

MENTAL PHYSICIANS AND THEIR PATIENTS
psychological medicine in the English pauper
lunatic asylums of the later nineteenth century

by

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SUMMARY

The objective of this thesis is to examine the pauper lunatic asylums of later Victorian England and assess the value of the psychological medicine which was carried on there. Broadly, it asks psychiatric, rather than strictly historical, questions in that it considers the benefits accruing to individual patients as being of central importance, whilst also evaluating the advantages gained by the medical profession and by outside society.

After an introductory chapter there follows an analysis of medical theory on insanity. This considers the function of theory and assesses its usefulness in handling the problems posed by those labelled "insane". The third chapter analyses theories of treatment. It looks first at somatic therapies - electricity, showers and drugs - then considers what "moral treatment" had by then become, concluding with an overall interpretation of therapy in this period.

In the section examining psychological medicine in practice, the first chapter is a reconstruction of asylum function using asylum admission registers. It shows mortality, lengths-of-stay, proportions of cures and so on according to various factors. Some analysis of patients' problems is also attempted. The following chapter pursues this theme with a study of asylum life as it affected the patient and, by implication, his or her course of treatment.

The last section sets psychological medicine in its social contexts, first of professionalisation, with the advantages accruing to doctors and attendants and the conditions under which this branch of medicine operated, then of social provision. Asylums were supported by county rates and their patients by the Poor Law authorities and their influence on the enterprise is considered.

It concludes that psychological medicine was self-defeating in its own terms because of the dominative nature of the relationship between the asylum and the patients. The perception of the patient as individual sufferer was occluded by a perception of him or her as social deviant. Thus the essential ingredient of the restoration of "normal" self-control - that the "self" be known and its needs recognised - was absent. The alternative to restoration, continued incarceration, was nevertheless socially acceptable and so persisted.

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PREFACE

Writing a Ph.D. thesis is rather like travelling on the London Underground. One emerges from a long unswerving tunnel into a new station which looks, oddly, much like the one left behind. The main difference seems to be the place-name on the wall.

In the same way the conclusion of a thesis feels much like ignorance re-located. Travelling conditions have meant that I arrived with much the same set of basic experiences, and therefore potential interpretations of things, as those with which I clambered aboard. There must have been junctions along the way, turn-offs in the dark leading to who knows what new location. Perhaps others will go back and pursue them.

I began the journey with vaguely anti-psychiatric intentions, enthusiasm and (in retrospect) a remarkably naive set of ideas about the world's workings. My travelling has brought some changes, perhaps the greatest of which came from trying to make sense out of my material having started with such crude beginnings.

Luckily, not all was darkness on the outside. Flashes of reality occasionally shone through. The period during which I was researching and writing this thesis saw many turbulent events, some closely connected with the future provision of health in this country, which set the academic venture into a realistic perspective. Involving myself in these events did not always benefit the work in hand, but in some ways the thesis helped to mediate some ideas, while leaving one hand free for other concerns, and probably both gained some advantage in the end.

Thus in fact, the darkness of the tunnel concealed not only turnings leading away to new discoveries but also branch-lines of outside experience leading in. None of this, of course, is revealed in the completed pages, which show instead the studied image of one point along the track.

This research was made possible by a three year grant from the Social Science Research Council, to whom my thanks are due. I would also like to extend special appreciation to Dr Roger Smith of Lancaster University who bears the responsibility for first introducing me to the subject, and to Dr John Walton, also of Lancaster University, both of whom provided valuable observations on work in progress.

My gratitude goes also to the staff and students of the Economic and Social History Department at Sheffield University, particularly to Dr John Woodward, my supervisor, and to Beryl Moore and Beverley Eaton, who provided essential support, as did the Crookesmoor Building catering staff. Thanks also to the staff of the main library at Sheffield University, particularly inter-library loans.

There are many others who gave special assistance at various times and to each of them I am greatly indebted. My thanks therefore to the staff of the Wellcome Institute for the History of Medicine for the use of their library facilities, to the staffs of Stanley Royd Hospital, Wakefield, Mapperley Hospital, Nottingham, and Middlewood Hospital, Sheffield, for letting me explore their records and discuss their work, to Laurence Ashworth, curator of Stanley Royd Hospital Museum, for valuable information and insights, and to Professor F.A. Jenner for several long conversations on the meaning, or otherwise, of the term "psychiatry".

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I owe a special word of thanks to Pam Smith for an excellent typing job despite inconsiderate revisions by the author and for an amazing ability to decipher illegible manuscript.

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CHAPTER 1: INTRODUCTION

The subject of this thesis is institutions, represented in this instance by the Victorian pauper lunatic asylums. I had not originally intended this particular emphasis but was drawn to it as the unavoidable outcome of my concern with the effectiveness of later nineteenth century medical involvement with the insane. It is not a study of institutions as such and does not seek to suggest that the lunatic asylum was a typical example. What it attempts to do is show how the Victorian institution was intimately related to fundamental aspects of contemporary socio-economic organisation through various perceived social problems.

The prison, the orphanage, the barrack school, even the workhouse, differed from one another in many respects. Each had its own fairly well defined potential population and its own stated purpose. Some were reformatory while others were more deliberately punitive. The lunatic asylum was probably the most benign, with the exception perhaps of the voluntary hospital and the sanatorium, and was dedicated officially to the pursuit of health and sanity through medical aid. Its potential population were those considered insane and its purpose was to cure them. In developing a study of the validity of its operation I was led beyond these official purposes to look at the way in which actual responses to the perceived problems of insanity were constrained at every turn by considerations which were not of the problems as such but of the social organisation which their existence disturbed. These constraints were present at all levels and seem to have been an overwhelmingly powerful shaping force in the development of what came to be known as psychiatry. This psychiatry still retained much of the benign intent - and certainly the rhetoric - of its overt purpose but had become overridden by an institutionalising process that made of it only another variant of the many other Victorian institutions in its actual functioning.

The history of nineteenth century psychological medicine is in any case a history of the asylum, though what that term signified changed greatly in the course of the century. I have attempted to examine the asylum of the later part of the century from within: to examine its inner life and routines, its staffing arrangements and the medical perspectives which were employed to regulate its function. My approach has been from the point of view of the needs of those persons in the position of patient under medical authority. This is not to say that those needs were in any clear sense accessible to historical analysis but rather that when evaluation has had to be made I have put this consideration foremost. It is a consideration which has not, perhaps, been uppermost in existing work in this area and so may prove fruitful in the continued study of the topic.

In this sense I have taken what could broadly be said to be a psychiatric viewpoint rather than a strictly historical one. In his examination of Victorian insanity trials, Roger Smith observes, "The historical task is to understand medical and legal discourse rather than to promote one or the other".⁽¹⁾ In this one instance I must disagree with him. In compiling this research I have been acutely aware that I am no neutral "historian" set solely about the business of pure understanding. I have, of course, attempted this much as far as I am capable. However, it would be less than honest to say that no other concerns directed my interpretations, that my own personal values and social beliefs were not at the same time directing the understanding of my material. Broadly speaking, I have taken the side of the individual patient, not as a champion of rights or defender of conscience, but out of a sense of sympathy for the sufferer in society, a sympathy no doubt displaced from elsewhere in my personal thinking yet relevant still in this historical context.

1. SMITH, Roger: Trial by Medicine: Insanity and Responsibility in Victorian Trials. Edinburgh, 1981, p.161.

In making this approach I have deliberately avoided the use of any one specific social model. The use of particular assumptions, however, cannot be avoided and I shall need to make my starting points plain in each area covered in the thesis if the argument is to be followed. I shall begin with a discussion of the nature of "mental illness" and then look at the background to each separate chapter.

The concept of mental illness has a history of contentious debate. The long-standing model employed by the psychiatric profession sees it as another form of illness in general, with an origin located in the organism. A major exponent of this view amongst psychiatric historians is Richard Hunter, who sees only organic bases for insanity, the rest being epiphenomena of these physical lesions.⁽¹⁾ The same organism-centred view of mental illness is common to that other main branch of psychiatry, psychotherapy. Here, the origins may or may not be "physical" but arise within the organism from unresolved conflicts in dealing with the world outside. These approaches (which are far more complex than outlined here) correspond to the "medical model", which begins from an assumption that the real problem lies within an individual, and then isolates him or her to effect a solution.

This medical hegemony has been steadily challenged in the course of the last two decades by critics both inside and outside the medical profession, who have replaced the emphasis on problems within an individual with problems between them. The organism-centred medical model was thus under attack, along with the view of "mental illness" as akin to physical disease. Foremost, perhaps, of the critics within the profession has been Thomas Szasz.⁽²⁾ Szasz sees all behaviour in terms of games-theory.

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1. HUNTER, Richard and Ida MacALPINE: Psychiatry for the Poor. 1974.
 2. SZASZ, Thomas: The Myth of Mental Illness. 1962.

Interpersonal relationships and the individual's attempt to "win" games shared with other players give rise to particular behaviours. The rules may not, however, be held in common, nor the goals, so that a person's responses may seem inappropriate to outsiders. Psychiatry is an organised attempt to isolate people behaving inappropriately and impose another set of cultural rules upon them. For Szasz, the term "mental illness" is a false metaphor which aids the cultural imperialism of the psychiatrists.

Critics outside the profession have seen psychiatry as a part of society's regulation of its individual constituents, in which unacceptable behaviours are labelled "deviant" and treated accordingly. Combined with ideas from new movements in psychotherapy, such as those of R.D. Laing and David Cooper, this "anti-psychiatry" school saw what has become known as "mental illness" as actually the results of problems of human relationship, viewed from the point of view of those who would control those results by controlling the individual rather than negotiate with the individual to seek a resolution of the original problem. The question of the necessary means to effect this response has concerned sociological critics of psychiatry and the ensuing conflicts between labelling theory and the medical model has, in T.J. Scheff's words, "engendered such furious partisanship" that neither side has absorbed a great deal from the other. (1)

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1. SCHEFF, T.J: Labelling Theory of Mental Illness. American Sociological Review, 39, 1974, pp.444-452. The sociological debate has itself been divided between the "labellers" (of whom Scheff is one) and the "social controllers", whom he is criticising, who see an active selection process at work. N.J. Davis, for example, draws upon Lemert's distinction between "primary" and "secondary" deviance to point out that the labelling process did not create the deviant behaviour initially. See DAVIS, N.J: Labelling Theory in Deviance Research, Sociological Quarterly, 13, 1972, pp.447-474. The "social control" model leads us back towards the form, if not the validity, of the medical model.

Complication on the issue of mental illness has arisen from sociological criticism of the concept of illness itself. It is not simply that a person with an "illness" is also a social actor who must play "patient" to conform to social norms,⁽¹⁾ but that even the very notion of physical "illness" is a culturally constructed concept, independent of biological circumstances. Fabriga,⁽²⁾ for example, emphasises that the term "disease" can be defined using constructs of biological, behavioural or phenomenological discontinuity. This definition of an "undesirable, organism-centred discontinuity" isolates the individual, reifies discontinuity as a discrete entity and imports value-judgements in recognising it as undesirable. "Disease", argues Fabriga, is "dis-ease", a collapse of personal well-being, arising from, but not identical with, a biological dysfunction. "Disease" in this sense is not, then, the direct result of biological dysfunction. It is the response of the individual, who "feeling disarticulated in a social or psychological sense, concludes that he is diseased".

I.K. Zola⁽³⁾ pursues the value-laden nature of the concept of illness by emphasising the moral content of medical rhetoric. Medicine is "good", not merely as an anti-dote to pain or suffering but because it is "humanitarian" and argues to release its subjects from the full pressures of legal or religious condemnation. Nevertheless, in doing so it has taken over functions of punishment and moral regulation for itself. Stigmatisation

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1. See, for example, ROBINSON, David: The Process of Becoming Ill, 1971. The "patient role" is a commonplace of medical knowledge, having been originally outlined by Talcott Parsons (The Social System, 1951) and does not conflict with the medical model, though in the latter's interpretation of mental illness its validity is very circumscribed, if not redundant.
 2. FABRIGA, H: Concepts of Disease. Perspectives in the Biology of Medicine, 15, 1972.
 3. ZOLA, I.K: Medicine as an Institution of Social Control. Socio-logical Review, NS 20, 1972, pp.487-504.

of the individual is replaced by a stigma placed upon an "illness" which must be exorcised by a doctor. If a patient fails to co-operate in this exorcism he is punished through disciplinary medical procedure. Not all conditions are allowed the status of illness. Those which are can be related to moral, or at least personally meaningful, concepts. A person asks, why am I ill? Overwork, stress, going out in the cold are all reasons given for a moral failure to stay healthy. Even when describing illness to children we use a moral paradigm: a "bad" leg, getting "better", and so on. "Frankly", says Zola, "it seems hard to believe that the English language is so poor that a moral rhetoric is needed to describe a supposedly amoral phenomenon - illness".⁽¹⁾

If we can see even physical illness as socially defined and bounded by specific cultural values, as both Fabriga and Zola do, then the distinction between physical and mental "illnesses" is blurred. Szasz's argument that psychiatrists have made illegitimate use of a medical metaphor falls to the ground, though his criticism in terms of cultural imperialism remains valid. The logical conclusion to the expanded definition of illness is for this cultural imperialism to apply across the board, wherever medical men and women involve themselves in their social regulatory practices. Some writers follow this logic and see medicine as a major threat to our well-being. Ivan Illich sees the medical establishment as depriving us of cultural choice and of actually causing more damage than it cures.⁽²⁾ Zola arrives at similar conclusions.⁽³⁾

Without denying that there is much to commend this view it does, like its anti-psychiatric counterpart, overlook a vitally important considera-

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1. ibid., p.492.
 2. ILLICH, Ivan: Limits to Medicine - Medical Nemesis, The Expropriation of Health, 1976.
 3. ZOLA, I.K: op.cit, p.500.

tion which medicine ideally embodies. Critics of traditional psychiatry have accused the profession of the abuse of patients through the violation of their social rights or of their humanity by medical intervention. Mental patients have been seen as the victims of cultural domination, professionalisation strategies⁽¹⁾ and moral control. One or two critics have carried this concern closer to the subjects of these abuses by seeking admission to mental hospitals and reporting on the responses they found there.⁽²⁾ On the whole, however, the sociological criticisms have not had such a sense of commitment to patients' welfare. Rather they have the manner of a professional rivalry, centring on competing academic conceptualisations of "disease", "mental" and "cure". This impression is strengthened by the degree of attention paid to the psychiatric profession as opposed to the patients within its care, particularly with regard to the legitimacy of its status within medicine.

Psychiatrists, on the other hand, have generally shown themselves more concerned with practical matters. Chastened, no doubt, by many of these criticisms they have absorbed the new ideas and incorporated them in their eclectic stock of therapeutic devices.⁽³⁾ With these they have set about responding to each of their various charges. Their conceptualisation of their role, however, contains an ingredient missing from those of sociological critics: an awareness of personal suffering by the patient or by those around the patient. They see patients as being disabled in some way from their own normal function in their own society and in need of restorative assistance.

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1. FREIDSON, E: The Profession of Medicine - a study of the Sociology of Applied Knowledge, 1970.
 2. ROSENHAN, D.L: On Being Sane in Insane Places. Science, 179, 1973, pp.250-8.
 3. As a review of a few years of the "British Journal of Psychiatry" reveals.

Conversely, their critics tend to locate the fault primarily in society outside the individual and imply that patients are in a way wronged by being singled out for exclusive treatment. There is a sense here, most strongly in the writings of Szasz, that the individual is well aware of what he or she intends and is able, but for purely societal obstacles, to effect a satisfactory solution to his or her needs. Any sense that the individual is unable to do this, or is able but not willing or prepared to overturn external arrangements affecting others, or is simply suffering and calling for help, is not relevant to such an analysis.⁽¹⁾

The central fallacy of the "anti-psychiatric" view lies in counterposing the "individual" to "society". This implies a state of struggle between two isolate components. Whilst this model may equate well with the liberal origins of much sociological thought it is an unhelpful one to persons who do not wish to take the world to task but merely find some relief from their difficulties. We are not separate entities from the social relations in which we are perpetually enmeshed, neither is it necessarily our desire to be. While obviously possessing an individual awareness we are nevertheless entirely social beings, pursuing that integration with others which is the essence of our humanity. We seek simply a modus vivendi in which we do not suffer and in which we retain a sense of personal worth and integrity.

One influential exponent of this view is Peter Sedgwick.⁽²⁾ Sedg-

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1. Consider, for example, Szasz's treatment of the Ganser Syndrome in "The Myth of Mental Illness". He entertains little question of the individual's incomplete control of emotional response and social identity nor does he recognise the actuality of personal suffering. For Szasz, the restoration of free choice absolves us all from responsibility for what happens to others. See SZASZ, Thomas, op.cit.
 2. SEDGWICK, Peter: Mental Illness is Illness. Salmagundi, 20, 1972, pp.196-225.

wick accepts that "mental illness" is a concept framed by social judgement and values in the same way that "illness" itself is. Thus mental illness is not conceptually different from forms of physical ill-health, as Szasz, for example, asserts, since it is the "illness" state which medicine addresses rather than any strictly physical or mental phenomenon. This in turn is a social enterprise in which the patient and the patient's world are to be reintegrated on a basis more satisfactory to his or her sense of well-being.

This view is complicated by the fact that an awareness of "illness" may result both from the initial incapacitation, which in itself may make normal social integration impossible, and from the secondary response to that incapacitation by others, which can add a further disablement. How to tackle this multiple problem, and in what measure of priority, is as much for the patient to validate as for the doctor to decide. So, too, is the question of the means of medical intervention. Whether the approach must be at a level of human social exchange or of chemical and other physical manipulations depends upon the priorities established by doctor and patient.

It is the balance of power in this relationship which presents the crucial problem of psychiatry. Who is to decide what is the nature of the "illness" and the order of priorities of the problems associated with it? What, in any case, are those problems, and who suffers from them? Who is to judge when a state of well-being exists? Neither patient nor doctor stands independently of social realities. The psychiatric enterprise necessarily calls into question a whole range of further issues, from personal interaction to the organisation of society itself, its demands, provisions and alternatives for any one individual. In particular, it opens up areas of debate concerning the social choices available to an individual and his or her freedom to make them. These are all relevant

concerns in the understanding of the history of psychiatry as much as of its present construction.

In turning from psychiatric theory to historical background these concerns on behalf of the individual sufferer remain the basis of my approach. I have attempted to look beyond the complexities of medical science and curative therapy to the practical délimitations of madness and responses to it, insofar as they touched upon the patient's needs and feelings. Because of this, much of the argument is of a demythologising nature. Myths are learned along with the facts and ideas which they interpret, from social sources. When an individual is precisely out of step with such social contexts - is aberrant, irrational, "insane" - the validity of those myths comes naturally into question.

This approach has dictated the formal presentation of the thesis. There are three main sections to the study which look in turn at psychological medicine in "theory," that is, its most mythological form, in "practice", as contrasted with its theoretical interpretation, and finally in its social context, which provides reference points outside of medical ones by which psychological medicine can be understood. Each of these sections contains two chapters, as follows.

It seems appropriate to begin a study of the subject by taking the theoretical underpinning of the doctors' enterprise and examining its content and its function. This draws heavily upon material published in the "Journal of Mental Science" - the mental physicians' own publication and source of much medical thinking within the profession at large - and upon contemporary text-books by more prominent medical men in the field. This theory was not a simple body of neutral knowledge, though it was presented as such. Rather it was a living construction, developed and altered over the years by its progenitors, which served particular purposes at any one

time. Behind the rhetoric were social relationships which determined (that is, informed and set limits to) what was actually passed for "science".

The analysis presented here serves as a useful introduction to the approach which is continued in subsequent chapters. There has been surprisingly little work done in this area considering its potential for a study of social scientific development. Mostly, writers have concentrated on the early years of the nineteenth century and taken a rather narrow "scientific" line.⁽¹⁾ Social influences, which become perhaps more marked later in the century, are less prominent.⁽²⁾ However, interest in the social content of mental physicians' activities is growing and work by

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1. Good scientific accounts are given by Otto Marx; MARX, Otto M: Nineteenth Century Medical Psychology - Griesinger, Meynert and Wernicke. Isis, 61, 1970, and particularly by R.M. Young; YOUNG, Robert M: The Functions of the Brain - Gall to Ferrier. Isis, 59, 1969, who establishes connections with evolutionary thinking. This approach is continued with particular reference to mental physicians in CLARK, Michael J: The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry, in, SCULL, Andrew (Ed.), Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era. 1981.
 2. Bynum began such an approach for the earlier century which was continued by Cooter, who makes interesting connections with phrenology and popular literacy. See BYNUM, W: Rationales for Therapy in British Psychiatry 1780-1834. Medical History, 18, 1974; COOTER, R.J: Phrenology and British Alienists, c1825-45. Medical History, 20, 1976. There has also, of course, been the interesting work done on masturbatory insanity by Hare, Englehardt, Gilbert and Neuman, and some examination of psychiatric theory in relation to social darwinism, though these have been mostly concerned with other areas of thought than the medical. See HARE, E.H: Masturbation and Society. Journal of Mental Science, 108, 1962; ENGLEHARDT, H.T: The Disease of Masturbation. Bulletin of Historical Medicine, 48, 1974; GILBERT, A.N: Doctor, Patient and Onanist Diseases in the Nineteenth Century. Journal of Historical Medicine, 30, 1975; NEUMAN, R.P: Masturbation, Madness and Modern Concepts of Childhood and Adolescence. Journal of Social History, 8, 1975. On social darwinism and medical ideas, see for example, ROSENBERG, C.E: The Bitter Fruit - heredity, disease and social thought in nineteenth-century America. Perspectives in American History, 8, 1974.

more recent writers has touched on this area.⁽¹⁾ Andrew Scull has written on the social content of earlier mental physicians' medical ideas, drawing on Bynum and Cooter to argue very plausibly that it was the simple assertion by doctors involved in lunacy that this condition was a physical disease of the brain which won for them their credibility as handlers of the insane.⁽²⁾ This analysis I have largely adopted. After looking at the content in terms of social values - particularly those concerned in evolutionary thinking - and of its function in regard to the medical men who propounded it I conclude that medical science's overriding concern with establishing the profession as an authoritative source of expertise limited its utility in regard to handling the problems posed by those labelled "insane" and acted as an actual denial of patients' real problems.

