objects of commiseration and guardianship.”88 Contemporaries and historians alike have critiqued this troubling relinquishment of rights, but the admission ritual was more Janus-faced than this singular focus implies. After all, just as the patient relinquished responsibility, Brigham and his staff shouldered it—and in cases of suicide, mistakes could mean the death of a patient.

The transfer of accountability from patient to staff first structured the process of classification, which atomized and targeted specific individuals for preventative efforts. The physician, responsible for identifying those with suicidal potential, subjected the patient to a painstaking process of observation and inquisition. He first inquired into a patient’s history and appropriated any objects that might double as a weapon.89 “Has suicide or other self-injury been attempted? In what manner? Is the propensity

83. Ibid.
84. Ibid.
85. Ibid.
86. The extent to which this imperative operated on the wider public is a fascinating question, and one that I consider in the longer manuscript. Brigham’s reports, which lament the low number of suicidal individuals admitted, suggest that the general public had not yet internalized this lesson.
now active?” What the patient would not tell, however, physicians should discern by attention to facial expressions or by questioning at a slant. They should look for downcast eyes, gloom, and quietude. They should ask about recent misfortunes or sickness. Only after this process could physicians then classify a patient with some measure of confidence. Though often dismissed as antiquated ritual, this careful taxonomy worked toward suicide prevention in several ways. First, it determined whether a patient would be assigned to a ward with sharply edged furniture or sizeable windows. It also crucially determined where and with whom a patient would sleep. Finally, it targeted particular individuals for a relational therapeutics that certain contemporaries deemed particularly effective among the suicidal: sympathy. For medical historians, this term is recognizable as a general explanatory framework with which medical practitioners of this period described relationships between discreet organs in the body. Asylum physicians, however, were just as interested in the term’s vernacular meaning. Indeed, sympathy as “fellow-feeling,” or “the quality of being affected by the affection of another,” was at times more important. It was this common definition, rather than the properly medical one, that allowed asylum physicians to develop a theory of intersubjectivity that underscored both the threatening and restorative potential of relationships.

Classification thus created a network of accountability, the success or failure of which relied to a remarkable degree upon the behavioral habituation of those who spent their days and nights among asylum residents. First, and most simply, this meant an exhausting vigilance. “Every patient must be in the charge of some responsible individual at all times,” Brigham implored. “The person who takes a patient from one of the galleries, shall be accountable.” Patients were not allowed to shave themselves, nor were they allowed to bathe themselves. Solitude, in fact, was scrupulously avoided. During meals, attendants stationed themselves throughout the dining hall and kept an eye “not merely to those under their immediate charge, but, with constant watchfulness, over all the patients.”

90. “Report of the Trustees of the State Lunatic Asylum” (n. 56), 16.
94. Ibid., 35.
guard against death by fork or knife. To bring home the novelty of this, it should be mentioned here that the very notion of using utensils was a relatively new one to the nineteenth century—it was part of a civilizing discourse that emphasized manners and social niceties, and we can see Brigham’s pride in the asylum’s conformity to these new standards when he reported in his first annual report, “We make no use of tin or wood dishes at any of the tables.”

Printers, artisans, and others charged with overseeing patient labor were beseeched to keep a careful eye toward their tools. Vigilance became particularly important when patients ventured beyond the preventative space of the asylum. When they walked out, they would encounter “railroads, canals, precipices, rivers, wells”—each an effective site for suicide, and each a danger to be avoided at all costs.

The obligation to prevent suicide touched even carriage drivers, charged with keeping patients away from weapons when they journeyed beyond the institution.

Classification also contributed to this endeavor by targeting individuals for heightened surveillance between the hours of nine at night and five in the morning, particularly charged hours at any institution. Those identified as resolutely suicidal might find themselves with no more than a mattress and bedding in an otherwise empty room. If trusted with furniture, these residents typically occupied chambers that connected to an attendant’s room by a door or window. In such cases, a lattice morphed from a practical object of obstruction to one of surveillance that aided in nighttime prevention efforts. As such, they were placed strategically throughout the building’s interior to render detectable even the softest of sounds and to allow the attendant to move swiftly from one room to the next. Attendants were aided in their endeavors by several additional safeguards. The use of morphine, for example, induced the deep slumber that not only contributed to ultimate physical restoration but also kept patients from the cognizance and motor function necessary to accomplish suicide. In addition, night watchmen shouldered the burden of surveillance between nine and five. The night watchman was to give “especial attention” to the suicidal, listening through the lattice or opening and

100. “Cases of Insanity” (n. 4), 246 (extract of conium, morphine), 247 (wine), 248 (morphine).
moving through doors according to a patient’s sleeping arrangements.\textsuperscript{101} An even more trusted method for implementing surveillance at night was the development of what Kirkbride termed “associated dormitories,” in which several patients and an attendant occupied a single large room.\textsuperscript{102} At night as in day, suicidal residents were subjected to scrutiny.\textsuperscript{103}