Whatever ideas medical men advanced to define insanity and establish their own control in that area, their ideas on therapy were of a largely different pedigree. Chapter 3 looks at these therapeutic ideas and at the reality behind them.

The therapeutic legacy which early nineteenth century insanity specialists bequeathed to their late Victorian counterparts was that of "moral treatment". This was the new method of treating the insane not as dangerous maniacs to be bound and beaten but as potentially recoverable members of society. The emphasis shifted away from physical restraints

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1. For example, Vieda Skultans makes some shrewd observations in her latest book on ideas of insanity and Roger Smith has made an original and valuable contribution to medical philosophy in his work on Victorian Trials. See SKULTANS, Vieda: English Madness: Ideas on Insanity 1580-1890. 1979.
SMITH, Roger: Trial by Medicine: Insanity and Responsibility in Victorian Trials. 1981.
 2. SCULL, Andrew T: Medical Men as Moral Entrepreneurs: from madness to mental illness. Archives Européennes de Sociologie, 26, 1975. See also his book, Museums of Madness: the Social Organisation of Insanity in Nineteenth Century England. 1979.

and coercion towards "psychological" or "moral" imperatives of labour, discipline and the cultivation of self-control within the confines of a building designed for that purpose.

The story of moral treatment and its intricate connections with the rise of the reformatory asylum, the public crusade against "mechanical restraint", as the mad-doctors' paraphernalia of chains, straight-waistcoats and bars came to be known, and the reorganisation of the medical profession is a complex one. The central dilemma concerns the actual nature of this new treatment of the insane. Was it a regeneration of humanity or a repression of waywardness? Was confinement in an asylum a necessary means of cure or was it mere custodialism?⁽¹⁾ Attitudes to the question of moral treatment have undergone a change with the revision of ideas on psychiatry over the last few years. Traditionalist interpretations still see it as progressive and humane.⁽²⁾ Others have looked upon moral treatment as commonly repressive.⁽³⁾ The terms "progressive" and "humane" have similarly been revised with the realisation that these terms are value-judgements that might no longer be shared by a radicalising

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1. Anne Digby begins her study of the York Retreat by asking these questions. The social content of "Moral Treatment" is further explored by Michael Fears whose work in the area has been sadly neglected. See DIGBY, Anne: Changes in the Asylum: the case of York, 1777-1815. Economic History Review, 2nd series, 36, 2, May 1983; FEARS, Michael: The 'moral treatment' of insanity: a study in the social construction of human nature. Unpublished Ph.D. thesis, Edinburgh, 1978. See also his article, Therapeutic Optimism and the Treatment of the Insane, in, DINGWALL, R. et al (Eds.): Health Care and Health Knowledge. 1977.
 2. This is still the common view given in standard medical text-books for students, for example, ARIETTI, S: American Handbook of Psychology, 2nd Edition, Vo..I, 1974. Kathleen Jones also shares this view. See JONES, K: Mental Health and Social Policy, 1845-1959. 1960.
 3. Psychiatrists of a more physiological orientation seem particularly to favour this view. See HUNTER, Richard and Ida MacALPINE: Three Hundred Years of Psychiatry. 1963; WALK, Alexander: Some Aspects of Moral Treatment of the Insane up to 1854. Journal of Mental Science, 100, 1954.

psychiatry or a revisionist liberal sociology.⁽¹⁾

My own view of this matter is that "repression" and "regeneration" have been unduly polarised and reflect not absolutes, but differences in our own viewpoint, hesitating between aspects of our liberal culture. The essential phenomenon of moral treatment, like any psychiatry, contained elements of both individual control and individual development - an accommodation of patient to society. The social origins of moral treatment, however, gave that brand of therapy a specific social location, amongst the Quaker brethren at York, or the emerging middle-classes of Pinel's society.⁽²⁾ As Fears remarks, the particular reconstruction of sanity involved in moral treatment became increasingly irrelevant as one moved further away from evangelical non-conformist society.⁽³⁾ The important question then becomes not whether treatment was progressive or repressive but who controlled the process and determined its outcome.

For contemporary reformers the answer was obvious: the insanity specialists controlled the whole procedure. Moral therapy was inseparable from the new reformatory asylum in which it was to be practiced, and the asylum, run by a single figure of authority, was the limb of a new principle of social organisation.

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1. This point is well made by CRAWFORD, C: The historiography of mental "illness": a case for the social history of madness. Unpublished M.Sc. thesis, Sussex, 1977. All the recent writers on the subject take a non-whiggish view of early nineteenth century "humanitarianism", for example, SCULL, A: op.cit; McCANDLESS, Peter: Insanity and Society. Unpublished Ph.D. thesis, Wisconsin, 1974; and DONNELLY, Michael: Managing the Mind: a study in the Development of Medical Psychology in Early 19th Century Britain. 1983.
 2. Pinel, of course, being the French reformer who first released insane inmates from their chains. Pinel's "Treatise on Insanity", espousing the new approach was translated by D.D. Davis and published in Britain in 1806.
 3. FEARS, M: op.cit.

The phenomenon of the asylum - this new development in public architecture - has attracted a good deal of attention from historians trying to understand its function. The lunatic asylum was only a part of the phenomenon, which included the penitentiary,⁽¹⁾ new schooling methods, the workhouse and the factory.⁽²⁾ All these buildings were designed to induce in their inmates a change of behaviour: to cure, to render honest, to instruct,⁽³⁾ to make diligent or to yield labour. Somewhere in its origins there lay the 'Panopticon' idea of Jeremy Bentham in which inmates were under constant scrutiny from a central observation tower - William Stark's Glasgow Lunatic Asylum and Joshua Jebb's prison architecture consciously borrowed this principle - and also the new factory discipline introduced by industrialists such as Wedgwood, Strutt and Boulton, who drew their inspiration from the same sources as the prison reformers.⁽⁴⁾ Michael Fears points out that Robert Owen's factory villages were a part of this new idea, extending the function of architecture to include the re-shaping of society itself.⁽⁵⁾ There was everywhere an emphasis on human malleability and its potential for "improvement".

Clearly, this historical development marked a shift in the nature of power in society and in particular an increase in state power. Much

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1. See DONNELLY, M: op.cit.
 2. See IGNATIEFF, Michael: A Just Measure of Pain; the penitentiary in the industrial revolution, 1750-1850. 1978.
 3. Or as Hylde Sims aptly put it in a letter to the 'Guardian', 26th July 1983, p.8, to "internalise the expectation of constant directed activity".
 4. IGNATIEFF, M: op.cit. A good example of the central observation tower principle in industrial architecture exists in Hebden Bridge, where workers' houses were arranged in such a way that from one room a supervisor could see into every bedroom. This structure dates from the late nineteenth century. (Author's own observations).
 5. FEARS, M: op.cit. The movement to define and solve social problems in architectural terms continued through the century and persisted into the twentieth with the garden suburbs. Its influence in many social areas, including health and housing, is still strong.

debate has resulted from this question of the asylum's role. Was it a humane institution in the specific sense of being therapeutic or reformatory, or was it a device for recapturing social order in times of rapid change?⁽¹⁾ This polarity is, of course, merely a rehearsal in historic time of contemporary political differences: how far the intrusion of state power worked toward "improvement" depends on how far one approves the new power. As Skultans comments on the belief of early nineteenth century insanity specialists, the ability to combat insanity (or, for that matter, ignorance or social inferiority) by cultivating habits of self-control was "part of the ideology of the emerging middle-classes".⁽²⁾

The reforming, institutionalising zeal displayed by early insanity specialists was more than the result of discovering certain "brutal" practices in madhouses or certain "abuses" in the system of existing care. Neither was the urgent realisation of the need for "humanitarian" treatment the consequence of the sudden discovery that the insane, too, were individuals, worthy of citizens' rights. These things were part of a new social perception resulting from the arrival of a new class of persons in places of control in society, with different attitudes to social organisation and a different relationship to sources of labour. Their influence extended far beyond ideology into the reorganisation of industrial activity upon a free market in labour power. Those who fell outside that free

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1. This was mostly generated by David Rothman's book, *The Discovery of the Asylum*, 1971, who sees it as an agency of social control. This view is vehemently opposed by Quen, who stresses the asylum's "humane" purpose: see QUEN, J.M.: *The Discovery of the Asylum*, by David Rothman - a review. Journal of Psychiatry and Law, 2, Spring 1974. Later critics, such as Grob and Zainaldin, take a meliorist stance, emphasising the existence of several purposes and many historical "accidents". See GROB, G.N.: *Rediscovering Asylums: the Unhistorical History of the Mental Hospital*. Hastings Center Report, 7, 4, New York, 1977; ZAINALDIN, J.S.: *Asylums and Society: an Approach to Industrial Change*. Journal of Social History, 13, 1, Fall 1979.
 2. SKULTANS, V.: op.cit., p.11.

market - through insanity or some other chronic inability to find employment - were subject to the new institutional discipline, which was as humane or repressive as the social order which it shored up.

In short, there was more to the asylum than its overt purpose. It stood upon the determining circumstances of an underlying social order. It was the Parliament of 1845 which passed the two Acts compelling the setting up of asylums on the county rates with inmates supported by the Poor Law and arranging that the medical profession should have charge of them. Their reasons for doing so were complex, far more than a vague desire to facilitate medical "advance".⁽¹⁾ They included a desire to protect society from the insane, with half an eye to potential assassins and other dangerous people, and a concern for the reduction of costs from curing those who would otherwise have to be kept on the parish.⁽²⁾ There was also a certain amount of private manoeuvring by the medical profession besides the personal campaigning of Ashley, later Earl of Shaftesbury, who proposed the original bills.

The esoteric medical function of the pauper lunatic asylums did not allow them to escape the realities of funding by county and parish rate-payers, which kept them broadly in line with the social policies managed at these levels. In looking at their explicit therapeutic function in the later nineteenth century, therefore, I have pursued their overt purpose to its logical point of determination - in the demands placed upon psychological medicine and the subjects of its concern by contemporary society. The examination thus becomes a practical case study in the relationship between

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1. Kathleen Jones sees the improvement of medicine and the unfolding progress of humanitarianism as the motives behind the passing of these Acts. Both concepts are extremely dubious, for reasons already given. See JONES, K: op.cit.
 2. For an examination of this view see McCANDLESS, Peter: Insanity and Society, op.cit.

ideology in medical science and the socio-economic conditions in which it is practiced.

In Part B of the thesis the practical workings of psychological medicine are explored further. Chapter 4 looks at the actual outcome of asylum functioning by an analysis of asylum records. This statistical portrait is drawn largely from admission registers covering a varied and therefore fairly representative sample of inmates. It shows mortality rates, lengths of stay, proportions of recoveries according to length of stay, sex and other factors. There is also some attempted analysis of patients' real problems from the records, but the scope for this is severely limited by the nature of those records, which reveal only what the doctors believed was important.

Chapter 5 explores this problem by using a different approach and different material. It takes as its theoretical starting point the assumption, stated by mental physicians throughout the period, that the entire asylum, with all its routines and living conditions, was in some way essential to the curative regime. Therefore, the impact of asylum life upon inmates has to be evaluated, and I have done this using autobiographical material where possible as well as reports by staff and visitors and by other medical observations. The scope for reconstructing the life of inmates within the walls of the asylum is still very limited and I have made some common-sense (I hope!) estimations of the impact of various aspects of asylum life. Part of my assumptions, too, has been cautious acceptance of some of the ideas expressed by Erving Goffman in his book, "Asylums",⁽¹⁾ such as the concept of the reconstruction of a sense of personal identity following the trauma of incarceration. The chapter

1. GOFFMAN, Erving: Asylums, Essays on the Social Situation of Mental Patients and Other Inmates. 1968.

examines the physical conditions of inmates, the impact on their lives of asylum routines, relations between inmates and finally relations between inmates and staff. It concludes that initiatives by inmates were thwarted at every turn, being generally regarded as signs of waywardness (whether of sane or insane inspiration being irrelevant) and repressed by an all-pervasive medical authority. It is suggested that this system was inherently unlikely to address patients' problems and could only repress them, pending spontaneous cures which, being rarely recognised, were not likely to improve an already dismal curative record.

Part C sets this dismal record against the other functions which the asylum served. The development of the public asylum was a watershed in the growth of a psychiatric profession within the wider medical profession. The terms of the 1845 Lunacy Act guaranteed that the superintendent was to be a medical man, and the compulsory building of asylums in each county, together with the construction of new asylums as the inmate populations grew, meant that a specialist branch of medicine dealing with the insane was bound to perpetuate itself so long as those arrangements persisted. In Chapter 6, the importance of the asylum, especially its physical isolation, is spelled out in terms of the opportunities given for insanity specialists to engage in their own unique type of work. The opportunities were nevertheless modest, and the profession maintained itself, with the aid of its own society⁽¹⁾ and journal,⁽²⁾ rather than expanded.

Some work on this aspect exists. Alexander Walk, in particular, has supplied very useful information from the Royal College of Psychiatry's

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1. The Association of Medical Officers of Hospitals for the Insane, founded in 1841. In 1865 it changed its name to the Medico-Psychological Association.
 2. The "Journal of Mental Science". This began in 1853 as the "Asylum Journal", changed its name to the "Asylum Journal of Mental Science" in 1855, then became the "Journal of Mental Science" in 1858. See Chapter 6, pp. 283-7, below.

archives on the profession's early years.⁽¹⁾ Notices in journals and superintendents' reports also provide information on the unfolding of the profession and help to create a picture of a fairly static body, with long-term engagements in the highest posts and the lesser posts filled by younger men who either remain many years in a subordinate capacity or move out quickly, sometimes to higher status but much more often to medical posts outside the speciality.

The asylum situation appeared to favour the few at the top fairly well, with rather less satisfaction given to medical men lower down the scale. It is perhaps not surprising that historical research has tended to concentrate on these figures, leaving the work of writing a history of the nursing staff to others beyond the profession's fringes. Fortunately that work is now being done.

Pioneering work on asylum attendants was done as long ago as 1949, by Santos and Stainbrook,⁽²⁾ but it appears not to have attracted enthusiasm. More recent interest in mental nursing staff has come from trade union history,⁽³⁾ which has introduced a welcome change of perspective. Social and medical historians are now beginning to show an interest with the realisation (first suggested a century and a half ago) that the work of

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1. WALK, A: The Centenary of the Journal of Mental Science. Journal of Mental Science, 99, 1953; idem. Gloucester and the Beginnings of the Royal Medico-Psychological Association. Journal of Mental Science, 107, 1961; idem. Medico-Psychologists, Maudsley and The Maudsley. British Journal of Psychiatry, 128, 1976; idem. Forty Years of Wanderings: the Medico-Psychological Association, 1855-1894. British Journal of Psychiatry, 132, 1978. See also, LEWIS, Aubrey Psychiatric Education: background and history, in, LEWIS, A: The State of Psychiatry: Essays and Addresses. 1967.
 2. SANTOS, E. and E. STAINBROOK: A History of Psychiatric Nursing in the Nineteenth Century. Journal of Historical Medicine and Allied Sciences, 4, 1949.
 3. ADAMS, F.R.: From Association to Union: Professional Organisation of Asylum Attendants, 1869-1919. British Journal of Sociology, 20, 1969; CARPENTER, Mick: Asylum Nursing Before 1914: a Chapter in the History of Labour, in, DAVIES, C: Rewriting Nursing History. 1979.

nurses and attendants formed a decisive influence over the quality of mental care and chances of recovery.⁽¹⁾ The relationship between them and their superiors was a curious one, characterised by an odd duality of attitude by medical superintendents who on the one hand praised the "ideal" attendant for the essential work which they performed and on whom so much depended, and on the other hand hounded them for their failings and were noticeably slow in offering educational or adequate financial resources. The neglect of mental nursing history combined with the perpetual emphasis on their importance given for over a century by doctors is a part of this ambiguity, which I have attempted to address. It is to be hoped that research in this area will continue.

The demands of profession-making were, however, a small factor in the development of the asylum. By far the most determinant - for both cures and careers - were those of social support, particularly of funding. The social structure within which the medical enterprise was set is explored in the last main chapter. Having traced the forms of mental science and therapy through their theoretical construction and their practical application I am able to indicate how social determinants, which in themselves are not concerned with the well-being of the insane, have shaped and set limits to what was called psychological medicine. This effectively picks up from the demythologising approach begun in Chapters 2 and 3, where the outlines of social structuring were discernible beneath the "scientific" constructions of medical theory and practice. The result is a view of psychological medicine as one aspect of the Victorian social order, neither independent of nor entirely a function of extra-medical purposes, but shaped by the

1. WALTON, John: The Treatment of Pauper Lunatics in Victorian England: the Case of the Lancaster Asylum, 1816-1870, in, SCULL, A.T. (Ed.): Madhouses, Mad-Doctors and Madmen: the Social History of Psychiatry in the Victorian Era. 1981; FINNANE, Mark: Insanity and the Insane in Post-Famine Ireland. 1981.

effective distribution of power between the various agents of "non-medical" social organisation, the medical profession and lastly the patients, who were rendered powerless by their status as marginalised paupers within a society oriented towards a free market in the hire of labour.

The physical embodiment of this power-distribution was the asylum itself. As a classic institution it may not have been typical of this Victorian innovation in the regulation of social problems, but it displayed features common to others of its kind, the prison, orphanage, industrial school and other hostels for the unfortunate. Ultimately, psychological medicine was the asylum. This, in turn, was a characteristic expression of the dominant Victorian response to those on the "outside". I conclude with the suggestion that we should perhaps be looking at the lunatic asylum not as a "medical" establishment at all, but as another variant of the great Victorian institution, and that in any case, a society's psychiatry is inseparable in the end from the wider conditions of its support of its whole population.

In working through the material presented here I have been less concerned with the validity of theoretical concepts of "mental illness" and so on than with the reality of suffering individuals in their historic context. Consequently, my use of various terms throughout the thesis does not necessarily reflect any fixed conception but is clear from each specific context. The term "mental disease" was the one most commonly used by Victorian doctors in lunacy and where I have used the term it refers to their concept of it. Similarly, I have placed such terms in quotation marks which should be understood as having had specific usages in their historical context rather than as being part of an accepted epistemology. For example, the term "insanity" is generally presented in this way, for though it has meant something in each historical use I do not know how

usefully to define it. I have used the descriptions "deviant", "aberrant" and "bizarre" more or less interchangeably to denote a recognised departure from "normal" behaviour in the given context. The term "deviance" has in any case now left the realms of specialised usage to become a part of everyday language, to be interpreted as such. The term "psychiatry" was not in general use in the nineteenth century, so I have not generally used it. Where necessary I have referred to "psychological medicine" as the practical activity and "mental science" as its theoretical aspect.

"Psychiatrist" was similarly not used. I have used the terms "mental physician", "doctor" or simply "medical men" (there were no women involved) to describe them. Oddly, the term "alienist" has become prevalent in most historical writings on the subject. It is hard to see why, since English doctors rarely used the word.⁽¹⁾ It was more common early in the nineteenth century when the influence of the French "alienists" was greater and particularly in America, where the term was very common well into the twentieth century.

Finally, some comment is called for on the use of the term "individual" when describing patients. I have already criticised its use as part of a supposed individual-social dichotomy. In this context, "individual" is a part of the liberal-bourgeois philosophy of society and is seen as a fundamental, atomistic social unit, between which rational exchange (social and economic) takes place, thus creating "society". This is not my use of it. I see no fundamental distinction between individual and social organisation save one: that each one of us feels, suffers and creates his or herself amid social relationships. Individuals in this sense are the points of active consciousness, but the content of conscious-

1. This observation has also been made by Michael Fears in his Ph.D. thesis, op.cit.

ness and the identity of self I do not see independently of historic social relation. I place importance upon the individual because this is where judgement is validated. I also emphasise the individual sufferer (or patient) as distinct from the individual as social deviant. We are talking here of attitudes and responses, not of human ontology. The distinction is made because "medicine" makes it. The medical enterprise isolates the individual patient and directs its remedies to him or her. Because my purpose in the following pages is to assess the value of that enterprise and explain its performance I must abide by its rules.

In writing on an interdisciplinary approach to medical history the sociologist L.S. King commented that

"a sociologist and a historian and a physician placed together, will not create a social history of medicine. There must be a synthesis. Masses of facts derived from separate disciplines, and placed side by side accomplish nothing Progress comes when an investigator in one field perceives the relevance of data in another field". (1)

I do not claim to have created a synthesis of this kind here. By presenting a study of psychiatry at one historic period in terms which question its medical rather than historical value I hope to be able to show that such a synthesis is due.

1. KING, L.S.: An Interdisciplinary approach to medical history.
Clio Medica, 9, 1974, p.6.

P A R T A

PSYCHOLOGICAL MEDICINE IN THEORY

CHAPTER 2: MENTAL SCIENCE AND MENTAL PHYSICIANS,
A STUDY IN THE LEGITIMATION OF AUTHORITY

By the beginning of the period which this thesis examines mental physicians had already captured the social area of "insanity" as their exclusive preserve. The Lunacy Acts of 1845, by which each county was compelled to erect a lunatic asylum through public expenditure, also ensured that medical men alone could be in charge.⁽¹⁾ Their campaign to win for themselves the advantages of this position necessitated the development of a body of theory by which lunacy could be understood as a medical speciality. This took the form of a steady polemic, sustained by the copious publication of treatises, centring on the notion of insanity as a physical lesion of the brain and therefore an appropriate condition to be dealt with by the relatively new group of doctors.⁽²⁾

With the change in status that followed this capture there was an alteration in the manner in which this scientific activity was carried on. These were the years of the construction of "mental science". Mental physicians were no longer addressing the lay public but themselves and the raw recruits to the profession. They were keenly aware that their position as medical men depended upon their possession of a coherent ideology in the form of scientific theory which could stand independently of the physicians themselves. With such theoretical underpinning they could be seen as men of science, engaged in the business of interpreting and applying certain fixed laws, the legitimate engineers of mental health.

This "mental science" was constructed within two main arenas. On

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1. 8, 9 Vict. c.100, and 8, 9 Vict. c.126.
 2. See, for example, SCULL, A.T: Medical Men as Moral Entrepreneurs: from madness to mental illness. European Journal of Sociology, 26, 1975, pp.218-61; BYNUM, W: Rationales for Therapy, c1780-1835. Medical History, 1974; also COOTER, Roger: Phrenology and British Alienists, c1825-1845. Medical History, 1976.

the one hand there were the medical text-books on lunacy which began to appear at this time, aimed at the rest of the medical profession, and on the other hand there was the mental physicians' own journal, the "Journal of Mental Science", which began publication in the fifties.⁽¹⁾

The first of the text-books of this kind was Bucknill and Tuke's "Manual of Psychological Medicine", which appeared in 1858, reaching a fourth edition in 1879. J.C. Bucknill was also the first editor of the "Journal" and later edited "Brain", a journal of neurology, as well as writing other books and articles. Daniel Hack Tuke,⁽²⁾ the co-author of the "Manual", was also an editor of the "Journal" and President of the mental physicians' society, the Medico-Psychological Association,⁽³⁾ as well as being a copious writer on mental disease. There were other writers whose text-books acquired relative popularity and staying power. W.H.O. Sankey's "Lectures on Clinical Diseases", first published in 1866, went into a second edition twenty years later, whilst G.H. Savage's "Insanity and Allied Neuroses" sold over ten thousand copies between 1884 and 1905. T.S. Clouston's "Clinical Lectures on Mental Diseases", published in 1883, sold a comparable quantity over a similar period of time. Savage and Clouston were also sometime editors of the "Journal of Mental Science".⁽⁴⁾ Another influential writer on the subject was W.B. Carpenter, a critic of scientific matters whose interests embraced lunacy, spiritualism and the ocean deep. His book, "Principles of Mental Physiology", was published in 1874 and by 1896 was into its seventh edition.

Popular text-books such as these contained all the basic elements of

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1. See Chapter 6, pp.289-297.
 2. No relation to the Tuke family who founded the York Retreat in 1792.
 3. See Chapter 6, pp.301-303.
 4. See WALK, A: "Forty Years of Wanderings" - the Medico-Psychological Association, 1855-1894. British Journal of Psychiatry, 132, 1978, pp.530-547.

the new "mental science", which were absorbed by men entering the profession and also by medical men who were outside the speciality. More elaborate theorising was to be found in the pages of the "Journal of Mental Science", which was read by all in the profession. Using these two sources we can examine the quality and function of mental physicians' scientific theory.

Some analysis of the content of this theory has already been attempted by recent historians. Michael J. Clark,⁽¹⁾ for example, has considered the medical profession's failure to develop a psychological, as opposed to a physiological and neurological, basis for treatment, and Vieda Skultans has looked briefly at later nineteenth century 'psychiatric' theory in her book, "English Madness".⁽²⁾

However, these studies remain primarily histories of ideas and concern themselves with the internal construction of medical models of "insanity" or with images of madness drawn from cultural perspectives. Both Clark and Skultans offer valuable insights on these matters, not least in demonstrating the strongly value-laden character of what was accepted as scientific thinking. The intention of this chapter, however, is to take a step closer to the actual constructors of that thought: the mental physicians, who worked in asylums, read the Journal and other publications and published ideas of their own. In that sense it is intended less as a history of ideas and more as a social history of "mental science" as evidenced in the "Journal" and elsewhere, and of the men who created and drew upon it.

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1. CLARK, Michael J: The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry, in, SCULL, Andrew (Ed.): Madhouses, Mad-Doctors and Madmen: the Social History of Psychiatry in the Victorian Era. 1981.
 2. SKULTANS, Vieda: English Madness: Ideas on insanity, 1580-1890. 1979.

The construction of medical theory was by no means the only aspect of mental physicians' efforts to establish their credentials as a newly-emerged professional body. They were engaged in a social discourse which brought them into conflict with more established forces than their own, not least of which were the Poor Law authorities and the legal profession.⁽¹⁾ However, in this chapter we are primarily concerned not so much with the total social meaning of what they were providing as with an element in the discourse which comprised the physicians' overt raison d'être - the claim to provide remedies for insanity. It is with questions relating to this fundamental concern that we approach the subject of "mental science". It is contended that the construction of an elaborate body of theoretical "knowledge" served a valuable function to the medical profession already implicated in treating insanity but that at the same time it held rather less value for those regarded as insane.

a) What is Insanity?

The difficulties of defining a "mental science" were immediately apparent when physicians asked 'What is insanity?' Of course, they were not seeking a philosophical answer, but rather they were trying to rationalise a basis by which the actual inmates of an asylum could be regarded as possessing a common feature, a business that was not without its difficulties. G.H. Savage, in his medical text-book of 1884, saw the term "insanity" as a "term of convenience" rather than as something absolute. It consists, he says, of a disease of the brain when seen "from the physician's side" and of an interference with the laws of society, when seen from a social perspective.⁽²⁾ W.H.O. Sankey, writing in the

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1. On the latter, see SMITH, Roger: Trial by Medicine: Insanity and Responsibility in Victorian Trials. Edinburgh, 1981.
 2. SAVAGE, George H: Insanity and Allied Neuroses, Practical and Clinical. London, 1884, p.1.

same year, attempted to be more precise. Drawing on the physical perspective which equates "insanity" with "disease" he concluded:

"By the word Disease is meant the sum of all the phenomena which are observed in a given case, including the first indications of deviation from health, the evolution of the symptoms, their progress, order of succession, and mode of termination". (1)

In other words "insanity" was to be recognised as a "deviation from health", by which was meant "normal behaviour". Since "normality" is scarcely open to any value-free interpretation no neutral basis for the term "insanity" could be derived from this definition. Nevertheless, mental physicians assumed that such a basis must exist in science, the difficulty thus becoming not that "insanity" was a problematic concept in itself, but that it was very hard to "discover" it. A.J. Sutherland, in an early article in the 'Asylum Journal of Mental Science', expressed the virtual impossibility of precisely defining "real" insanity:

"There are a thousand shades of madness more or less distinct, a thousand variations of colouring more or less vivid; but still they are all classed under the general term of Insanity, and the pupil naturally asks, what are the means furnished one for detecting the disease? What is the standard which is to guide one in determining this man to be eccentric, that man mad? It must be confessed that this problem has never satisfactorily been solved, definition after definition has been invented, but with little success; eccentricity and passion run so imperceptibly into insanity, that it is sometimes very difficult to say where one ends and the other begins" (2)

It is significant that Sutherland says "it is sometimes very difficult to say where one ends and the other begins" because this implies that quite often it is not, and then we really can see true "insanity". Yet despite the assumption that a "true" or "neutral" insanity exists,

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1. SANKEY, W.H.O: Lectures on Mental Disease. 2nd Ed. London, 1884, p.100.
 2. SUTHERLAND, A.J: Introductory Lecture to a Course of Lectures on the Pathology and Treatment of Insanity. Asylum Journal of Mental Science, II, 15, 1855, pp.22-3.

Sutherland is well aware of the dangers of relying on this assumption to categorise individuals:

"The most comprehensive definitions indeed often show that he who has invented them has become involved in a vicious circle. When Aristotle defined prudence, he seems to have been oppressed with the same sort of difficulty; he says ("Ethics", Book vi, Chap.5) 'Observe the habits and actions of the prudent man, and you will then know what prudence is'; so will you be able to learn what madness is, by observing the conduct and conversation of the insane". (1)

The final phrase leads us back to the social reality of the category of "the insane", although Sutherland was unable to overcome the belief that such a category was a neutral "fact". J.C. Bucknill, editor of the "Journal of Mental Science", avoided the whole dilemma by saying bluntly:

"I have never yet seen a definition (of insanity) which could not be torn to pieces with very little effort. I shall therefore call that insanity which all people understand by the term". (2)

We should be cautious of the view that mental physicians were unaware of the problems associated with assigning individuals to a category which they held to be a scientific "fact". What is more important is that they asserted the validity of that category by expressing it in neutral terms, as if it existed independently of social criteria, ultimately discernible independently of what people might judge it to be. This inevitably emphasised the value of their "scientific" approach to those people which it was held to encompass. Moreover, by characterising the categorisation of "insanity" as the recognition (no matter how difficult) of a "fact", they rendered invisible the actual social processes which had first outlined that category, so that their own control of the insane appeared to be a natural fait accompli.

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1. ibid., p.23.
 2. BUCKNILL, J.C.: The Diagnosis of Insanity. Asylum Journal of Mental Science, II, 16, 1855, pp.229-230.

This appeal to natural processes, and thereby the natural right of the medical profession to deal with the insane, was further emphasised by the repeated use of physiological parallels. Sankey could describe insanity in these terms with the assurance of one who felt himself in the mainstream of opinion:

"In other medical treatises the pathologist may assume that the physiology of each organ, the diseases of which he is about to describe, is already acquired by the student. This cannot be said to be the case when the disease is mental. The physiology of the mental functions, or psychology, is omitted of late years in the text-books". (1)

It is not difficult to see in this passage the outline of the earlier argument that "insanity is a disease of the brain" here less assertive in tone than previously, rather more regarded as already an established fact. Sankey actually devoted the first hundred pages of his book to supplying the "physiology of the mental functions", on the assumption that such a physiology allowed a scientific study of what he called "Mind":

"The study of Mind, formerly called Philosophy as though it were the only subject of learning, is of very ancient date, and was almost the first subject which excited the attention of contemplative minds. In those early times it was of course considered entirely apart from the body. Mental philosophy long preceded the study of anatomy". (2)

Here are "Mind" and "anatomy" clearly set in one precept, and all suggesting that "mental science" had now superceded what was "formerly called Philosophy".

Finally, Samuel Wilks, Physician to Guy's Hospital, put the accepted view of the mental physician on the mind-body relationship in a nutshell in an article in the 'Journal of Mental Science' in 1875:

"(The scientific man) sees the brain and the human faculties associated with it, he knows nothing of one without the other, and the problem of their union to him is not necessarily of greater difficulty than the association of

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1. SANKEY, W.H.O: op.cit., p.1.
 2. ibid., p.1.

other features with their respective organs, or the ordinary properties of phenomena of matter with the subject matter itself. It is quite true that no study of the mind alone would have lighted upon cerebral substance, nor is it likely that a study of the bile would have suggested a liver, or the most minute analysis of another secretion suggested a kidney. We know that certain organs have certain actions, and we may say the same of the brain; and with many persons there is no more difficulty in accepting this fact than any other fact in nature". (1)

Three things are worth noting in this passage. Firstly, the analogy between "mind" and "bile", which effectively renders the former a material object capable of full comprehension through objective study. Secondly, the ease with which these two things are so compared, an ease which dismisses Sankey's⁽²⁾ "Philosophy" as decisively as did Sankey himself. It cannot be assumed even in 1875 that educated opinion saw no objection to so materialist a comparison, as the continuing debate on human evolution at the time showed. Yet Wilks' assurance is unwavering as he informs us, lastly, that this interpretation of "mind" is a "fact in nature". This reference back to the natural world, where "facts" are not open to question, seals the whole argument. Whatever interpretation may henceforth be given to mental behaviour - whether, for example, it is to be considered as "insanity", a judgement which we have already seen was openly admitted to be a judgement of value - it becomes an unanswerable "fact in nature". This assurance makes possible such statements as that of

W.G. Balfour, Medical Superintendent at the Hampstead Asylum:

"Exposure to cold will in one man produce coryza, in a second rheumatism, and in a third pneumonia; so poverty and want will in one man lead to mania, and in a second to melancholia, the form of insanity being due, in a great measure to the nerve-cells of the brain". (3)

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1. WILKS, Samuel: The Study of the Human Mind from a Physiological Point of View. Journal of Mental Science, XX, 92, 1875, p.492.
 2. SANKEY, W.H.O: op.cit., p.1.
 3. BALFOUR, W.G: Pathological Appearances Observed in the Brains of the Insane. Journal of Mental Science, XX, 89, 1874, pp.59-60.

Thus the judgement of a medical man, even in matters of the interpretation of human behaviour, cannot be questioned without apparently overturning the whole order of nature.

b) The Classification of Insanity

The assurance that mental physicians had derived from their original assertion that insanity "is a disease of the brain", subsequently repeated as accepted fact,⁽¹⁾ gave them the confidence to outline various types and categories of insanity itself. Nevertheless, they were often considerably more cautious about the construction of theoretical categories than may be supposed. We find again, as with the definition of the original category of "insanity", that an acceptance of such categories as being "real" or "natural" does not make any easier the business of "recognising" them in practice.

There were, to begin with, no settled systems of classification of mental disease. It could be defined by symptoms, by the time of life or, indeed, by whatever system made sense to its designer. Bucknill and Tuke⁽²⁾ preferred to classify by "function". Mind, they argued, had a three-fold nature, part intellect, part emotion and part volition. Insanity could be classified therefore by intellectual disorders: dementia, monomania and idiocy - by emotional, or "moral" disorders: melancholia, exaltation - or by disorder of the "propensities": mania, homicidal and suicidal impulses, kleptomania, and so on. T.S. Clouston,⁽³⁾ preferred to classify by symptom. Thus insanity fell into "mania", "melancholia", "manic-depression", "monomania", "dementia" and "psychocoma" (when the

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1. BUCKNILL, J.C. and D.H. TUKE: A Manual of Psychological Medicine. London, 1858.
 2. ibid.
 3. CLOUSTON, T.S: Clinical Lectures on Mental Diseases. 2nd Ed. London, 1888, p.18.

patient was "dead to the world"). These categories at least eschewed any supposition of any meaningful consistency of physical disorders of the brain underlining these types of insanity, yet the urge to link insanity with such a basis led Clouston, along with David Skae, to outline many a "type" of insanity based, allegedly, on physical disorders. Thus, in the Morisonian Lectures on Insanity for 1873, we find:

"Puerperal Insanity is a disease recurring within a month, or by a little latitude it may be extended to cases within six or eight weeks after confinement". (1)

or again, "Insanity of Lactation", "Climacteric Insanity" and "Ovario-Mania", (this latter Clouston often regards as "old maid's insanity - they imagine their clergyman has made love to them, has attempted to seduce them, or to poison them because they would not be seduced, that their medical attendant has played the same game").

It is difficult to tell in these cases whether mental physicians were led into making rash classifications by assuming a real and physical basis for insanity or whether they were simply being pragmatic in isolating relatively distinct phenomena. Skae and Clouston⁽²⁾ go on to describe "Traumatic Insanity" caused by sunstroke or blows to the head; "Rheumatic Insanity" which results in "intense delirious excitement, with violent ungrounded fears, and an utter carelessness of the consequences of jumping through windows, or throwing himself against walls, or anything of that sort"; and even "Choreic Insanity" which they regard as "an insanity of the motor centres". These do appear to relate to a distinctive class of problems which must have been observed in the patients under their care, and so might be regarded as reasonably "objective" - in the sense of being

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1. SKAE, David and T.S. CLOUSTON (Eds.): The Morisonian Lectures on Insanity for 1873, Part III. *Journal of Mental Science*, XX, 89, 1874, pp.1-2.
 2. ibid., Part IV, *Journal of Mental Science*, XX, 90, 1874, pp.203-4.

fairly self-evident to the observer, but then we find "Insanity of Masturbation", "Satyriasis", "Nymphomania" and Clouston's "old maid's insanity",⁽¹⁾ where objective description has clearly been informed by a moral condemnation for which the physical explanations given are apparently rationalisations.

The best we can say of these attempts at classification is that they were honest attempts to order a whole mass of incoherent phenomena passing under the general heading of "insanity". The worst is that they were a futile exercise in taxonomy designed to provide assurance, for writer as well as audience, that this really was a brand of science and served some sort of purpose. Sankey⁽²⁾ seems to illustrate the point nicely. His system of classification was even accompanied by a diagram showing how all forms of insanity are linked, yet despite his elaborate use of subcategories all insanity that lacked any obvious physical basis were simply put under the heading of "ordinary insanity".

Skæe, however, was in no doubt that beneath such classifications, however arrived at, lay "real diseases",

"It must be clear to all that 'mania', 'melancholia' etc., are not diseases, but mere signs of disease, which may properly enough be compared with such signs of disease as the quick pulse, spasmodic breathing, etc".⁽³⁾

No matter how difficult it may be to recognise "insanity" or the "real" forms of it, nevertheless they are "there". They are "facts in nature". The old, polemic assertion that "insanity is a disease of the brain" had not directly influenced the efforts of mental physicians to classify insanity but it had added plausibility to the enterprise itself by suggest-

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1. SKÆE, David: The Morisonian Lectures on Insanity for 1873, Part II. Journal of Mental Science, XIX, 88, 1874, pp.498-499.
 2. SANKEY, W.H.O: op.cit., p.102.
 3. SKÆE, David: The Morisonian Lectures on Insanity for 1873, Part I. Journal of Mental Science, XIX, 87, 1873, p.353.

ing for it an observable basis which could be assumed to underlie any categories which doctors felt reasonably confident about to agree on.

c) The Causes of Insanity

Although the ubiquity of this assertion allowed them to talk in the terms of a scientific neutrality, physicians were actually dealing in unacknowledged value-judgements. This is well illustrated by their views on the supposed causes and mechanics of insanity. It was a commonplace of psychiatric writing at this time that the causes of insanity could best be described under the twin headings of "predisposing" and "exciting" (or "precipitating") and indeed this system is still carried on today. It is really an open-ended model for exploring possible causation rather than a rigid pattern of classification, which at its worst, becomes a mere catch-all formula, for "predisposing" can mean any preceding condition, while "exciting" may only refer to whatever incident happened to coincide most directly with the onset of the patient's symptoms. Nevertheless it can serve as a tool for focussing ideas.

Bucknill and Tuke⁽¹⁾ relied on this system, and so did Maudsley, another major influence on the direction of medical thinking on insanity.⁽²⁾ Nevertheless, as with classifications of "types" of insanity, one is left wondering how far this system was used to progress ideas on causation and how far it was rather a kind of ritual process which helped to obscure from mental physicians the true extent of their lack of knowledge, whilst not actually furnishing any way of improving that knowledge. If we consider the ideas listed under 'predisposing causes' we find that they tend in general to draw upon popular notions of the 'unnaturalness' of civilisa-

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1. BUCKNILL, J.C. and D.H. TUKE: op.cit.
 2. MAUDSLEY, Henry: The Physiology and Pathology of Mind. 2nd Edn., London, 1868. See below, pp.48-52 and pp.76-81; also Chapter 6, pp.296-300.

tion, or other commonly held ideas of this kind. For example, Bucknill and Tuke listed among their causes such things as 'hereditary disposition', the effect of living in large towns, or even celibacy, especially in women. Maudsley added to these. For him, civilisation itself in all its varied effects upon the human organism could be the very agent that made insanity possible. He took this opportunity to rail against many of those injustices in society which he happened to feel most keenly about. He attacked the "Money-Getting Gospel" of the age, arguing that at both top and bottom, people were forced to be mean-minded and un-altruistic, which "deteriorates the nature of humanity", and went on to criticise the difficult role given to women in the society of his day, particularly as regards the impossibility of unmarried respectable women ever being able to express their "sexual feelings". In connection with the apparently higher rate of insanity amongst women than amongst men, Maudsley had this to say:

"The female sex is certainly weaker, and on this account will be more likely to suffer from the adverse circumstances of life, especially in a complex social state, where it is precluded so much from active work, suffers from a bad system of education, has so few resources and is enfeebled by dependence". (1)

The comment makes an interesting contrast to some of the more commonly-accepted Victorian views of women, if only in adding social factors to the usual biological disadvantages, and it is clearly a value-laden, not to say downright political, statement.

Maudsley had much to say about the deleterious effects of religion, too. Methodism he regarded as an excitement of religious feeling, leading to moroseness, while High Church religion, and outright Catholicism, had a "baneful effect on women" because priests "mistake for deep religious feel-

1. MAUDSLEY, Henry: The Physiology and Pathology of Mind. 2nd Ed., London, 1868, p.236.

ing what is really at times a morbid self-feeling arising out of an unsatisfied sexual instinct".⁽¹⁾ He also took to task such matters as the "struggle for life", parental harshness and neglect and even poor housing. All these things predisposed toward insanity, he argued. There is no doubt that many lay voices agreed with him. Indeed, the Parliamentary Report on the Increase of Insanity, 1877, was ready to cite the "hurry and restless movement, the keen competition and struggle, growth and corresponding evils of large cities"⁽²⁾ as without doubt a possible cause of insanity, though its findings qualify this view to some extent.

Despite the sometimes fascinating nature of these suggestions it is hard to believe that such "causes" were other than appeals to general approbation, pleas for credibility from the public by giving forth popular prejudices as medical opinion. Not that "medical opinion" is ever really free from such prejudices and assumptions. As I.K. Zola reminds us, disease is invariably described in moral language.

"On nearly every level, from getting sick to recovering, a moral battle is waged. Frankly, it seems hard to believe that the English language is so poor that a moral rhetoric is needed to describe a supposed amoral phenomena - illness". (3)

We may even express doubts that what Maudsley and other mental physicians were talking about was in any case considered "amoral" at all, doubts which become greater when we consider the second major category in the paradigm of causation - "proximate", or "exciting".

Here we find again the distinction between "physical" and "moral" causes. The former category is clear enough; it comprises head injuries,

1. ibid., p.240.
2. Special Report on the Alleged Increase in Lunacy, 1877.
3. ZOLA, I.K: Medicine as an Institution of Social Control. Sociological Review, NS 20, 1972, p.492.

brain tumours, poisoning, "old age" (according to Bucknill and Tuke) as well as alcoholism (an ambiguous classification) and epilepsy. This last, of course, being one of the staple diseases of nineteenth century psychiatry. Insofar as physical injury was detectably present in such cases, the category of "physical" causation - given the existing bias toward somatic interpretations of behaviour - seems understandable. So, too, do some of the "moral" causes, but not all, at least not to a modern audience (which only serves to remind us that a value-judgement is no less so because we happen to share it). Thus, among "moral" causes, Bucknill and Tuke list "disappointed affections", "domestic troubles", "grief", "religious anxiety", "political and other excitement", "wounded feeling", "fright" and "overstudy",* but there are many similar "causes" listed throughout psychiatric works of this period. Given that doctors claimed to be handling scientific knowledge, the question which needs to be asked is, in what sense are these listed eventualities intended as knowledge of causation?