Associated dormitories did not just enable vigilance; rather, they also enabled a broader therapeutics of sympathy that demanded emotional performance from both patients and attendants. In addition to advocating the restorative powers of warm baths, tonics, sedatives, and a nutritious diet, many asylum physicians argued that a “person will not commit suicide if placed in a room with others.”\textsuperscript{104} This phenomenon was at times attributed to a fear of interruption triggered by the simple proximity of others. At other times, though, it was seen as a way to cultivate a patient’s sense of accountability.\textsuperscript{105} That is, an unwillingness to commit suicide in the presence of others might remind a patient of his or her responsibilities to fellow residents; as such, “they to some extent protect each other.”\textsuperscript{106} Unbeknownst to themselves, patients participated in this subtle preventative therapy in other ways, as well.\textsuperscript{107} Physicians hoped that assigning suicidal patients to the same ward would encourage a decentering of the self that would, in turn, stay the hand of the suicidal. “It is sometimes advantageous to permit two persons who labor under some deep, imaginary sorrow, to communicate freely with each other,” wrote one. “The sufferer learns, at the same time, that he is not miserable beyond all others.”\textsuperscript{108} Brigham echoed this sentiment when he noted that, by forming relationships with fellow residents at the asylum, “other feelings are aroused into activity by the . . . perhaps more painful condition of their fellow-sufferers.”\textsuperscript{109} Within

\textsuperscript{101} Ibid., 248–49; Kirkbride, \textit{On the Construction} (n. 77), 50.
\textsuperscript{102} “Cases of Insanity” (n. 4), 248–49; Kirkbride, \textit{On the Construction} (n. 77), 18.
\textsuperscript{103} Brigham, “Sixth Annual Report” (n. 39), 34–35.
\textsuperscript{105} “Report of the Trustees of the State Lunatic Asylum” (n. 56), 22.
\textsuperscript{107} Ibid., 152.
\textsuperscript{108} Ibid.
\textsuperscript{109} “Cases of Insanity” (n. 4), 244.
the protective confines of irresponsibility, then, patients encountered the imperatives of accountability in quite specific ways.

Attendants, too, were implicated in such therapeutics. Amid the gloomily suicidal, asylum physicians emphasized that it was absolutely necessary for an attendant to show “a cheerful countenance over a heavy heart.” Indeed, the more consistently disciplined an attendant’s emotional life, “the better will be the care extended to the patients, and the more rapid will be the cures.” The asylum managers expected “perfect attendants,” for example, to evince “complete dominion over the passions.” This was especially difficult for attendants at Utica, where the laws governing the institution fixed the prices so that it was impossible to achieve the one-to-one ratio so important for effective vigilance. “Hence much additional labor and loss of sleep, were imposed upon our attendants.” Even amid exhaustion and overwork, the presence of the suicidal demanded an emotional restraint required to first sympathize with their patients—that is, “enter deeply into their feelings”—and then perform in perfect opposition to patients’ emotional manifestations. Assuming responsibility for a suicidal patient thus meant that attendants’ emotions and intersubjectivities, like their bodies, were subject to a rigorous discipline.

Conclusion

The preventative program at Utica encompassed architecture and construction, furniture and sleeping arrangements, sanitation practices and recreation, mealtimes and labor. It impacted the relationships and emotional lives of all individuals who encountered the suicidal—from those who delivered an individual to the asylum, to the medical staff and attendants, to cooks and carriage drivers. Creating a network of accountability required a remarkable amount of energy, resources, and discipline. To fully appreciate the significance of the disciplinary apparatus as it worked in the case of suicidal asylum residents, however, we must situate it within the broader legal trends that structured realities and circumscribed possibilities. We must take seriously what one superintendent succinctly noted in 1853: that the defining characteristic of the modern asylum was the

111. “Report of the Trustees of the State Lunatic Asylum” (n. 56), 200.
112. Ibid.
114. “Report of the Trustees of the State Lunatic Asylum” (n. 56), 22.
fact that “Patients, now-a-days, are not responsible.”¹¹⁵ The law did not end at the courtroom door; rather, it operated in creative and productive ways to influence the shape and structure of asylum life.

Nor did these influences end with Utica or with the closing of the 1840s. On the contrary, much as concerns about suicide and accountability underwrote the decline of the pledge system, they also played a leading role in debates about mechanical restraints: the “straps and belts, and waists and muffes, and mits [sic] and cribs, and bedstraps” sometimes used to control patients.¹¹⁶ These would continue for the remainder of the century and would involve more than just asylum physicians and their medical staffs.¹¹⁷ The critiques advanced by former patients, British asylum physicians, and neurologists regularly highlighted a restraining device of Brigham’s own invention—the covered bed dubbed the “Utica crib.”¹¹⁸ These and similarly negative appraisals contributed directly to a loss of confidence in moral treatment, as well as to its ultimate decline.

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¹¹⁶. Phebe B. Davis, Two Years and Three Months in the New-York State Lunatic Asylum, at Utica (Syracuse, N.Y., 1855), 69, 84–85.

¹¹⁷. Their continued use was in juxtaposition to Great Britain’s nonrestraint system. Anne Shepherd and David Wright have studied how asylum physicians managed the suicidal without the benefit of these devices. Anne Shepherd and David Wright, “Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-restraint,” Med. Hist. 46 (2002): 175–96.