That mental physicians did intend them to be taken as a serious contribution to "mental science" is evident from the extensive tables of causes published from time to time in the 'Journal of Mental Science' and in Reports of the Commissioners in Lunacy, but again, as with the "predisposing" causes, one wonders how far these alleged causes were mere rationalisations of events which popular prejudice held were "bad" for you and how far doctors believed there really was some element of "scientific" knowledge behind them. How, after all, did doctors verify these supposed

* a common euphemism for habitual indulgence in alcohol. The terms "disappointment in love", "domestic troubles" and so on were also used euphemistically. Probably the first, at least, refers to an illegitimate birth. This in itself raises questions concerning doctors' moral enterprise which are not answered anywhere in their literature or their records.

causes? The answer is that they appear not to have done so but simply assumed the veracity of any given causes in the first place. Thus

Sankey wrote:

"The moral causes given by the Commissioners in Lunacy, from returns furnished to them, are the following:

Domestic troubles, including loss of relatives or friends,
Adverse circumstances and cares of business,
Religious impressions and convictions,
Love affairs, seduction, etc." (1)

Coming from such an impressive body as the Commissioners themselves, Sankey hardly doubted the veracity of this information. Yet what was the Commissioners' original source? In practice, the information supplied regularly to the Commissioners in Lunacy came from the asylums, where details were taken from individual patients' case-notes contained in the registers. The entry under "supposed cause" in the admission register was invariably a straight copy from the original document of committal which was completed before the patient was presented to an asylum.⁽²⁾ In other words, a "suppose cause" was written down on a certificate of lunacy by the first doctor to see the patient, who was never a doctor associated with an asylum, but usually a Poor Law Medical Officer. This information then passed straight through the asylum bureaucracy unaltered until arriving finally at the office of the Commissioners in Lunacy and so into their Reports. Thus the status of this information is, to say the least, dubious. Moreover, the information concerning the supposed cause did not always originate with the Medical Officer who saw the patient but sometimes with the patient himself or his relatives.

We can therefore say with certainty that the "precipitating moral

1. SANKEY, W.H.O: op.cit., p.378.
2. Cf, for example, the reception orders for the West Riding Lunatic Asylum with the entries in the asylum admission registers. Stanley Royd Hospital Museum and the PRO, Wakefield, C85 123.

causes" published as medical knowledge in the most prestigious text-books of the time had little value, at least, as elements of pathology. Mental physicians may not, it is true, have been aware of this, although a writer of text-books who is so out of touch with asylum procedure as not to be familiar with the passage of information on such matters may stand guilty of omission in any case. But this is not the point. Physicians should have been aware of the true value of what they passed out as "knowledge" if they were to be credible men of science. There is, about supposed causes, a distinct lack of the circumspect, cautious attitude which we saw prevailed when insanity was defined or classified.

But we can go further. For although the information on causation was in fact of little value, mental physicians believed it was valuable and by continued publication of such tables as we have earlier seen implied this to be so to the world at large. For some doctors, we may take Sankey as an example of these, this value rested on the authority of the Commissioners in Lunacy. But for doctors in general, and for the Commissioners, the value of this information appears to rest upon the authority of the medical profession itself. Mental physicians having set themselves up as the experts on matters on insanity and published many "scientific" studies on the subject, appear in this case to have presumed a body of knowledge which it was actually their business to discover. In the process, physicians appear to have neglected such attempts at discovery. Whether such an attempt would have met with any success is a matter we cannot answer. What we can say is that in this case the assumption of authority by the profession preceded any justification for it and inhibited such research as may otherwise have been done.

d) The Mechanics of Insanity

What are the consequences of this assumption of authority for the theoretical understanding of insanity? Undoubtedly, mental physicians felt it encumbant upon themselves to present a theoretical construction of insanity and devoted a great deal of time and publication space to this activity. Yet with only thinly-veiled value-judgement and popular prejudice to work on this theoretical construction was unsatisfactory in many respects. We have already seen that mental physicians were anxious to cast their ideas into the terminology of a "neutral" science, and that their approach was apparently determined by the use of the somatic argument by which the medical profession first captured insanity for itself. This meant that any description of the insane process would have to be in the form of an "objective", scientific account. Yet the very nature of the material which mental physicians were organising made this a virtual impossibility. Thus we find pseudo-scientific accounts which carefully explain nothing at all. Savage⁽¹⁾ provides a useful example. "Insanity", he tells us, "rarely springs into existence, it begins to grow long before it is seen". A little further on he elaborates on the causes, saying there are a great many, and that "cause" must be seen in its "widest sense", just as "the sun, the rain, the dissolving soil, the very earth-cast of the worm" are all "causes" of the growth of grass. If this analogy is to be followed then clearly Savage is not offering us science but self-fulfilling myth. One may as well say that Sunday is the "cause" of Monday.

The inherent difficulty of casting human values into the form of "science" is evidenced by the theoretical manoeuvres mental physicians had to go through to explain how emotional events such as "grief" or

1. SAVAGE, George H: op.cit., p.16.

"disappointed affections" could result in the physical disease which they claimed existed. For it was crucial to their position that insanity be seen as a "disease of the brain", which only medical men could cope with, and not as a problem of human relationships or relationships between individuals and society, for this allowed the intervention of other bodies beside the medical profession. Indeed, the mental physicians were engaged in a running battle with the legal profession over those aspects of aberrant behaviour which fell foul of the criminal law⁽¹⁾ and one can detect in Maudsley's comments outlined above, a certain hostility towards that other professional body who felt implicated in problems of human relationship - the clergy. Yet the material in which they worked was all against them. "Grief", "disappointed affections" and "overwork" appear to be stubbornly human problems.

In their attempt to square this circle mental physicians drew heavily upon the concept of man as a rational being, whose thoughts and actions were governed by the exercise of his own will. W.B. Carpenter, for example, trying to distinguish sanity from insanity, found the notion of will a convenient touchstone:

"Between the state of the well-balanced Mind, in which the habit of self-control has been thoroughly established, so that its whole activity is directed by the Moral Will of the Ego - and that of the raving madman, whose reasoning power is utterly gone, who is the sport of uncontrollable passion, and is lost to every feeling of affection, of right and even of decency, - vast as the interval may seem, there is an insensible gradation". (2)

The ideas and actions of the "madman", in falling outside the direction of the will, lost all human meaning and became mere manifestations of a malfunctioning biological machine. As Michael J. Clark says

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1. ANON: The Trial of Victor Townley, Journal of Mental Science, IX, 48, p.592.
 2. CARPENTER, W.B: Mental Physiology. 6th Ed., 1888, p.611.

"Thought and feeling were progressively removed from the sphere of volitional control, deprived of their self-determined character, and eventually reduced to the level of mere epiphenomena of underlying morbid states of the brain and nervous system or other implicated viscera". (1)

Loss of "will" removed the only obstacle to seeing man as a complex mechanism, definable entirely by "scientific laws" - if only they could be discovered. It was across that bridge, from "man" to "mechanism", that mental physicians went in search of a curative rationale as well as a justification of their self-appointed role as men of science.⁽²⁾ Thus in the early stages of insanity, according to Carpenter,⁽³⁾ there was a deficiency of volitional control over thought and feeling, an incipient weakness which may yet be corrected by a sufficient exercise of the will to self-control. But once volitional control had been lost, there existed a true insanity. Thus, citing the "disease" of "monomania" Carpenter argued that an insane idea "forces the body (so to speak) into the movements which express it". The patient no longer had a will of his own and his condition could now be described in terms of physical disorder, outside the realm of normal morality and instead within the domain of medical "science". To substantiate this view Carpenter outlined the physical processes which, he supposed, paralleled this gradual decline into complete insanity. At first, he says, emotional excitement or other excessive mental activity resulted in an altered state of the blood. This brought on the early stages of the disease which, as blood was a subtle,

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1. CLARK, Michael J: op.cit, p.275.
 2. See, for example, SMITH, Roger: (op.cit): "Knowledge of the hierarchy of functional levels in the nervous system gave alienism a scientific basis. Maudsley put the programme in its strongest form in his Physiology and Pathology of Mind (1867) It was a tour de force for the discourse which turned a lunatic into an 'organic machine automatically impelled by disordered nerve-centres'. It was not just a metaphor, it was also a programme for social action in which the insane, like machines, required maintenance". pp.51-2.
 3. CARPENTER, W.B: Mental Physiology. 6th Ed., 1888, p.657.

labile substance, was still reversible by the exercise of the will. This reacted upon the blood and, with luck restored it to normal. If no such exercise of will was forthcoming the "poisoned" blood caused physical damage to the cerebrum. This, of course, was irreversible.

The strength of this model of the physical process of insanity lay in its use of the blood as mediator between sanity and madness. In the one state we may suppose the body to exist in a "natural" or "normal" way, controlled by the "Moral Will". In the other the body is structurally "damaged", and so uncontrollable. Between the two is the "alterable" state of the blood which corresponds conveniently with the ambivalent volitional nature of insanity in its early stages. No evidence was offered for these physical changes and, indeed, none was expected, for the model was offered solely to confirm the prior assumption that insanity was in fact "real" and did fall within the scope of a verifiable science. The details of insanity's physical basis could therefore be worked out later, as science "progressed". That, of course, was a job for mental physicians.

e) The Mechanics of Mental Science

Essential to any science is the concept of universality. If mental physicians were to establish a reliable method of interpreting and dealing with insanity there must be a consistency within the phenomena under scrutiny. So in the science of even living things there were scientific "laws" to which those phenomena are held to conform. The effect of drawing upon the assumption of such "laws" can be seen from the following article in the 'Journal of Mental Science' by E. Jarvis, an American "alienist" (this being the more common American term for mental physician):

"To all things created and grown there are fixed laws and conditions of being and action. To every living organism, whether animal or vegetable, as equally to dead machinery and structures, there is assigned a definite purpose or

function, which it is appointed to fulfil or discharge. If it be properly constructed, its parts or elements suitably arranged and harmonised, and all endowed with their due strength, each performs its own work or bears its own burden. But neither their structure, nor their organisation, nor their strength, will permit them to be applied to any other purpose, or to perform any other work, or to bear any other or greater burden, than those which are appointed for them, without suffering or injury ...

The same law is immovably imposed upon everything endowed with life; upon all animal organs, all that performs the living operations, - the stomach, the muscles, the brain, the nervous system, and even the moral and mental powers, the passions and the affections. All transgressions of the limit of power or the restricted sphere of action, are necessarily followed by injury and disorder". (1)
(italics added)

Writing in 1860, only one year after the publication of Darwin's "Origin of Species", Jarvis was in the forefront of scientific opinion in assigning the "fixed laws" of "things" to all animal and human life and even to "the moral and mental powers". He was saved from an amoral materialism by his assumption of teleology in those laws, the "definite purpose", which, nevertheless, remained entirely undefined. Yet in the process those same "fixed laws" appeared not as internal consistencies arising from the very substance under "scientific" analysis, but as laws imposed by that purpose. Only by interpreting the passage in this light can the notion of a "transgression" of those "fixed laws" make any sense, for if they are capable of being violated then they are not laws in any universalist, "scientific" sense.

Here lay the ambiguity: manufactured "laws" (or rules) which originate from some authority, whether God, man or some "definite purpose", were conflated with the "laws" or presumed consistencies, arising out of material itself. In this passage Jarvis alternated between the two.

1. JARVIS, E: The Causes of Mental Disease. Journal of Mental Science, VI, 32, 1860, p.120.

Thus he was moving from man the wilful transgressor of authority to man the mechanism who breaks the fixed laws only to bring "injury and disorder", and in so doing he was turning the human problem of grief, disappointed affection or other "causes" of insanity into a "scientific" problem of disorder within the "natural" universe. He de-humanised the insane and made them mere individual examples of an "objective" natural process. We may ask, what function is this invocation of "fixed laws" serving? Were not the recognition of "injury and disorder" in a person enough to adjudge insanity, and indeed, all there was to judge by? One answer would be that if injury and disorder were the consequence of transgressions (whatever that can mean in the circumstances) of "fixed laws" then the judgement becomes absolute, and with it the judge. The "definite purpose" upon which the whole accusation of transgression must hang becomes whatever it is understood to be by the controlling value-systems that are involved. But by being construed in absolute terms they no longer appear as human values, open to debate. The "laws" made them unnegotiable and ensured the authority of he who invoked them.

In the same volume as Jarvis' article appears the first published work by a man who grounded the thinking of mental physicians more firmly in the realm of "natural laws" than anyone of his time: Henry Maudsley.⁽¹⁾ Maudsley's first article was entitled "The Correlation of Mental and Physical Force; or Man a Part of Nature", and it took an evolutionary view of nature and of man. It is implausible, he argued, that one order of natural evolution should reach so far into man's own nature only to break off before we get to "mind". If there is a force that "progresses" nature, then the same force (or one evolved out of it directly) also

1. MAUDSLEY, Henry: The Correlation of Mental and Physical Force; or, Man a Part of Nature. Journal of Mental Science, VI, 31, 1859, pp.50-78.

"progresses" the mind of man. He saw the growth of civilisation as just such a "progress of intellect" impelled by what he called the "mental force". Yet Maudsley was sensitive to the implication of moral values in man. He eschewed "pure materialism", but having already said that "mental force" evolved directly from "physical force" - the imperative behind natural evolution - he was bound to qualify the notion of the "physical force" itself. Thus he concluded:

"All forces are then but modes of manifestations of one force - the will of God - manifest in highest form, and with least observation in the temple of man's body". (1)

What naturally emerges from this view is a broadly Lamarckian, rather than Darwinian, concept of evolution. The religious tone is misleading. That the adaptive principle should be described as the "will of God" merely satisfied the preference of his contemporaries for casting intuitively-held moral values in religious forms; it does not affect the substance of the argument. Moral values - the source of our humanity - have been re-located at the source of an otherwise material process of change.

Insanity, when seen in these terms, was ultimately the separation of the material organism from this moral source. It was the consequence of a failure of organic adaptation, operating through "distorted mental mouldings", (2) or weaknesses in the "mental organisation" which adaptive evolution had produced. Thus

"When unfavourable action from without conspires with an infirmity of nature within, ... a discord, or madman, is produced". (3)

The job of the mental physician, says Maudsley,

"is to find out by what causes and in what ways this fine and complex substratum of the mental organisation is deranged". (4)

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1. MAUDSLEY, Henry: op.cit, Journal of Mental Science, VI, 31, 1859, p.78.
 2. MAUDSLEY, Henry: The Pathology of Mind; a study of its distempers, deformities, and disorders. London, 1895, p.16.
 3. MAUDSLEY, Henry: The Physiology and Pathology of Mind. 2nd Ed., London, 1868, p.227.
 4. MAUDSLEY, Henry: The Pathology of Mind. London, 1895, p.18.

It perhaps needs to be emphasised here that although Maudsley's account of the etiology of insanity appears to make social environment the original source of adaptation and maladaptation of the "mental organisation", this in no way corresponds to a socially-based, or interpersonal, psychology. What he called the "historical and social" origins of insanity referred only to the environment to which human organisms have, through many generations, been forced to adapt. Thus,

"the mental organisation has been perfected by a gradual development through untold generations and embodies in its formal structure the acquisitions of race through the ages, from the first gains of culture to the latest gifts of heredity". (1)

It therefore becomes possible for Maudsley to shift from socially-based explanations of insanity to organic explanations which dispense with human choice or values at any level.

By linking a theory of insanity in this way to existing concepts of human evolution, Maudsley had struck the central vein of social thought in his time. We still find the organic simplicity of Carpenter but more firmly grounded in the current terminology of ideas. Thus we find the same concern with a "fixed" and unalterable component of man, the physical basis of his behaviour, and also with a "plastic" and changeable component, which corresponds with man's learning process as he equips himself to deal with his environment. Only whereas Carpenter offered us the model of the individual man, with his will-power acting through the plastic medium of the blood, Maudsley shows us an evolutionary process of many generations. Will-power is no longer the dominant notion; it is the adaptive impulse. The seat of this impulse is the brain:

"The developing part of man is his brain; it is through it that nature is carrying forward its line of organic evolution; its plastic elements therefore might conceivably be respondent to and retentive of impressions made on the individual by the special experience of his life". (2)

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1. ibid., p.18.
 2. ibid., p.39.

These "plastic elements" only tend towards inheritance through succeeding generations. Insofar as they do they become a part of the "fixed" elements of man.

Insanity then, struck first at the vulnerable "plastic elements", where characteristics acquired by the individual were, in a sense, stored, and then at the more "fixed", heritable elements, which were more the store-house of human, or "racial" characteristics:

"the individual loses first his best social or moral qualities, after that his family qualities, and last of all his general human qualities". (1)

Insanity which had reached this last stage was thus deeply embedded in the "mental constitution", which, being the most unchangeable part of a person's nature, was effectively unalterable.

Maudsley stressed that at any time the "fixed" elements of his nature were overlain by "plastic" elements which contained learned knowledge and behaviour, but that the former effectively set a limit upon the latter.⁽²⁾ Thus the former elements may contain the predisposition to insanity only. Not until something acting as a trigger worked upon that predisposition did the man actually go mad. But when that did happen, the madness was at the level of the physical organisation of the "mental constitution" and not in the realm of human value-based ideas, which could only trigger madness.

"How far grief, remorse, disappointed love, domestic cares and anxieties, jealousy, pride and the like are really the causes which they are said and appear to be are questions too vague and general, too wanting in precision, to admit of instructive answers. One thing we may conclude certainly of all moral commotions and mental overstrains which cause insanities; that they do it by straining and breaking the molecular ties of the nerve-structure and so injuring or destroying its vital elasticity." (3)

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1. ibid., p.42.
 2. ibid., p.43.
 3. ibid., p.85.

Thus Maudsley, in keeping with the trend of "scientific" thought on insanity removed the "human" from human problems of "grief" and so on and made it a thing, an aspect of a physical "mental structure".

f) Mental Science and Evolutionism

Maudsley has necessarily been done an injustice in this brief outline of his views on the basis of insanity. Of all writers on the subject at the time he was by far the most inventive and penetrating, yet however much he strained against it he was unable to escape from a perspective on human and social behaviour which looked for a real basis in biology and the assumption of a neutral viewpoint from which this could be surveyed. For lesser writers, and for mental physicians in general, that perspective was dominant and unquestionable. Moreover, it gave weight to more than only psychological theories. It was a philosophical construct within which a whole wealth of social and political ideas were validated by reference to human evolutionary theory. When concepts of insanity were linked with concepts of human evolution this dominant perspective served to underline the association that was thus made between the value-implications of both. We therefore need to look more closely at the social implications of current evolutionary theory in order to comprehend the full significance of theories of insanity that located themselves within it.

Although by no means the originator of the concept of human evolution Charles Darwin was the key figure in bringing about its general acceptance.⁽¹⁾ His theory of natural selection as the mechanism by which evolution may have

1. see ELLEGARD, A: Darwin and the General Reader. Goteborg, 1958, Ch.14; also GREENE, J.C: The Death of Adam. London, 1959, Chs. 8, 9 and 10; and BURROW, J.W: Evolution and Society; a study in Victorian Social Theory. Cambridge, 1966.
HIMMELFARB, G: Darwin and the Darwinian Revolution. London, 1959.

proceeded, which he first outlined in a joint paper delivered in conjunction with Alfred Russel Wallace, who had independently hit on the same idea, to the Linnaean Society in 1858, shifted the burden of proof onto the 'anti-evolutionists'. In the following year Darwin's book, 'The Origin of Species' was to drive the message home. Henceforth, championed by that skilful populariser and polemicist T.H. Huxley, the evolution of the human race by entirely natural means was to be taken as the most salient "fact" in individual or social life. Darwin's theory, in a nutshell, was that since species propagated themselves in geometric progression there would periodically arise a pressure upon natural resources. In such a situation "natural selection" would favour those individuals of the species which possessed some slight advantage, whilst less fortunate individuals would die or be progressively reduced in number through insufficient reproduction. These "advantages" arose as a result of natural variation within the species itself and since these variations were assumed to be transmitted through the generations the effect would be cumulative. In time, and Darwin envisaged millions of years, new species would arise, each particularly well-suited to their environment, through a process of differential reproduction and constant modification. Darwin's phrase "natural selection" seemed to imply some active agency, but he intended no such implication, and in the sixth edition of 'Origin' he adopted Herbert Spencer's phrase "survival of the fittest". As it happened, this phrase was probably even more ambiguous, but it was a phrase which stuck.

The concept of human evolution, now given "scientific" weight by Darwin's theory, had never been a purely scientific speculation. It was always bound up with social and political theory, much of it centred on asserting and explaining why it seemed to be the case that English society was so much better and altogether more worthy than that of other "races",

particularly the so-called "uncivilised" races. Thus in 1851, Forbes Winslow, editor of the "Journal of Psychological Medicine", was able to assure us that

"the blubber-eating Esquimo is almost an intellectual sloth; his mind well-nigh a blank". (1)

and that

"the whole life of the Moslem is one voluptuous dream, his heaven is the paradise of harlots".

Walter Bagehot⁽²⁾ outlined a model for the "progress" of race from original savagery, through rule to law to an early kind of civilisation, to a more fully "civilised" condition through the adoption of representative institutions and a belief in discussion and debate. In doing this, he was simply drawing upon approaches already made by writers such as E.B. Tylor⁽³⁾ and J.F. MacLennan⁽⁴⁾. Probably the most obvious use of the concept of human evolution for the purpose of illustrating English society's superiority came from Spencer,⁽⁵⁾ who viewed all creation as part of one progressive movement toward perfection and drew on this idea to present an apology for industrial society and a vigorous defence of non-interventionist, laissez-faire, government in his essay 'The Social Organism', published in 1860.

Thus Darwin's (and Wallace's) continuation of the evolutionary idea burst upon an intellectual world already charged with social visions and political assertions, built around the notion of a hierarchy of mankind from middle-class Englishmen, to his lesser European counterpart, to the "static" societies of Asia, right down to the savage Pygmies and the

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1. WINSLOW, Forbes: On the Psychical Progress of Nations. Journal of Psychological Medicine, 9, 1851.
 2. BAGEHOT, W: Physics and Politics; or Thoughts on the Application of the Principles of 'Natural Selection' and 'Inheritance' to Political Society. London, 1869.
 3. TYLOR, E.B: Researches into the Early History of Mankind. London, 1865.
 4. MacLENNAN, J.F: Primitive Marriage. 1865.
 5. SPENCER, H: The Social Organism. 1860.

"blubber-eating Esquimos". Darwin⁽¹⁾ and Wallace⁽²⁾ both partook of such a concept. With such new authority, the hierarchical view of mankind came to be applied to every area of social and political thought under the general term "social darwinism", until there was hardly a part of human life untouched by it.

"Social darwinism" as a term is vague,⁽³⁾ and the ideas generally denoted by it hardly any clearer. It is not necessary here to go into any deep study of the phenomenon, only to note its dominant political tone. Taking the "hierarchy of mankind" as an unquestioned "given" there were two main stresses which the Darwinian controversy had added: the inheritance of individual characteristics (though not, as yet, in any clear genetic interpretation) and the "struggle for survival". Thus we find Francis Galton⁽⁴⁾ expounding on the hereditary nature of "eminence", even providing elaborate statistical tables in support of his contention that "genius", leading inevitably to social pre-eminence, is inherited through the generations. With such "scientific" information he feels able to commend a programme of eugenics to improve the "race". Gregg⁽⁵⁾ shares a similar view, but stresses a belief that hereditary privilege and artificial conditions of civilisation have weakened the aristocracy and, more vitally, have preserved the "less fit" from the "struggle for survival". Thus an explanation for the ever-more-visible poverty in England's industrial

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1. DARWIN, Charles: The Descent of Man and Selection in Relation to Sex. 2nd Ed., London, 1874.
 2. WALLACE, A.R.: The Origin of Human Races and the Antiquity of Man Deduced from the Theory of "Natural Selection". Journal of the Anthropological Society, London, 2, 1864.
also The Limits of Natural Selection as Applied to Man, in "Natural Selection and Tropical Nature". London, 1891.
 3. HALLIDAY, R.J.: Social Darwinism - a definition. Victorian Studies, 14, 1971.
 4. GALTON, F.: Hereditary Talent and Character. MacMillans Magazine, 12, 1865.
Hereditary Genius; an inquiry into its laws and consequences, 1869.
 5. GREGG, W.R.: On the Failure of "Natural Selection" in the Case of Man. Fraser's Magazine, 78, 1868.

cities was found in terms of the excessive breeding of the "lower classes", leading to overpopulation, vice and crime. If natural conditions of "struggle" were not returned (and since this would involve abandoning the protecting hand of civilisation, this was obviously out of the question) thus eugenics or "manmade selection" would have to be employed. The political implications of all this are far-reaching, and all, most significantly, is founded on the now unshakeable "science" of evolution. Thus in political thought, as much as in psychiatric thought, value-laden concepts were rendered into the language of an apparently neutral science conceived in "objective", or material terms, which thereby lent them an unanswerable credibility.

This science of evolution, and the social darwinism that went with it, can be seen to invade even ideas on the functions of the brain or the nature of insanity itself. R.M. Young⁽¹⁾ shows how an original Cartesian concept of mind and brain was gradually replaced by evolutionary ideas which effectively grounded all consciousness and behaviour in physical phenomena. The beginning of the transition away from Cartesian dualism were the phrenological doctrines of Gall and Spurzheim⁽²⁾ which asserted that the brain was the organ of the mind. Gall did not thereby imply that the mind was the prisoner of the brain but rather that mental activity influenced the development of the organ responsible for it. Thus the brain reflected, in its development, the mental powers of its owner. But the first real breach in the division between the mental and physical was made. Across this breach came Bain⁽³⁾ and Spencer⁽⁴⁾ who, influenced by phrenology and

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1. YOUNG, R.M.: The Functions of the Brain - Gall to Ferrier. Isis, 59, 1969, 251-8.
 2. COOTER, R.J.: Phrenology and British Alienists, c1825-45. Med. Hist., 1976.
 3. BAIN, A.: The Senses and the Intellect. London, 1855.
 4. SPENCER, H.: The Comparative Psychology of Man, in "Essays", Vol.III, 1875.

even more by the notion of evolution, began to assert that the brain was in fact the instrument of evolutionary adaptation through which the "mind" sought harmony with its environment. It is at this point that the influence of the Darwin-Wallace theory and subsequent social darwinist thought is most clearly felt. For with their emphasis upon 'natural' forces in the process of evolution, the philosophical outlook which regarded all living processes as objectively knowable, and therefore material, was firmly established. Thus it was Hughlings Jackson who asserted that if evolution were true (and he hardly doubted it) then the brain must be a kind of vastly complex sensori-motor reflex system, ever adapting to its environment. The "mind" was a sort of epiphenomena, or parallel subjective experience. Thus David Ferrier has the last word:

"It must follow from the experimental data that the mental operations in the last analysis must be merely the subjective side of sensory and motor substrata". (1)

In crossing the breach between the mental and physical, theorists had also opened the door to seeing man as a mechanism.* This they were able to do because they had lost sight of Gall's original view of mental activity as a product of the will and saw the "struggle for life" only in material terms.

But it was the emphasis given by social darwinist ideas to heredity which most profoundly affected rationalisations of "insanity" and thereby attitudes to the insane. We have seen how the nineteenth century already possessed a hierarchical view of mankind not only in terms of "races" but

* The mechanistic view of man was avoided (in the case of sane individuals, at least,) by the assumption that the 'proper' workings of biological evolution coincided with a higher moral purpose, though the source of that purpose was not indicated through the scientific debate. In practice it was simply assumed, either by the acceptance of religious teaching or by an intuitive leap. (See, e.g., HUXLEY, T.H.: Prolegomena, 1894; Evolution and Ethics, 1893; Science and Morals, 1886, etc.).

1. FERRIER, David: The Functions of the Brain. London, 1876, pp.256-7.

also within the various levels of society itself - from the cultural efflorescence of the educated middle-classes down to the "lowest" of the lower-classes, criminals, beggars and the like. Since these qualities were supposed to be inherent in each individual, according to social darwinist thinking, they must flow from the mental qualities contained in the brain. Moreover, each "class", like each "race", has a distinctive physical appearance, marking off 'social' qualities as actually biologically-based. Statements like that of Nicolson in 'The Journal of Mental Science' are common:

"(The thorough criminal) possesses an unmistakable physique, with rough and irregular outline and a massiveness in the seats of animal expression. His physiognomy is distinctive and seems to be a very embodiment of grossness and unworthiness. His repeated crimes tell us that the social instincts and sympathies have almost no place in his nature, and we cannot therefore expect much in the way of moral sentiment

Criminal-mindedness ... is the very lowest form of mental sanity among prisoners, and it is supported by an appearance of motive and self-interest just sufficient to prevent it falling within the range of insanity". (1)

Thus to the dismal count of beggars and criminals we must now add the insane on our list of hereditary degenerates.

For 'degenerates' was how they had come to be seen. It was a Frenchman, Morel, who in 1837 first charted the path of this degeneration in his book 'A Treatise on Intellectual and Moral Degeneracy'. He noted five distinct stages by which insanity progresses from one generation to the next. Firstly came the "childish" or "disordered" stage. Then the alcoholic stage. Then, through mania to idiocy and finally to complete sterility and death. This sequence of degeneration was linked to the hierarchy of physical qualities with which human evolution had endowed various individuals. If evolution was progressive, adding higher and

1. NICOLSON, David: The Morbid Psychology of Criminals. Journal of Mental Science, XIX, 86, 1873, pp.224-5.

higher levels of mental ability, then insanity was its opposite, a relapse into total degeneracy. Insanity could then be seen as really only one type of disease, with many symptoms denoting the various stages of this relapse.

We are reminded of Maudsley's description of the course of insanity:

"Going through the regressive degenerations of madness, he ceases first to be himself, then loses his social and family nature, and last of all has nothing human left but the form and name of his kind". (1)

Maudsley was himself greatly influenced by Morel and particularly by the notion of inherited madness. Thus he saw the predisposing effects of a competitive society resulting in a deterioration of human nature. This "evil heritage" is transmitted to the next generation who thus may well become insane:

"Any condition that is injurious to mental and bodily health, though it does not produce insanity directly, may so far predispose to it in the next generation". (2)

Moreover, as this process occurs it is accompanied by a loss of fertility until eventually the insane line dies out through sterility. A ruthless logic, backed by the material determinants of the social darwinist outlook, had given the insane a new identity - as the failures of evolution, the very lowest class in a vigorously class-conscious society.

But the logic was circular, and the insane had been caught up in its revolution. Social darwinism did not stem from Darwin's theory of natural selection but merely drew support from it. It battered on to the "scientific" aspect of it to declare its own conclusion: "facts of nature". Yet not even Darwin's theory was free from social influences. It grew out of the rich soil of early nineteenth century political thought even as it

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1. MAUDSLEY, Henry: The Pathology of Mind. London, 1895, p.42.
 2. MAUDSLEY, Henry: The Physiology and Pathology of Mind. 2nd Ed., London, 1864, p.235.

was fed back into the self-same soil some half a century later. It was informed by an individualist philosophy that recognised social organisation only in the form of relations occurring between separate atomistic units. It thus inevitably referred questions of social organisation back to the body and the mind, the dual aspects of the human being. Perhaps only an English gentleman of the mid-Victorian era would take it for granted that the basic unit in biology was the individual, the basic instinct self-interest and the basic activity a competitive struggle for resources. Had Darwin approached nature with a different set of social referents he would have developed a different theory, indeed, a different biology, asking different questions of nature. By his selection of the "origin of species" as almost the only question we need ask of nature, Darwin created a scientific theory which reflected all the social values whose questions it appeared to answer.

Not only was it a theory conveniently adapted to its intellectual climate, it drew for its basic premises upon an openly political piece of polemic: Thomas Malthus' "Essay on the Principle of Population, as it Affects the Future Improvement of Society". This work, first produced in 1798, was intended as a political tract aimed against Jacobinism and the prevalent notions that society could indeed be improved. To that end, Malthus sought to show that society was naturally unimprovable. Those who believed in

"the possible existence of a society, all the members of which, should live in ease, happiness and comparative leisure; and feel no anxiety about providing the means of subsistence for themselves and their families",

would find his principle of population

"conclusive against the perfectibility of the mass of mankind". (1)

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1. MALTHUS, Thomas: Essay on the Principle of Population, as it Affects the Future Improvement of Society. London, 1926, pp.16-17.

The principle, simply, was that since population increased geometrically and resources only arithmetically, sooner or later there would be over-population, starvation, struggle for survival and an overall reduction in living standards until death had carried off the surplus population.

Malthus offered no evidence for the arithmetic progression of the increase of resources and his assertion that populations necessarily increased geometrically still remains contentious. Nevertheless, it impressed those whom it was designed to impress (and Darwin besides), so that it acquired great influence. Malthus was a parson, and he supported the landowners and their view of society. Thus "Principles of Population" was an observation on human society written for political ends. It is hardly surprising then, that Darwin's theory should so successfully serve political thought of the later nineteenth century, and particularly conservative thought. As Engels said

"The whole Darwinian theory of the struggle for existence is simply the transference from society to organic nature of Hobbes' bellum omnium contra omnes, and of the bourgeois economic theory of competition, as well as the Malthusian theory of population. When once this feat has been accomplished (the unconditional justification for which, especially as regards Malthusian theory, is still very questionable), it is very easy to transfer those theories back again from natural history to the history of society, and altogether too naive to maintain that thereby those assertions had been proved as eternal natural laws of society". (1)

But that was exactly what the social darwinists had done. They had taken political theory, dipped it in "science", and brought it out as political fact. The values and arguments were still the same but the power of assertion had increased tenfold. Moreover, what had actually been man-made was described as "natural". It was not man who made society but the forces of nature. Henceforth the ramifications of power could be described as simple "natural laws". Darwinian evolutionary thought had become the unassailable justification for the political and economic status quo.

1. ENGELS, F.: The Dialectics of Nature. London, 1940, pp.209-210.

By accepting a link between the theories of insanity and those of human evolution, mental physicians embedded all interpretations of insanity - or of any insane act - in these dominant values of the English establishment. Thereby they not only found a place for insanity within the general theoretical framework of human understanding prevailing at the time, they also found a place for the insane, at the bottom of the social hierarchy, in the asylums for paupers. Henceforth, any development in the understanding of insanity was restricted to scientific interpretation, while any improvement in the status of lunatics would have to wait until society, and the "science" dependent on it, was reorganised.

g) Mental Science in Practice

However credible mental science may have become in the course of its development as a theoretical discipline it confronted a harshly real world when it had to be applied in practice. It had to handle that reality as well as satisfy the aims of the medical men who had constructed it in accordance with ideas of their own. Clearly, any concept of human reality must meet these two demands if it is to be acceptable in practice; though shaped in one direction by the assumptions of those who contrive it, it must ultimately depend for its final form upon actual material conditions as they become apparent. In this sense, mental science was given final shape by the social realities with which it had to deal.⁽¹⁾

The fact that nineteenth-century mental physicians relied on supposedly "scientific" concepts and defined insanity as "real" disease -

1. This contrasts with Michael J. Clark's view, which appears to give priority to purely theoretical constraints in the developing application of psychological medicine. This, I feel, is a product of his concern with the internal construction of ideas without regard to their social context. (See CLARK, M.J: op.cit).

no matter how difficult its discovery - did not result in a witch-hunt for "real" disease entities to the detriment of those problems which were the more to the fore. In this connection we may regard G.H. Savage's remarks in his Presidential Address to the Annual Meeting of the Medico-Psychological Association in 1886 as typical of the profession's priorities:

"There is a great evil in this definite aspect of disease; thus a student asks if "religious mania" is specially dangerous, and another asks if epilepsy is ever recovered from. I should at once decline to give definite answers to such questions, letting the student understand that for the convenience of discussing groups of symptoms we have to label them; but I would not allow him to think that there is a definite something which is mania, or you at once get to the dangerous position of having a definite something which must have as definite an antidote". (1)

Without surrendering the "scientific reality" of whatever it was he was attempting to classify he made it plain that it was the phenomenon before one's eyes that was the matter to be dealt with. "Science" may have hammered home the doctors' qualifications for their enterprise, but despite this they never lost touch with their real social function.

We have already seen in the writings of Jarvis,⁽²⁾ Sutherland,⁽³⁾ Bucknill⁽⁴⁾ and others that the elaboration of theoretical categories of insanity co-existed with a belief in an underlying scientific "reality" in terms of which their theory was constructed. Yet despite this belief it is clear that a social activity was being performed besides that of consolidating a "mental science". It may have been conceived in scientific terms, but it drew its ground-rules from far more practical, and more intuitive, sources. That is to say, doctors perforce responded to their patients according to the role which they had taken upon themselves,

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1. SAVAGE, George H: Presidential Address. Journal of Mental Science, XXXII, NS 103, 1886, p.316.
 2. JARVIS, E: op.cit.
 3. SUTHERLAND, A.J: op.cit.
 4. BUCKNILL, J.C: The Diagnosis of Insanity. Journal of Mental Science, II, 16, 1855, pp.229-30.

as ministers to the sick and assistants to the incapacitated, a role which ultimately drew its orientation from the circumstances presented by the patient (or by those affected by the patient's condition). This response operated without explanation in medical theory because it was simply taken for granted as a part of the doctor's duty. It did, nevertheless, function despite the all-pervading scientific positivist outlook which appeared to bring everything back to inescapable, objective "realities".

Neither should this be surprising. Scientific positivism was not a 'theory' nor even a paradigm for reality, but a language of thought, a framework of certain fixed references which still left the door open to intuitive or moral judgement. Thus Bucknill and Tuke could easily make the generally-felt distinction between the potential lunatic and the merely eccentric:

"The difference between a Mormonite, a Princeite, a clairvoyant, a table-rapper, and a true monomaniac, depends on this - that in the former the absurd opinion is the natural consequence of ignorance, and ineptitude to apply rightly the faculties of observation and judgement, in the latter, it is one of a train of symptoms of a pathological condition of the brain, and is consequent upon the well-known causes of such a condition". (1)

Despite the opacity of this distinction it was one which Bucknill and Tuke felt was perfectly clear in practice:

"An alienist physician of judgement and experience would be able to point out, in the circle of society with which he is acquainted, nearly all the men who are very likely to become insane".

The difference between a prospective lunatic and an eccentric was apparently that the former was under great strain to strive for others' good opinion, whereas the latter was strong-minded, struck his own attitudes and held them with great moral courage.

1. BUCKNILL, J.C. and D.H. TUKE: op.cit., p.397.

Such casuistry was also applied to another commonly-held distinction, that between insanity and genius, a speculation which often reached the pages of popular journals. Thus the 'Nineteenth Century'⁽¹⁾ carried an article entitled "Genius and Insanity" which rejected the similarities between the two as "superficial". The genius had ideas which were real, though not usually perceived by lesser mortals, whereas the lunatic had "vivid ideas which have no basis in external reality". The whole manner of the argument, however, was a priori. 'Genius' was simply taken to be a different thing from 'insanity'; therefore any similarities observed must be conceived as superficial. The reality of this distinction was seen to be 'out there' in the real world, though, as we might want to argue today, it actually lay in the eye of the beholder. (Of course, since the beholder himself was 'out there', so must his distinction be, too. The important difference here is that scientific positivism meant that the same distinction must be made by everyone, not simply by individual peculiarity).

This point is important. Mental physicians spent a good deal of their writing time distinguishing 'madness' from 'depravity' (for reasons which were closely connected with their constant friction with the legal profession). That the distinction is made, by this a priori reasoning if not by a consistency of theory, shows the freedom of a particular social judgement to surface despite the prevalent use of the language of scientific neutrality. In the process of prior assumption though, the universalist pretensions of "science" could be seriously damaged. Thus, according to a Report of the Commissioners in Lunacy, published in 'Cornhill Magazine' in 1862,⁽²⁾ 'madness' consists in a transgression of the "principle of human nature". Yet if those "principles" can be violated, in what sense are they basic to human nature? In practice, a distinction was made on the basis of

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1. SULLY, James: Genius and Insanity. Nineteenth Century, XVII, June 1885.
 2. STEPHEN, Fitzjames: Commissioners of Lunacy. Cornhill, V, Feb. 1862, pp.220-232.

will. 'Violation' of the "principles of human nature" (which were, of course, nothing more than a particular code of accepted behaviour) was "wicked" when done deliberately and "insane" when the individual lacked, or was held to lack, self-control.* In practice, whole areas of human experience were thus excluded from scientific analysis on the basis of a prior judgement. Only those lacking in "will" - the insane organisms - could properly be accounted for in this way. As we shall see, mental science was perfectly capable of accommodating itself to these various socially contingent judgements despite its claim to a universal "scientific" neutrality. Even though in medical practice such accommodations were obscure or confused, there was no loss of value-assumption drawn from social criteria in the actual practice of mental physicians.

None of this is to deny that whatever the state of mental science, doctors were face to face with people who posed real problems. A couple of entries in an asylum admission register will confirm that. One patient was admitted with

"delusions that he had been in Heaven and Hell. On admission said that he was King of the World". (1)

Another, a woman, believed she was

"related to the Czar of Russia, that the Royal Courts have property and money belonging to her and that Wentworth Castle belongs to her and her sister". (2)

The sister, on the other hand, disputed this claim, arguing that it was she and not her sister who was related to the Czar. People with delusions such as these are always likely to be problematic. Moreover, the nature of the problem lies not in any aberration definable through "science" but

* The lawyers had a different view of the matter when dealing with criminal insanity in their professional capacity. See Roger Smith (op.cit).

1. Admission Register for 1892, Middlewood Hospital (Wadsley Lunatic Asylum). Held at the Hospital.
2. Admission Register for 1893, Middlewood Hospital (Wadsley Lunatic Asylum). Held at the Hospital.

precisely in the area of human value and judgement. One other patient under mental physicians' care will reaffirm this point. In Guy's Hospital lived a patient who said that

"he was going to fill up the sea, but mingled together in his description of his proposed procedure, a tight-rope journey to Australia, pig's food, building materials, clothing, agricultural produce, money and all sorts of incongruities, in quantities of hundreds, and thousands, and millions, without connection or logic, or remembrance in one expression of that which he spoke in the preceding sentence". (1)

Problematic individuals with more obvious physical-based difficulties also abounded. The 'Journal of Mental Science' in 1872⁽²⁾ carried one of several articles on the effects of lead poisoning. This, it was stated, commonly resulted in 'Monomania' and 'Depression' as well as other, purely physical, symptoms. Furthermore, the asylums were always well-stocked with patients suffering from General Paralysis of the Insane, particularly when this had resulted in grandiose thought and other mental aberrations. There were also patients who were found subsequently to have been the victims of tumours or of meningitis. Clearly, "scientific" ideas did not invent these problems (though the attribution of the term "insanity" to describe them can be said to be a kind of invention) and since mental physicians were attempting to cope with them they were not entirely ill-equipped by their particular construction of theory.

The question remains, however, were they coping with them as effectively as they might if those problems had been interpreted in ways that did not rest in the end upon the theoretical assumption of a "fault" in the brain perceptible only to scientific authority? For the consequence of such an assumption was that it gave a basis in theory for social

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1. DICKSEN, J. Thompson: The Science and Practice of Medicine in Relation to Mind, the Anthology of Nerve Centres and the Jurisprudence of Insanity, being a course of lectures delivered at Guy's Hospital (in 1869), 1874, p.248.
 2. ANON: Monomania and Depression from Lead-Poisoning. Journal of Mental Science, XVIII, 82, 1872, pp.233-4.

relations between doctor and patient constructed on a model of authoritarian control, since not only were medical men the "experts" but if the logic of their approach was carried through then the views and feelings of the patient were void of significance precisely because they were the product of a faulty nervous mechanism. The patient's voice could be entirely discounted. This assumption of "expertise" obscured, by its very nature, the social basis of the judgement which the term "insanity" nevertheless involved, and so allowed in unacknowledged a whole set of norms of value, taken for granted by doctors, but made to seem part of a universal "natural law" and so unnegotiable between doctor and patient.* The significance of this unnegotiability needs to be considered more fully.

The acceptance of "mental science" served to make over authority for the judgement of "insanity" to mental physicians. Once this decision-making power had been acquired doctors then proceeded according to the usual socially-based criteria for assessing their patients. Bucknill and Tuke outline their recommended method:

"(The mental physician) must employ that tact derived from good sense and knowledge of mankind, without which he will find himself lame and impotent in this field of medical practice". (1)

They recommended doctors to observe any "peculiarities of residence or dress", and "peculiarities of gesture", any "vacant, meaningless expression", "strangeness or irregularity" or "childlike absurdity of action".

* Cf Roger Smith: "Medical discourse integrated a scientific ideal and a moralistic practice. While the discourse contained many esoteric elements, it also reformulated everyday concerns. Its strength lay in a capacity to rationalise so much within its frame of reference. It was at its weakest when forced to confront specific problems". *Op.cit.*, p.56. Nevertheless, it did confront them, a confrontation which was moreover fundamental to the mental physicians' enterprise.

1. BUCKNILL, J.C. and D.H. TUKE: *op.cit.*, p.394.

Maudsley was more conscious of the difficulties of judging the existence of insanity. Some apparently insane actions were performed by some criminals anxious to avoid the due punishment of law, he says, while some criminals were actually insane. Each case must be argued on its own merits.

"It is certainly far from evident that the popular opinion is correct which assumes that a rough common sense is best suited to guide decision". (1)

What else must be used is left unclear. What Maudsley was implying, of course, was that the judgement should be made by a professional man.

Thus he says,

"we are concerned exclusively with insanity as a physical disease, not with subjects of moral enquiry". (2)

The diagnostic process, however, including as it did taking an account of life history and social circumstances as well as assuming a "normal" behaviour for that particular patient, contained already the subjects of moral enquiry considered as symptoms of *physical disease*. *Carpenter*, however, had no patience with such philosophical matters and cut straight across any niceties. To draw a line between sanity and insanity, he said, was no more possible than to draw a line between bodily health and disease, but it was

"not usually difficult in practice". (3)

The possibilities for moral enquiry are boundless, but it is probably no more than a modern psychiatrist might claim (allowing, of course, for such verifiable "knowledge" which subsequent research has produced). No doctor could long withstand a sharp difference in moral judgement from opinion popularly held within his own social milieu, particularly that upon which his professional position stands, though perhaps a modern doctor has learnt to be more aware of differing values throughout society. The Victorian

1. MAUDSLEY, Henry: The Physiology and Pathology of Mind. 2nd Ed. 1864, p.472.
2. ibid., p.474.
3. CARPENTER, W.B: op.cit., p.619.

mad-doctor's only effective contribution to the situation was his category of "insanity" as scientifically real. In practice, he was assigning individuals to realms governed by a universalist concept of knowledge, not on the basis of that knowledge - if it ever existed - but on the basis of a social judgement which promptly denied all cognizance of itself.

Moreover, the limited social perspectives of a professional man in a sharply class-divided and sex-divided society allowed moral judgements that were more overt than would otherwise have been the case. W.G. Balfour cited cases in which a patient

"suffered from a severe pain in her face for ten years previous to her admission followed by a complete change in her habits and disposition, from virtue to vice". (1) (*italics added*)

whilst another suffered

"a complete change in her way of life, from being a good wife, steady, industrious, she became drunken and dissipated and had many illusions".

Nowhere is the contradiction between an assumed neutrality and an actual moral bias more obvious than in passages such as these. They are not confined to the occasional slip of the pen but are at the heart of medical description of "insanity". Time and again, a supposedly abnormal, or diseased, condition is described in "normal" terms. Thus in his main text-book, "Insanity and Allied Neuroses", Savage writes,

"the characteristic of all hysterical cases is the tendency to laziness, want of will, and getting into bad habits". (2)

Neither was this "normal" vocabulary employed without the clear moral implication associated with them. Bucknill and Tuke's third edition of their "Psychological Medicine", reprinted in part in the 'Journal of

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1. BALFOUR, W.G.: op.cit, pp.59-60.
 2. SAVAGE, George H.: Insanity and Allied Neuroses, Practical and Clinical. 1884, p.85.

Mental Science', contains this passage:

"(The Insane Diathesis is) the condition of a person who is really of sound mind, yet who from constitutional fault (n.b.) is more liable than others to mental disease

(This results in) a reckless spirit of audacity and defiance of and resistance to all rule, often accompanied in children by lying and cruelty, and passing, with advancing years, into outrageous irregularities of life and debauchery. Another form is overweening self-conceit and preposterous vanity; or simple detestable temper, or moroseness varied with outrageous passion". (1)

Again, Daniel Hack Tuke, co-author with J.C. Bucknill of "A Manual of Psychological Medicine", described the behaviour of one "insane" man as

"constant waywardness, and obvious wilfulness (sic - though "insanity" is considered a loss of will), in a word, wrong-headedness, combined with untruthfulness". (2)

If such attitudes were combined with a belief (often one-sided) in the scientific authority of the medical man then one shudders to envisage the result of the encounter between mental physician and patient. It is immediately striking that what upset these men more than anything appeared to be the challenge to authority, whether theirs or that of the social status quo. As is so often the case when such concerns predominate there is an absence of any awareness of suffering or of personal need by the patient. Indeed, the patient was hardly listened to and quickly dismissed as "wrongheaded". And always there was "mental science" to validate this judgement.

A further effect of such overt moral judgements being imposed by the doctors upon the medical encounter was the avoidance of any enquiry into the actual nature of the problem at hand. "Wrongheadedness" due to a "constitutional fault" or to a "disease of the brain" could cover for anything, the more so since "insanity" by definition contained no sense, so that the

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1. BUCKNILL, J.C. and D.H. TUKE: A Manual of Psychological Medicine, 3rd Edn., reprinted in Journal of Mental Science, XX, 90, July 1874, p.225.
 2. TUKE, D.H: The Hermit of Red-Coat's Green. Journal of Mental Science, XX, NS 55, 1874, pp.361-372.

doctors' explanation fitted no matter how unlikely the circumstances.

All other explanations were pre-empted. Perhaps the most illustrative of this tendency is the case of the sewing-machine operators investigated by J. Castellanos,⁽¹⁾ which revolved around the intensely value-laden concept of "masturbatory insanity". The history of this curious disease has been well documented.⁽²⁾ Here, the American mental specialist Castellanos found it to be the most obvious explanation of what lay before him.

He had been called in to a clothing factory to find out why it was that the working women, who arrived chubby and rosy-cheeked from the country (so he said) should all leave within a year or so looking pale and emaciated and suffering from backache, head-pains and eyestrain. He observed the sewing-machines and their operators, who were not allowed to stop working in order to speak to him, and arrived at his conclusion "within twenty minutes". Apparently, the constant action of peddling the machines which the women performed whilst seated on a kind of saddle, was causing them undue sexual excitement which, naturally, drained them of vital energy. Perhaps it was not merely medical short-sightedness which formed this conclusion from abundant evidence of overwork, unhealthy conditions and sheer exploitation. Nevertheless, "masturbatory insanity" became a popular medical stand-by in cases of "wrongheadedness", particularly amongst the young. Other problems were excluded by this authoritative device. The moral condemnation which crept in alongside this particular "scientific" diagnosis was probably the strongest of all. Thus Maudsley

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1. CASTELLANOS, J.: The Influence of Sewing Machines upon the Health and Morality of the Females Using Them. Southern J. Ment. Sci., (USA), 1866-7.
 2. see HARE, E.H.: Masturbation and Society, Journal of Mental Science, 108, 1962, p.21;
GILBERT, A.N.: Doctor, Patient and Onanist Diseases in the Nineteenth Century. J.Hist. Med., 30, 1975;
NEUMAN, R.P.: Masturbation, Madness and Modern Concepts of Childhood and Adolescence. J. Soc. Hist., 8, 1975;
ENGELHARDT, H.T.: The Disease of Masturbation; values and the concept of disease. Bull. Hist. Med., 48, 1974.

could say of a typical case of the "insanity of self-abuse" that

"the sooner he sinks to his degraded rest the better for himself, and the better for the world which is well rid of him". (1)

Clearly, the kind of approach which turned a deaf ear to patients' own evaluation of their experience easily fell into a routine of repressing what the doctors, and those for whom they worked, regarded as unacceptable behaviour. By relying on these unstated social norms as a base-line from which to operate mental physicians were affirming the values and ideologies of those on whom their status as doctors and men of science depended. Indeed, even their own commonsense view of their activities as "scientific" and therefore valid required that these values remain unchallenged. However, in adopting this stance they abandoned the opportunity to come to terms with, and so learn to understand and contain, the problematic manifestations of much individual experience.

h) The Effectiveness of Mental Science

A sense which emerges from a study of medical theory on "insanity" is that doctors were unduly emphatic about matters where the possibility of certain knowledge was quite simply lacking. Yet the conclusion that they were merely reflecting the extent of common ignorance regarding mental illness misses the point. Certainly, we now have a body of knowledge relating to these questions which did not exist then, but to pursue this view would be to contaminate the perspectives of one age with those of another. Knowledge in an applied "science" such as medicine is, after all, very much a function of our ability to achieve what we want to do, rather than a representation of any fixed quantity of neutral information. More relevant is how one conducts oneself with the knowledge of one's own time.

1. MAUDSLEY, Henry: Illustrations of a Variety of Insanity. Journal of Mental Science, XIV, 66, 1868, p.161.

Equally beside the point would be the view that doctors, either individually or as a conscious group, sought to act as agents for any particular set of moral values. Whatever moral framework individual doctors may have pursued, it is in the profession as a social object that we are interested, an object of a certain structure set within a society which had its own relationships of power and constraints of function and of conceptualisation in matters of "knowledge". The point is that doctors were operating within those given structures, structures which tended towards the establishment of a view that originated with a dominant, minority class. This tendency therefore necessarily favoured those authoritarian attitudes which were consistent with such minority class dominance. Thus any curative, or even simply benign, response would have had to move through that authoritairial medium. In the process, these responses may have led to some degree of modification of that medium over a long period of time, though not significantly within the period of our examination. Indeed, on the surface the entire period has the appearance of a great calm.

Beneath the surface, however, there were cross-currents which resulted in growing tensions. Because the starting-point of the 'psychiatric' venture in real social terms was the doctor-patient interaction, doctors' actual responses were towards the needs, stated or inferred of the patients or (more commonly) of those affected by the patient's condition. Yet with the power of decision-making and control of the whole interaction made over to the doctor the patient's own felt needs were rendered unnegotiable within the medical relationship. The doctor's interpretation held full sway. How might the sewing-machine operators have responded if they had been asked the cause of their disability by a genuine inquiring doctor? What if the "wrong-headedness" and rebelliousness of the young was seen in the context of an overbearing family control

and intolerable codes of conduct? How far could doctors really understand the felt needs of working-class patients, with different social values and customs, different attitudes to drink, work and family life? Yet their enterprise necessarily drew them into a full confrontation with those "alternative" values, towards the democracy of individual needs in a pluralistic world, and away from the science-substantiated, bourgeois values on which their enterprise was built.

Such considerations were yet to break surface in medical debate. Doctors as yet felt no confusion when drawing on their "scientific" authority to make statements about the advisability of marriage or the intrinsic nature of criminality, whilst urging their benevolent concern for health upon the medical world. Thus Bucknill and Tuke could say without flinching that

"no medical man having regard to the health of the community, or even that of the family, will possibly feel himself justified in recommending the marriage of any person of either sex in whom the insane diathesis is well marked. The marriage of threatened lunatics is a veritable Pandora's Box of physical and moral evil".⁽¹⁾

Similarly, Havelock Ellis could easily link insanity and criminality. Like the lunatic, the criminal had inherited characteristics which predetermined his behaviour. Drawing upon the accepted social darwinism of the age, Ellis could show the criminal as a distinct "physical type", who could be studied by "criminal anthropology". This view was sufficiently shared by mental physicians for Havelock Ellis to write in the 'Journal of Mental Science' that

"it is now time to study the criminal symptomology, his diagnosis, his pathology", ⁽²⁾

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1. BUCKNILL, J.C. and D.H. TUKE: The Treatment of Insanity (extract from "A Manual of Psychological Medicine", 3rd Ed.). Journal of Mental Science, XX, 90, 1874, p.226.
 2. ELLIS, Havelock: The Study of the Criminal. Journal of Mental Science, XXXVI, 52, 1890, pp.14-15.

a statement which confidently put doctors in the same administrative role as lawyers and prison officers. It was a role which doctors seemed to take to more easily than that of understanding the humanity of their patients.

i) Mental Science and the Physicians

The men who elaborated these theoretical views of "insanity" knew very well that their approach had not succeeded in providing cures. Their own figures revealed that actual cure-rates in the late nineteenth-century asylums were very poor.⁽¹⁾ It is largely because of this poverty that we have considered at such length the value and function of thinking on insanity which mental physicians meanwhile produced. The main benefit of this thinking, as we have seen, did not accrue to the patients. Their voice in the medical encounter was unheard and their human problems turned into a matter of "scientific" discussion to which they had no access. But if psychiatric medicine had largely failed in its own terms, as a curative activity, medical theory nevertheless helped to make a success of the profession in other ways. In short, it helped it to survive. It was success at this level that gave the type of thinking current at this time its main justification.

Probably the best representative of medical theory is again Henry Maudsley. Of all writers on insanity he stands out by his personality and sheer volume of output, and his influence on 'psychiatric' thought was considerable. Therefore we shall conclude this examination of medical theory by assessing some of the factors which gave his work such popular reception. In all, there were three main areas where his work had particular appeal for mental physicians. Firstly, his pessimistic interpretation of insanity with its emphasis on inherited physical factors and

1. See Chapter 4.

the slide into 'degeneracy' seemed to provide an assurance of physicians' value at a time when cures were hard to come by. Secondly, by linking insanity with evolutionary concepts he gave "mental science" a status equal to that of any other field of medicine or human study. Thirdly, he offered a kind of ritual behaviour which doctors could still perform in lieu of real curative treatment - the constant observation, classification and interpretation of asylum inmates, within the paradigm of a human science:

"It behoves us not to let these failures, these abortive minds, pass away without learning the lesson which their history conveys: they are instructive instances well fitted to teach the causes of failure, and thus to indicate the method of a successful adaptation to external nature". (1)

Thus Maudsley was able to support a caucus of medical authority by providing firstly a protection from the most obvious critique of that authority by explaining the 'reason' why no cure could be expected, then to give a justification of authority based on an appeal to science far wider than that made previously, and lastly to equip mental physicians with their own mystique as students of this peculiar branch of esoteric human experience.

To do this he was able to draw upon the one-sidedness of the profession's relations with its patients by selecting only that evidence which supported such an image of the doctors and ignoring any patient perspectives, which, after all, do not figure in medical theory. Thus "The Pathology of Mind", and "Responsibility in Mental Disease" concentrate very largely on general human "characteristics".

"A man can no more will than he can speak without having learnt to do so, nor can he be taught volition any more than he can be taught speech except by practice. It was a pregnant saying that the history of a man is his character; to which one might add that whatsoever would transform a character must undo a life history. The fixed and unchanging laws by which events come to pass hold sway in the mind as in every other domain of nature". (2)

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1. MAUDSLEY, Henry: The Physiology and Pathology of Mind. 2nd Ed., London, 1864, pp.296-7.
 2. MAUDSLEY, Henry: Responsibility in Mental Diseases. London, 1874, p.272.

A student of insanity might usefully ask why so much space is devoted to a kind of human philosophy and so little to examples of observed insanity. The answer would probably be that an appeal to all human nature is stronger than a reference to the obscure nature of lunatics in justifying a pessimistic approach to cure. (Though Maudsley, to his credit, also devotes much attention to the role of large public asylums in retarding any chance of cure.⁽¹⁾)

There was also a tendency by Maudsley to equate insanity with idiocy. Again the effect was the same - idiocy is an extreme congenital condition which persists through life. We find this equation made constantly, even in articles printed in 'The Lancet' and so available to the entire medical profession. Thus in 1870, Maudsley writes

"Clearing, then the question (of what mental disorders are) as completely as possible from the haze which metaphysics has cast round it, let us ask - How comes idiocy, or insanity? What is the scientific meaning of them? We may take it to be beyond question that they are not accidents; that they come to pass, as every other event in nature does, by natural law". (2)

Maudsley then appears to attend to "moral" causation:

"When two persons undergo a similar moral shock, or a similar prolonged anxiety, and one of them goes mad in consequence, while the other goes to sleep and goes to work and recovers his equanimity, it is plain that all the co-operating conditions have been different". (3)

But it is only a device for stressing the physical basis of all insanity. The difference, he says, lies in the former example possessing "a certain hereditary neurosis". This enables Maudsley to talk about insanity in purely biological terms. Then comes the substitution of congenital idiocy for insanity, a substitution made possible by this physical emphasis.

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1. MAUDSLEY, Henry: The Physiology and Pathology of Mind. London, 1867.
 2. MAUDSLEY, Henry: The Relations Between Mind and Body, Part II. Lancet, 30th April 1870, p.609.
 3. ibid.

"The congenital idiot is deprived of his human birthright; for he is born with such a defect of brain that he cannot display any, or can only display very feeble and imperfect, mental functions". (1)

To make the validity of this substitution quite clear Maudsley writes:

"Insanity in the parent may issue in idiocy in the offspring, which is, so to speak, the natural term of mental degeneracy when it proceeds unchecked through generations. It may be affirmed with no little confidence, that if the experiment of intermarrying insane persons for two or three generations were tried, the result would be sterile idiocy and extinction of the family".

Thus with no little confidence Maudsley tells the medical profession that insanity and congenital idiocy are really one and the same "mental degeneracy".

The purpose of the article is clearly polemical. It is a problematic branch of medicine making its defence; yet it was a defence which it undoubtedly believed in. We need not suppose that Maudsley suspected the validity of describing "insanity" by giving us examples of idiocy, though we may want to question whether the experiment with insane couples over two or three generations had actually been tried, or whether Maudsley thought it had. He regards the incurability of insanity, as self-evident and his conflation of the two as justified on this assertion. Similarly, his references to evolutionary "science", the backbone of his profession's claim to scientific status, show a questionable logic. "The human brain", he says

"may revert to, or fall below, that type of development from which, if the theory of Darwin be true, it has gradually ascended by evolution through the ages". (2)

"If the theory of Darwin be true" the way is open to describing insanity in terms of a degeneration. Yet in a later paragraph Maudsley says

"I should take up a long time if I were to enumerate the various brute-like characteristics that are at times

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1. ibid., p.610.
 2. ibid., p.610.

witnessed among the insane; enough to say that some very strong facts and arguments in support of Mr. Darwin's views might be drawn from the field of morbid psychology". (1)

The circularity of the argument is overlooked in Maudsley's confidence that the view is "scientifically" sound. Even his enthusiasm for examining the brains of the insane survives the recognition that contemporary microscopes were so limited that

"We might almost as well look to discover the anatomy of a gnat with a telescope". (2)

What Maudsley is doing here is constructing a myth of mental science. In none of the three areas we have examined does he provide us with any tangible justification. Insanity is incurable only if we choose to identify it with idiocy. The "very strong facts" supporting evolution and degeneration theories are nothing but assertion, relying on evolutionism's popular acceptance. The study of "these failures, these abortive minds" is impossible because microscopes are hopelessly inadequate. But Maudsley's confidence overrides all and the willingness of mental physicians to accept the defence allows the case to stand.

But what sort of case is it really? It is not enough to say that later developments would draw upon the dissections of diseased brains or the opportunities for observation made possible by the Victorian asylum. Given these things, what else could later development employ? In fact, much significant development in psychiatry came not from asylums but from the clinic - from the experiments of Janet, Charcot and Freud. (3)

Maudsley needed justification for his profession's activities in his own time, and it is in their own time that mental physicians must be judged. It is perhaps not being too harsh to ask how anything in Maudsley's

1. ibid., p.611.

2. ibid., p.612.

3. see HEARNSHAW, L.S.: A Short History of British Psychology, 1840-1940. 1964.

writings, or those of other leading men of his field, could possibly have led to the cure of a single patient. Yet what else are doctors for (in their own estimation, at least)?

j) Conclusion

We have seen how in constructing a theory of insanity mental physicians sought to confirm their own authority in this field of medicine by drawing upon notions of a scientific positivism which necessarily placed them in an authoritarian position with regard to their patients. It is not denied that such an approach could allow doctors to encompass some of the problems associated with those labelled "insane", if only by abandoning theory to common-sense judgement in face-to-face confrontation. Yet even here, theory held the key to dominance in the medical interaction, by backing up such judgements with "science". It can be argued that such an authoritarian assumption was a necessary part of the process of controlling, and so 'curing' the insane. Yet the truth is that the theory worked far more successfully in legitimating mental physicians' control of their chosen field of human suffering than in understanding, and so helping to contain, the suffering itself. For all the volumes written on mental science there was scarcely any recognition of the existence of actual suffering on the part of patients. Their experience is dehumanised by a "scientific" mythology leaving, at worst, one condition of mental degeneracy which is inexorable and incurable. Mental physicians adopted the authoritarian mode which came most easily to their class in their society, but their assumption of power, whilst it offered cohesion and status to the profession, was also an act of disregard to many of their patients' real problems.

CHAPTER 3: PAUPER ASYLUMS AND THE TREATMENT OF INSANITY

"It must be frankly granted that Psychological Medicine can boast, as yet, of no specifics, nor is it likely, perhaps, that such a boast will ever be made". (1)

David Hack Tuke was thus under no illusions about the curative powers of "psychological medicine" when he published his "Chapters on the History of the Insane in the British Isles", in 1882. The lack of curative theory is evident in all the text-books of the day. Bevan Lewis,⁽²⁾ in a standard work on insanity as late as 1899, devoted only twenty-five pages to treatment out of a total of over six hundred. Other writers were equally brief. For all their elaboration of ideas on what insanity was and how it was caused the leading mental physicians had failed to establish a basis for individual cure that had any theoretical standing. As T.S. Clouston remarked in 1870,

"the looseness and divergence of opinion in regard to (treatment), the corner-stone of our speciality, is most unsatisfactory; nay, is almost scandalous". (3)

Such curative theory as did exist suggested a few basic procedures. These could be found in almost any work on the subject, repeated, very often, for each of the listed "categories" of insanity. Savage,⁽⁴⁾ for example, divides his patients into three general groups for the purposes of cure. These are the "hysterical", the "acute delirious maniac" and "recurrent mania". For the first group he recommends good food, warmth, exercise and the absence of friends. Possibly a blister or leech may be applied to lower the blood pressure. For the second group Savage speci-

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1. TUKE, David Hack: Chapters in the History of the Insane in the British Isles. 1882, p.487.
 2. LEWIS, W. Bevan: A Text-book of Mental Diseases, with special reference to the Pathological Aspects of Insanity. 2nd Edn. 1899.
 3. CLOUSTON, T.S.: The Medical Treatment of Insanity. Journal of Mental Science, XVI, 74, 1870, p.24.
 4. SAVAGE, George H.: Insanity and Allied Neuroses: Practical and Clinical. 1884.

fies easily digestible food, together with spirits, bromide of potassium and chloral. If deemed necessary luke-warm baths may be given. For the last group hyoscyamine and comium juice are suggested, along with the earlier recommendations. All patients not falling under any of these three categories are presumably regarded as incurable.

Bevan Lewis⁽¹⁾ prefers to subdivide the treatments rather than the patients, and offers "psychological or hygenic", "moral" and "therapeutic".

The essence of the "psychological or hygenic" treatment is that

"All sources of irritation to the organism, where detected, must be removed, whether these be physical, mental, or both conjoined". (2)

"Moral" treatment has the advantage of

"The direct effect of mind upon mind, whether this be of the nature of a soothing, calmative influence, or of judicious repressive measures adopted towards any vicious or dangerous tendencies on the part of the patient".

"Therapeutic" treatment, however is dealt with in a more reserved way.

After all, a physical basis as a model for insanity allowed only very inadequate measures of interference and Lewis is quick to recognise this.

"The treatment of insanity", he says

"by drugs, electricity, hydrotherapeutics, and other measures rests as yet, upon an unsatisfactory basis, insofar as it is to a great extent palliative only, and, at the same time, empirical".

Beyond these general statements Bevan Lewis is loath to go.

Henry Maudsley in his "Physiology and Pathology of Mind"⁽³⁾ scarcely ventures any further. Patients, he says, must be removed from their surroundings, kept regularly employed and persuaded as far as possible of the error of their delusions. Under what he terms "medical treatment" he, like Savage, recommends an improved diet (including the liberal use of wine -

1. LEWIS, W. Bevan: op.cit.

2. ibid., p.460.

3. MAUDSLEY, Henry: The Physiology and Pathology of Mind. 2nd Ed., 1868, pp.492-516.

a recommendation intended probably for private, rather than pauper, asylums), regular exercise and some degree of blood-letting by leech or dry-cupping so as to simulate the natural reduction of blood-pressure during sleep. (This latter procedure was actually an ancient medical practice which had received an updated rationale, rather than being itself suggested by any medical "theory"). As far as drugs were concerned he shared the view of Bevan Lewis that these were very much a palliative, being directed only at bodily symptoms.

"Drugs can no more directly quell an insane delusion than they can eradicate an envy or abate an ambition". (1)

They had a use, however, in encouraging sleep with the use of opium or morphia; as a "nerve-tonic" in the form of arsenic, strychnine or cod-liver oil, or as a remedy for constipation, by means of senna, liquorice, mercury or colocynth.

Evidently, writers could offer little to the medical men working in asylums with pauper patients. It is noticeable that the flourish with which insanity had been defined, particularly within the context of biological degeneration, collapsed as soon as treatment was discussed. Even that theoretical basis which looked to a physical lesion within the brain to explain the phenomenon was curiously sterile. Its logical approach to cure would be through physical intervention in the substance of the brain by means of chemicals acting upon nerve-tissue and brain-matter (since brain-surgery was hardly a possibility until very late in the century). However, there was as yet no biochemical basis for such an approach, "insanity" being still defined in purely behavioural terms, despite its theoretical explanations. Writers were therefore very cautious as to the value of drugs, seeing them as purely secondary to real curative treatment.

1. ibid., p.546.

In a sense, the prevailing attitude to cure, based upon a pragmatic approach to patient behaviour, contained a reversal of the process of objectivisation by which psychiatric theory had been created. The social judgements which outlined "insanity" and which were cast into the language of a neutral "science" re-emerge from their theoretical guise as soon as patients crossed the asylum's threshold and doctors were faced with a human reality. A person's removal from society may have been justified by his having a "disease of the brain" but his reintegration was attempted by the same common-sense judgements which had isolated him in the first place. Thus it is, after all, only common-sense to quieten down maniacal patients, to offer distractions to people obsessed with awkward or painful ideas and to ease their lot with nourishment and well-intentioned conversation. All this could have been suggested without recourse to the concepts of "natural law", inherited weakness of nerve-tissue and the like which "explained" insanity to the public at large.

Even so, doctors themselves believed in their own medical role and the theoretical concepts generated to underpin it, so they were understandably uneasy at the failure of theory in regard to cure. Common-sense responses hardly justified the status which doctors perceived for themselves and there was therefore a degree of pressure on them to devote at least some of their time to developing a more "scientific" curative regime. However, all such attempts foundered through the dependency of any concept of cure upon those familiar value-judgements which constituted the initial recognition of "insanity". Thus, inevitably, all such regimes became merely esoteric ways of achieving the obvious results, with any rationality that was advanced being purely speculative. Two of these - electricity and bathing - deserve attention if only for the interest they attracted in the medical journals, while a third, the administration of drugs, was widespread enough to constitute a routine medical procedure. These three form the essential triad of these "scientific" remedies for insanity.

Electricity had fascinated experimenters from the eighteenth century onwards and occasional use had been made of it in the treatment of insanity in the first half of the nineteenth. According to Berlie,⁽¹⁾ J.C. Bucknill was using potassium iodide with an electric current in 1849. The first use of it to be published in an English journal was, however, in 1862, by Dr. James Rorie of Dundee. His patient, originally a cheerful soul, became

"reserved, melancholic, complains of feeling ill, and that he feels an impediment about the jaws when he speaks, and also at the root of his tongue".⁽²⁾

There followed tremors, voices in the ears and an impairment of sight followed by mild epileptic fits. The patient at this time claimed to be one of the monsters in the Book of Revelations. Rorie's response was to attach electrodes to the ear-lobes and pass "a pretty strong current for about 5 minutes" through the head. When this was done the noises in the ears increased, but afterwards they disappeared for some 10-12 hours. After several of these sessions Rorie reported that the voices did not return and the patient "to a great extent recovered his former cheerfulness".

In the Sussex asylum eleven years later A.H. Newth was using a specially constructed frame supporting forty pairs of zinc and carbon plates with which to experiment with electricity upon his patients. Soon, Beard,⁽³⁾ Althaus⁽⁴⁾ and Wigglesworth⁽⁵⁾ had all published findings and electricity, or "galvanism", became a familiar feature in the doctor's panoply of curative treatments. The methods used do not, however, always

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1. BERLIE, M.: Du Traitement de l'Alienation Mentale dans les Aisles d'Angleterre. Ann. med-psychol., Paris, 1849, 5, p.224.
 2. RORIE, James: On the Treatment of Hallucination by Electrolization. Journal of Mental Science, VIII, 43, 1862, pp.363-5.
 3. BEARD, George M.: The Treatment of Insanity by Electricity. Journal of Mental Science, XIX, 87, 1873, p.357.
 4. ALTHAUS, Julius: A Treatise on Medical Electricity, Theoretical and Practical, and its Use in the Treatment of Paralysis, Neuralgia and other diseases. Journal of Mental Science, XX, 89, 1874, pp.99-111.
 5. WIGLESWORTH, J.: On the Use of Galvanism in the Treatment of Certain Forms of Insanity. Journal of Mental Science, 33, 1887, p.385.

suggest any attempt to influence mental function directly, Rorie's example being apparently something of an exception (at least insofar as published accounts show). Rather electricity was applied to the body in general as a sort of tonic. In Newth's experiment

"the positive pole was applied to the side of the head, over the temporal muscle, and the negative was placed at the inner side of the foot at first, afterwards the hand". (1)

Newth's experiments were not always consistent. In some cases,

"the hands or feet were placed in a basin of acidulated water with one of the electrodes dipping in it, the other being applied to the head or spine".

Althaus appeared to be more concerned with applying the tonic effect to the brain (one of the very few nineteenth century physicians even to attempt an intervention in the brain-matter itself) and recommended attaching one electrode to the nape of the neck and the other to any other part of the body in the belief that electricity was a kind of fluid, so that

"it is possible that the fluid traverses the blood vessels, and enters the brain by them". (2)

More direct influence upon the matter of the brain could be effected by placing electrodes to the front and back of the head, on each temple, or on each mastoid process. If a tonic to the nerves, rather than the brain, was required, Althaus suggested attaching electrodes across the spine or even along the full length of the spine with one electrode actually placed at the back of the mouth.

Whatever value was derived in terms of establishing medical theory from such experiments, however, was lost through haphazard documentation. The methods of application were not linked to individual cases in the published accounts. Neither was the strength of the current recorded.

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1. NEWTH, A.H.: The Galvanic Current applied in the Treatment of Insanity. Journal of Mental Science, XIX, 85, 1883, pp.79-86.
 2. ALTHAUS, Julius: op.cit., p.105.

Rorie, as we saw, was content with "a pretty strong current". Newth admitted that

"In my observations I have made no attempt to estimate even approximately the amount of electricity each case received.... It is always well to begin with a low power at first; we thus gain the patient's confidence In order to test if the patient is receiving a sufficient quantity to be of any use, it is only necessary to reverse the current; if he starts it is of sufficient strength". (1)

In experiments conducted throughout county asylums the method was clearly open to any kind of speculation. There was no guide as to what effects upon patients were desirable and in many cases the fascination with experiment must have come before the aim of their individual improvement. Thus, according to Stainbrook⁽²⁾

"frequently ... the uninterrupted current caused muscular contractions and raised hair all over the body when the patient was connected to the machine".

After sessions of twenty minutes Wigglesworth noted

"I have seen faintness, retching, actual vomiting, and a peculiar form of hysteroid convulsions result from too strong or too prolonged current". (3)

The Swiss experimenter Engelskjøn also observed sleeplessness, depression, restlessness and abnormal limb sensations in many of his patients thus treated.⁽⁴⁾ These results were, of course, deplored, but they appear to have been common enough.

How many patients were treated by this method in asylums we can only guess. Certainly, with sessions of ten or fifteen minutes each, repeated daily or on alternate days (in Althaus' experiment) only a minority of

1. NEWTN, A.H.: op.cit., p.79.
2. STAINBROOK, E.: The Use of Electricity in Psychiatric Treatment During the Nineteenth Century. Bull.Hist.Med., 22, 1948, p.169.
3. WIGLESWORTH, J.: op.cit.
4. ENGELSKJØN, C.: Die ungleichordige therapeutische Wirkungsweise der beiden elektrischen Stromesarten und die elektrodagnostische Gesichtsfelduntersuchung. Ach.Psychiat., November 15, 1884, p.305, in STAINBROOK, E.: op.cit.

patients would have been selected for "galvanism". Newth's account describes only fifteen cases and it seems likely that his reported high success rate reflected a considerable degree of selection in choosing patients both amenable to treatment and likely to respond favourably. Neither can we estimate the success of such treatment in real curative terms. There is simply no way we (or contemporary doctors, for that matter) can judge how plausible electrical treatment may have been for people whose only recorded condition was "mania", "melancholia", "dementia" and the like. If Newth's own results are to be accepted then it was "more or less successful" in most cases, the two exceptions being "dementia" and "locomotor ataxia", but we are at liberty to treat such published findings with caution. There is no evidence of an improved cure-rate at any significant statistical level and we may concur with Stainbrook that by the 1890s there was increasing doubt as to the validity of "galvanism" altogether.⁽¹⁾

Why, then, had it been such a popular subject for the medical journals? Partly, no doubt, because the mysterious force of electricity had an appeal to a sternly somatic medical culture which nevertheless was conscious of dealing with equally mysterious life-forces.⁽²⁾ Partly, too, because from this, suitably esoteric "knowledge" could emerge which could lend greater authenticity to doctors as "men of science" while, of course, providing a means for lesser-known medical men to attract more attention. But the therapeutic rationale which grew up around electrical treatment was unco-ordinated. Engelskjøn⁽³⁾ explained its action in terms of a dilation of the vascular system. Other views linked its action more directly to the

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1. STAINBROOK, E.: ibid.
 2. See, for example, MAUDSLEY, Henry: The Correlation of Mental and Physical Force; or, Man as Part of Nature. Journal of Mental Science, VI, 31, 1859, pp.50-78.
 3. ENGELSKJON, C.: op.cit.

skin itself, no doubt drawing upon the observation that an electrical current tended to lift hair and raise goose-pimples. Althaus assumed that it acted upon the skin rather like a cold bath. The skin, he claimed, was "intimately connected with the brain" through the nerves. Thus "galvanism" came to be advocated as a general panacea for almost any bodily dysfunction or mental abnormality. As Althaus declared,

"It will either stimulate or sooth both nerve and muscle, according to its variety and mode of application; it will frequently restore voluntary movement; it will relieve pain, heighten temperature, recall sensation, coagulate the blood, and dissolve or slowly cause the absorption of tumours". (1)

A rather more widespread therapeutic activity was the use of baths and showers. These had an even longer history than "galvanism" by the time they came to be systematically applied to the insane, but by the middle of the nineteenth century both bath and shower were regarded as possessing curative qualities if used in a properly controlled manner. At first sight, water may seem to have rather less scope for esoteric interpretation than electricity, but attempts were made and the usual panacea offered as a result. Medical superintendents received guidance in setting up their own treatments from Harrington Tuke, writing in the 'Journal of Mental Science' in 1858.⁽²⁾ There were, he explained, two essential classes of such treatments: warm and cold. Warm water cures, in the form of warm baths, were "almost universally employed in the English treatment of insanity". Baths measuring six feet by three feet wide and three feet deep were recommended and the procedure was held to be effective in calming excited patients and inducing sleep. (These baths were prolonged for several hours and one can only speculate as to whether the patients fell

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1. ALTHAUS, Julius: op.cit., p.110.
 2. TUKE, Harrington: On Warm and Cold Baths in the Treatment of Insanity. Journal of Mental Science, V, 26, 1858, pp.532-552.

asleep whilst in them, and if so, whether they were then left until they awoke or were subsequently removed during sleep. But would not this have awoken them prematurely?)

Of the cold water cures Tuke rejects the once popular "plunge-bath" into which patients in the throes of maniacal excitement were literally plunged and submerged until they quietened down as being of "doubtful value". Instead cold water should be given either by shower or by a continuous stream, known as the "douche". The shower, at a rate of some fourteen gallons a minute for ten to twenty minutes, was effective, said Tuke, as an anti-depressant, and if the water was very cold then its shock-value was also useful against manias. The "douche" was used in cases of coma and dementia, though Tuke does not say if this was ever successful. Combined with the warm bath - the "douche" directed solely at the head - an all-round treatment could be obtained that would act against anything from acute mania to chronic depression. As Tuke says,

"there is no remedy, I believe, more valuable in the treatment of mental diseases than the warm bath. It will calm the fury of the maniac, or sooth the anguish of the melancholic; under different circumstances it will act either as a tonic or as a depressant, as a sedative or as a stimulent". (1)

Whatever the powers of the warm bath, the effects of the cold shower were sometimes startling. In 1857, Daniel Dolley collapsed and died after a treatment by Mr. Snape of the Surrey asylum. This became the subject of an enquiry by the Commissioners in Lunacy, who prosecuted Snape for neglect, though he was acquitted. Snape, in his defence, argued that he was experimenting with a new method of treatment which might yet yield beneficial results. Forbes Winslow, however, was not convinced. "Has he", he wrote in the 'Journal of Psychological Medicine', (2)

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1. ibid., V, 27, 1858, p.108.
 2. WINSLOW, Forbes: Prolonged Shower-baths in the Treatment of the Insane. J.Psych.Med., NS V, 1857, p.3.

"as he appears to believe, discovered a new and valuable agent for the cure of Insanity? If Mr. Snape is right then he should have all credit due for suggesting a novel and beneficial mode of treating one of the most distressing class of affections with which the medical man has to deal".

But Winslow was sceptical of Snape's methodology. Indeed, he accused him of playing fast and loose with medical ideas by basing too much on guesswork and imprecision. Moreover, there was some doubt as to what the precise nature of the treatment had been in that case. The Commissioners discovered that the shower-bath in question had a rate of flow of thirty-nine gallons per minute for the first thirty seconds, then twenty-six gallons per minute for ninety seconds, then during the remaining twenty-six minutes water fell at a rate of nineteen and a half gallons per minute. In all, 567 gallons of cold water must have descended on David Dolley's head in the space of just under half an hour. Snape, on the other hand, claimed that the shower had lasted only fifteen or twenty minutes.

Whether this discrepancy really mattered is perhaps less significant than the fact that Winslow thought it did. It appeared that medical "science" needed something more precise than improvised treatments with no standard procedure and only sketchy records. Moreover, Winslow was caught in a cleft stick, in that he found himself having to defend a medical practice whilst condemning its results, and the only way this could be done was by attacking the medical rationale behind the particular treatment in question. Consequently, Winslow's actions appear less motivated by a concern with the bad effects of cold water per se than with the lack of proper procedure and reasoning. But what reasoning could Winslow offer? Snape had argued that insanity required to be overpowered by a constant onslaught onto the physical body and in accordance with this view he afterwards gave tartrate of antimony to his shower-bath patients, which further weakened them through diarrhoea and vomiting. Against this view Winslow could only say that insanity was already a "distressing and exhausting disease" which

required that the patient be given "stimulating" treatment and general physical support.

Yet whatever Winslow's misgivings about the state of medical theory, Snape's experiment was not untypical of the spirit of innovation which pervaded the medical response to insanity, for elsewhere we find improvisation and lack of precision regarding techniques of control to be the stock in trade of the doctors' enterprise. C. Lockhart Robertson,⁽¹⁾ in 1862, published the results of a technique he had developed at the Sussex asylum using the roman bath. Here, the patients endured a steam-filled atmosphere of 145°F for twenty minutes, followed by soaping, sluishing with tepid water and finally a cold douche. This treatment, given to a few selected patients twice a week, was held to ensure "a full and free action of the skin", and resulted in an improvement in appetite and, in female patients, the restoration of regular menstruation. Although attempted with patients suffering from "mania" and "dementia" it was apparently only effective in cases of "melancholia", especially where this was accompanied by refusal of food. No rationale beyond the usual reference to skin and bodily functions was offered for this action.

A variation of this technique was tried by Edgar Sheppard at Colney Hatch.⁽²⁾ Here, the turkish bath was used; the hot, dry atmosphere of between 150°F and 160°F relieved only by a cold douche to the head. Patients who experienced this treatment sometimes complained of scorching sensations, though others seem to have enjoyed the bath and were happy to repeat the experience. Sheppard does not bother to suggest any particular length of time for this treatment but urges its importance in causing

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1. ROBERTSON, C. Lockhart: Cases Illustrating the Use of the Roman Bath in the Treatment of Mental Disease. Journal of Mental Science, VIII, 42, 1862, pp.159-176.
 2. SHEPPARD, Edgar: on the Turkish Bath, Journal of Mental Science, XII, 1866, p.74.

profuse sweating and so cleaning the skin. In one case cited a patient with "melancholic delusions" was subjected to this bath at 180°F. Afterwards he fell asleep in the cooling room and slept for nine hours. Later he was "cheerful" and able to play cricket in the asylum grounds. The same technique was tried at the York Retreat in 1875.⁽¹⁾ It was apparently effective in cases of alcoholism and lead-poisoning and was of some use in puerperal insanity, epilepsy and general paralysis. The effectiveness of the treatment was explained, as before, by its action on the skin, which thereby excreted "the deleterious materials circulating in the blood". For the conditions referred to (none of which would be regarded today as a mental condition) this must have made some sense, but at an installation cost of £1,400 and a running cost of around ten shillings a week thereafter, the turkish bath was well outside the budget of the pauper asylums.

In truth, not only the turkish bath but even the warm bath was a far from universal feature in asylums in 1857, according to the Commissioners in Lunacy,⁽²⁾ for there was simply no facility in many of them for hot water. Furthermore, many asylums had no fixed shower-bath or sufficient clean water to provide more than a two or three minute shower. This pattern changed gradually over the years, but baths and showers were never quite as common in pauper asylums as medical writers implied. One reason for this was the difficulty of obtaining a supply of water fit to use. Most asylums relied on wells and rain-water tanks, over which drinking and the flushing of lavatories had priority. Water supplied by private companies was not always of an acceptable standard, as Crichton Browne reported in 1875 concerning the large and well-established asylum in the West Riding of

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1. BAKER, Robert: Notes of Ten Years' Experience in the Use of the Turkish Bath in the Treatment of Mental Ill-health. Journal of Mental Science, XXXV, 150, 1889, p.187.
 2. COMMISSIONERS IN LUNACY: Eleventh Annual Report, 1857, p.36.

Yorkshire. "During the greater part of this quarter", he told the Commissioners,

"this water has been of brown and shiny in appearance (sic), putrid in odour and full of animal and vegetable life of the most unmistakable description, even leeches of large size having been found swimming in it. So bad was the water that some of the inmates, who are not very nice in such matters, declined to wash in it". (1)

Despite the immediate installation of filters it is questionable how common the use of showers as treatment (over and above ordinary hygiene) was before purified piped water was guaranteed to all asylums. In short, the doctors' enthusiasm for innovative techniques was a poor reflection of the treatments that were actually given, but it did provide a fascinating alternative to the more hum-drum business of daily care and provision for hundreds of inmates.

The third area in which "specifics for insanity" were sought, and one which was also widely applied, was that of the use of drugs. The text-book writers, as we have seen, did emphasise the importance of their use, though they regarded such physical techniques of influencing mental behaviour as secondary to real curative treatment. They could hardly have overlooked the importance of drugs, indeed, since potions, stimulants, powders, cordials and "medicines" generally were probably the most enduring feature of the doctor's trade over the years, and it would be difficult to argue that they were not seen as a primary means to cure by the medical staff of lunatic asylums, whatever the "theorists" might say. Chemicals had long been administered which were found to have, or were supposed to have, certain overall effects upon bodily and mental function. Following a line of presumed continuity from "normal" to "insane" minds and bodies, these chemicals were regarded as valuable in coping with certain behaviours

1. Report of the West Riding Lunatic Asylum, July 1875. (Wakefield P.R.O., C85 123).

manifested by asylum inmates. Bevan Lewis gives a fair summary of their application.

According to him, opium was invaluable to the doctor's trade, given in many different forms for almost any condition in which a gentle euphoria seemed useful. "Opium" says Bevan Lewis,

"and opium alone - has any powerful curative influence over such melancholic reductions as are attended by notable restlessness, mental disquiet, anxious fears, and depressing delusions". (1)

Other drugs apart from opium were regularly given. In conditions of sub-acute mania hyoscyamine was recommended, and in full-blown maniacal excitement cannabis was regarded as a "valuable sedative", usually given together with potassium bromide. This was also recommended for epilepsy and imbecility.

More generally drugs were used as sleeping draughts or purgatives and as such became an established part of asylum routine. For the former use, Bevan Lewis suggested chloral hydrate, particularly in mania, epilepsy and delirium tremens. Also chloralamide was recommended and a common standby until well into the twentieth century - paraldehyde. Castor oil⁽²⁾ and croton oil⁽³⁾ were the usual purgatives though Bucknill and Tuke⁽⁴⁾ also recommended calomel. They further suggested opium for the relief of mania, rather than melancholia (in contradistinction to Bevan Lewis' use of it), and drugs such as sulphate of quinine, dissolved in port wine, or sulphuric ether, for use in depressive conditions. To this list Maudsley⁽⁵⁾ added morphia and digitalis to subdue excitement, hydrocyanic acid and tartar emetic in cases of "furious mania", and potassium bromide, potassium iodide

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1. LEWIS, W. Bevan: op.cit., p.481.
 2. BUCKNILL, J.C. and D.H. TUKE: A Manual of Psychological Medicine, 1858.
 3. LOMAX, Montagu: The Experience of an Asylum Doctor, 1921.
 4. BUCKNILL, J.C. and D.H. TUKE: op.cit.
 5. MAUDSLEY, Henry: op.cit., p.512.

and mercury bichloride for the suppression of the symptoms of general paralysis. For good measure he also recommended iron-rich foods and plenty of wine for general use.

It is noticeable that these drugs were recommended in a wholly pragmatic way with no theoretical basis for their use being suggested. Furthermore, they were clearly only of value in "controlling or suppressing hyperactivity. In cases of melancholia and fixed delusions there was little that could be done. Even so, there was some attempt at constructing some kind of theory around their use, though, as in the case of electricity and shower-baths, it never amounted to very much. Lockhart Robertson⁽¹⁾ published his account of a controlled experiment in the use of digitalis in the treatment of mania in which graded quantities dissolved in water were tested on maniacal patients, including some in the second stage of general paralysis. The usual dose was half a drachm three times a day, and Robertson reported favourably on the ability of this treatment to control "cerebral excitement". In 1870, an article appeared in the 'Journal of Mental Science'⁽²⁾ which recommended hydrate of chloral as "a therapeutic agent of great value" in cases where opium could not be used. It could also serve "instead of morphia and henbane" to induce sleep in the maniacal, to calm the suicidal and epileptic and to ease the pain of sufferers from neuralgia of the face. Three years later, W. Julius Mickle⁽³⁾ published his account of the use of digitalis in mania, finding it "decidedly calmative" and commenting of one patient that "she was decidedly worse when the digitalis was omitted for the sake of experiment". No doubt many other experiments on patients were carried out without their results

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1. ROBERTSON, C.L.: Cases Illustrating the use of Digitalis in the Treatment of Mania. Journal of Mental Science, IX, 48, 1864, pp.547-558.
 2. ANON: On Hydrate of Chloral. Journal of Mental Science, 74, 1870, pp.255-7.
 3. MICKLE, W. Julius: The Use of Digitalis in Maniacal Excitement, Journal of Mental Science, XIX, 86, 1873.

being published (perhaps because they did not work?) though there was a growing feeling during the last thirty years of the nineteenth century that not even drugs could provide an answer. All they could do was mask the real problem and so lend themselves to abuse. In 1881, F. Pritchard Davies of the Kent asylum, wrote of the use of morphia and other drugs that

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"chemical is following mechanical restraint, and will, I trust, soon become as obsolete a line of practice, only recommended as a matter of history or as something to be avoided". (1)

Accordingly he phased out the use of all these drugs in his asylum, along with the dispensation of alcohol. Indeed, he went so far as to suggest that alcohol was the main cause of the excitement which the soothing drugs were used to control.

We do not know how closely the writings of leading mental physicians were reflected in actual asylum practice, but the accounts suggest that attempts at finding effective cures for insanity were being abandoned during the last quarter of the nineteenth century. Of course, this was seldom presented in this light, emphasis rather being given to the falseness of earlier methods, but the telling lack of better alternatives pointed all too dismal a message. Bevan Lewis writing at the turn of the century, commented that

"during the past quarter of a century the treatment of insanity by therapeutic measures has undergone a complete revolution. Three decades ago antiphlogistic theories still maintained their ascendancy over certain minds, and depletion by bleeding, either lancet or leech, active purgation, powerful drugs, especially the tartrate of antimony, were all in vogue. Excited patients were often kept for days together on the verge of narcosis, croton oil and tartrated antimonial ointments were vigorously rubbed into the scalp, and this was considered an heroic and consistent mode of treatment". (2)

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1. DAVIES, F. Pritchard: Chemical Restraint and Alcohol. Journal of Mental Science, NS 80, 1881, p.526.
 2. LEWIS, W. Bevan: op.cit., pp.463-4.

But as we have seen, Lewis felt unable to go any further than to suggest that all these former hopeful systems of treatment rested "upon an unsatisfactory basis", being merely palliative and empirical. Ultimately all treatment which could by any stretch of the imagination be labelled "scientific" failed to yield any significant results in the nineteenth century and simply degenerated into becoming mere adjuncts to precisely those common-sense notions of general care and support which was all that the apparently large body of "knowledge" on insanity had been able to provide.

If the possession of this theoretical body of "knowledge" had been the real cornerstone of the mental physicians' speciality they would have been standing on very insecure ground. But it was not. In fact, the medical profession had established its hegemony over the treatment of the insane before these constructions of "mental science" had been worked out. Admittedly, the rhetoric that insanity was a "disease of the brain" had played its part in making acceptable the dominance of the medical profession in this field, but the essence of this dominance lay in their capture and control of the new county asylums which Acts of Parliament, and in particular the 1845 Lunacy Act, had caused to grow up in every county in England.⁽¹⁾ Consequently, mental physicians were able to be guided in their therapeutic attempts by the routines of asylum practice and particularly by the rationale by which these asylums had been justified to the public. This rationale was quite different from that which underlay medical theory, for it governed the treatment, rather than the identification, of "insane" individuals. As a rationale it sustained the doctors' belief in their role, substituting for medical theory when the "specifics" for insanity which they hoped for proved elusive, so that it tended to become in their work the mental physicians' guiding principle.

1. See Chapter 1, pp.16-18, and Chapter 7, pp.325-29.

Yet it was never clear precisely what this rationale was. It hung suspended somewhere in the vacant air between the almost magical terms "moral treatment" and "non-restraint". These two terms signify slightly different things and it is important for us to bear in mind this difference all the more because the doctors of the day confused them entirely. We have dealt with the development of these two concepts in the Introduction and it will suffice here to say that, broadly speaking, "moral treatment" referred to a societal response to the "insane" as a category which located its raison d'etre within the society to which the insane were to be readjusted, whilst "non-restraint" was a response which located an essential part of its rational appeal within the humane feelings of the individual himself who, although insane, was still susceptible to the suffering caused by brutal treatment. The two, of course, are closely related, yet by failing to perceive any distinction at all, mental physicians succeeded in embedding deep within their thinking a tension between the needs of society and of the individual which, though never recognised during the nineteenth century, nevertheless constituted an important element in the ambiguity of the relationship between mental physicians and their patients.

Mental physicians were very proud of their heritage of "humanitarian" reform through which the asylums and new attitudes to the insane came about. They seldom missed an opportunity of soliloquising on the virtuous Pinel who, as nearly everyone in the profession had remarked at one time or another, "struck the chains" from the unfortunate lunatic inmates at the Bicêtre in Paris in 1793.^{(1)*} This removal of the restraining manacles

* The phrase acquires an almost ritual status at times - the tell-tale sign of a myth in the making.

1. WYNTER, Andrew: The Borderlands of Insanity, and other allied papers. 1875, and Brain Difficulties, Edinburgh Review, CXII, 1860.
see also: MAUDSLEY, Henry, op.cit., pp.492-500;
TUKE, D.H.: Chapters in the History of the Insane in the British Isles.

from a handful of imprisoned wretches was cited as the first act in the progress of lunacy reforms which subsequently swept through 'The Retreat' at York⁽¹⁾ and then the asylums at Lincoln and Hanwell, where first Gardiner Hill⁽²⁾ and then Conolly⁽³⁾ carried the process of abandoning all overt forms of mechanical restraint to its logical conclusion. This was the classic picture of "non-restraint". As a movement it was closely tied up with an attack upon private madhouses, which was an essential pre-condition for the establishment of public asylums. Much publicity was given at the time to the terrible conditions which prevailed in many of these houses and which were associated with the need to prevent inmates escaping by chaining them to the furniture or to the floor.⁽⁴⁾ It was also pointed out that in these profit-making institutions it paid to keep inmates restrained, so saving on the cost of employing attendants to control them.⁽⁵⁾

Whatever may be said about the motivation of the reform movement (and it is certain that the catalogue of horrors which the reformers published to the world contained some gross distortions and misrepresentations⁽⁶⁾) the feeling of disgust which the movement generated at such inhumane conditions was genuine enough. In retrospect, that which ultimately came out of the movement - the public asylum with its principle

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1. FEARS, Michael: Therapeutic Optimism and the Treatment of the Insane. Some Comments on the Interpretation of Psychiatric Reform at the End of the Eighteenth Century, in DINGWALL, R. et al (Eds): Health Care and Health Knowledge. 1977.
 2. FRANK, J.A.: Non-Restraint and Robert Gardiner Hill. Bull.Hist.Med., XLI, 1967, pp.140-160.
 3. HUNTER, R. and Ida MACALPINE (Eds): "The Indications of Insanity" by John Conolly. Introduction. 1964. See also: LEIGH, Denis: The Historical Development of British Psychiatry, Vol.I, 1961.
 4. PARRY-JONES, W.L.: The Trade in Lunacy: a study of private madhouses in England in the Eighteenth and Nineteenth Centuries, 1972.
see also: JONES, K.: Mental Health and Social Policy, 1845-1959, 1960.
 5. PARRY-JONES, W.L.: ibid.
 6. SCULL, Andrew T.: Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England. Chapters 3 and 4. 1979.
see also: IGNATIEFF, Michael: A Just Measure of Pain. The Penitentiary in the Industrial Revolution, 1750-1850. 1978, pp.213-5.
DONNELLY, Michael: Managing the Mind: a study in the development of medical psychology in early 19th century Britain. 1983.

of "non-restraint" - was inevitably seen by later apologists as being impelled by those values that had opposed such conditions. It was very much in keeping with this view that Daniel Hack Tuke was able to reflect, with evident self-satisfaction, on the virtues of the asylum in the 1880s by citing a passage from the Report of the Commissioners in Lunacy for 1844.

"The refractory patients were confined in strong chairs, their arms being also fastened to the chair. One of these - a woman - was entirely naked on both the days the Commissioners visited the asylum, and without doubt during the night. The stench was so offensive that it was almost impossible to remain there'. In another, 'in the small cheerless day-room of the males, with only one (unglazed) window, five men were restrained by leg-locks, called hobbles, and two were wearing, in addition, iron hand-cuffs and fetters from the wrist to the ankle; they were all tranquil. Chains were fastened to the floors in many places, and to many of the bedsteads'" (1)

1. TUKE, D.H: op.cit., pp.212-3.

Compare this description from one made almost a century later by James Scott, an ex-patient whose autobiographical experiences, "Sane in Asylum Walls", was published in 1931.

"In certain of the wards, along one side, are rows of rooms just large enough to contain a single bed, so that the occupant has just sufficient space at one side, and the foot, to get in and out of the apartment, or bed

When the occupant is locked in this side room with the shutter over the window he is in total darkness at night-time The blackness is pitchy; and during the twelve hours for which a patient lies in bed, he has an exceptionally miserable time

Simultaneously, there are men banging their doors or shutters with their rubber bed-chambers, or their heads, or their fists

After lying, and breathing, for twelve hours in such a small room, with no real avenues of ventilation, the late occupants stank abominably the stench which was liberated along with such a patient was indescribable! I have seen the floor of a room, day after day, as the door was opened to allow a patient to emerge, glistening like a pond. At the same time excrement was piled in a corner, spattered about the floor and sticking to the men's feet!" (pp.85-6)

Plus ça change!

But the horrors which Tuke so lovingly rehearsed were already an old story by that time. The image of progressive reform which he was drawing had already been overlain by two different - and historically later - impressions. One of these was the impression that the asylum per se (that is, shorn of its "non-restraint" rationale) was itself a humanitarian and progressive institution. Thus Tuke, here quoting Dr. Kirkbride, can assert that

"Asylums can never be dispensed with - no matter how persistently ignorance, prejudice, or sophistry may declare to the contrary - without retrograding to a greater or less extent to the conditions of a past period with all the inhumanity and barbarity connected with it". (1)

The second of these was the impression that the improvement of the conditions in which the insane were kept was dependent upon the discovery that insanity was a "disease". Thus the concept of insanity as a disease was conflated with the humanitarian image of the lunacy reform movement. (Of course, as we have already seen, the true origin of insanity as a "disease of the brain" lay with the professional ambitions of early nineteenth century medical men, who were able to offer no sound evidence for their proposition at the time). "One great principle" wrote Griesinger in 1867,

"pervades the whole system of modern psychiatrie - the great principle of humanity in the treatment of the insane, in contradistinction to the former barbarianism which sometimes persecuted the mentally afflicted with trials for sorcery and death at the stake; it was that forced acknowledgement of insanity to be a disease that first achieved their recognition as human beings by society, towards whom protection and help was (sic) due;" (2)

The medieval reference was another common element in the mental physicians' construction of a progressive mythology of "modern psychiatrie", which could be substituted for the recitations from early Commissioners' Reports.

1. ibid., pp.457-8.

2. GRIESINGER, W.: Mental Pathology and Therapeutics. Trans.
C. Lockhart Robertson and James Rutherford. 1867, p.459.

W.T. Gairdner,⁽¹⁾ too, used the same imagery to sustain a thesis of modern lunatic asylums as humane and progressive. Similarly, S.A.K. Strahan of the Northamptonshire asylum, combined both images into a single impression of steady humanitarian progress whose logical culmination was the "discovery" of a disease.

"With the general advancement of knowledge and civilisation, the lamentable lot of the madmen improved. One barbarous and inhumane custom after another was dropped, and at length it was dimly recognised that madness was a disease. Then for the lunatic the day of salvation was at hand - the cell, the chains, and the whip became things of the past, and he stood emancipated from all but his terrible disease". (2)

And, of course, if there is "disease" so there must be "cure", which is progressive too. But here there arose the problem that doctors actually had no cures, as such. As Tuke, on this occasion quoting from Dr. Stokes of Baltimore, said of modern curative therapy,

"Forty years ago large blood-lettings - in the standing, recumbent, or sitting posture, to the amount of thirty or forty ounces - were recommended in acute mania, followed by local depletion, by leeches, to the number of twenty or thirty, to the temples. The moral treatment, hygienic measures, exercise, and suitable occupation were almost wholly ignored!" (3)

And a little further on Tuke himself comments,

"We must rest satisfied with the general advance in treatment in a scientific direction". (4)

If "disease" was the product of a humane perception, then "cure" was the application of humane treatment. It was, after all, the best Tuke could do.

Dr. Stokes' reference to "moral treatment" introduces the second major influence upon mental physicians' image of their speciality's history. The best account of the origin and nature of moral treatment is found in

1. GAIRDNER, W.T.: Insanity: Modern Views as to its Nature and Treatment. Glasgow, 1885.
2. STRAHAN, S.A.K.: The Necessity for Hospital Treatment for Curable Cases of Insanity. Journal of Mental Science, XXXI, 134, 1885.
3. TUKE, D.H.: op.cit., pp.484-5.
4. ibid., p.487.

Michael Fears⁽¹⁾ and further elaboration comes from Anne Digby.⁽²⁾ It was a concept of treatment based on a personal - often one-to-one - relationship between patient and therapist in which mental discipline and the control of an outside authority might re-shape the patient's mental condition. The emphasis was on encouraging, and often coercing, the patient to control himself. Conducted originally within the confines of the Quaker Retreat at York, where a culturally homogenous population of staff and patients made the technique comparatively successful, it was transplanted in various versions to the new county asylums, where a sharp class division between patients and staff and a far greater ratio of the one to the other, altered the whole nature of the technique. Consequently, the impression which mental physicians had of moral treatment altered over the years, and in this process of alteration it became sufficiently indistinct for it to become assimilated into their general rhetoric of humanitarianism and cure.

The process was not entirely straightforward. At first, medical men perceived that a method of treatment that rested so much upon therapist as man-of-authority, to the detriment of traditional medicines, might weaken the logic of their control of the field of insanity. J.A. Arlidge wrote,

"The so-called moral treatment usurps the too exclusive consideration of psychological physicians, as if insanity were something other than a corporeal disease, or a malady not amenable to medicine.

The preponderating importance given to moral treatment is undoubtedly the result of the strong reaction against the neglect of it during past ages; but the pendulum of opinion has swung too far". (3)

However, writing in 1855, Arlidge was still able to hold to the optimistic belief that the medical profession could (as it had claimed) offer real cures.

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1. FEARS, Michael: op.cit.
 2. DIGBY, Anne: Changes in the Asylum: the case of York, 1777-1815. Econ. Hist. Rev., 2nd series, 36, 2, May 1983. See also SCULL, A.T: op.cit.
 3. ARLIDGE, J.A: An Examination of the Practice of Bloodletting in Mental Disorders. Journal of Mental Science, II, 16, 1855, p.167.

A few years later the mood of the profession changed in the face of obvious difficulties in living up to their ambitions and had great need of those sheltering images of its past progress which Tuke and many others now began to provide. In the following year, W.H.O. Sankey wrote in the 'Journal of Mental Science' that

"the treatment of insanity may be said to resemble more a long-continued siege than a vigorous warfare. It is not by action and measures, and certainly not by certain formulae of medical agents that we can hope to make any progress against the disease; not that it is less the province of the medical practitioner to direct the treatment, whatever the means adopted: the progress of the malady has to be watched, and the means of cure varied as circumstances arise". (1)

A few years later the dilemma was resolved once and for all by simply adding "moral treatment" to the list of improvisations which mental physicians had now resorted to as a matter of course. Thus, moral treatment, too, crept under the umbrella of Tuke's "humanitarianism". As W.A.F. Browne remarked in 1864,

"Benevolence and sympathy (Browne was thinking of the abolition of mechanical restraint) suggested and developed, and, in my opinion, unfortunately enhanced the employment of moral means, either to the exclusion or to the undue disparagement of physical means, of cure and alleviation

We know it is a physiological truth that we cannot reach the mind even when employing purely psychical means, when bringing mind to act upon mind, except through material organs. It may be that even moral means exercise their influence by stimulating or producing changes in organisation!

What is to be understood and taught of Moral Treatment are not the comforts, and indulgencies, and embellishments, by which the insane are now surrounded, but the reasons upon which these are provided, the objects in view". (2)

Whichever way the pieces were put together, whether "benevolence and sympathy" were an adjunct to medicine or medicine subservient to a general

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1. SANKEY, W.H.O.: Do the Public Asylums of England, as at present constructed, afford the greatest facilities for the cure and treatment of the Insane? Journal of Mental Science, II, 18, 1856, pp.466-479.
 2. BROWNE, W.A.F.: The Moral Treatment of the Insane. Journal of Mental Science, X, 51, 1864, pp.311-2.

humanitarian aim, the way was now open for mental physicians to see themselves as engaged in one vast and noble strategy for the treatment of insanity in which "moral treatment" could mean anything that was required of it.

For Sankey it meant "rest for the affected organ"⁽¹⁾ and was likened to a broken leg in a splint. For Maudsley⁽²⁾ it meant removal from the surroundings in which the insanity was produced, even travel if it could be afforded (the poor would have to make do with the journey to the local asylum), while Bevan Lewis remarked in 1899 that

"the whole aim of moral treatment is that of individualising the subject to the fullest possible extent " (3)

though unfortunately that is all he says of it. In the 1880s, attendants on the insane were advised to

"try to lead the mind into a more healthy groove of action, to repress morbid acts or habits, and to train the patient to more healthy and correct habits". (4)

They were further advised that delusions should neither be contradicted nor accepted, but flatly ignored. In short, "moral treatment" meant that whole collection of comforts, distractions, occupational routines and exhortations personal and spiritual which reflected what the doctors saw as their benevolent and sympathetic duty towards the insane. As Sankey remarked,

"It is not a well-furnished dispensary, or a large assortment of drugs with which (the medical practitioner) has to be supplied, his agents are rather careful nursing, wholesome diet, regular employments, diversified amusements, cheerful dwelling, personal cleanliness, and such like". (5)

Bucknill and Tuke, in an excerpt from their text-book quoted in the 'Journal

1. SANKEY, W.H.O.: Lectures on Mental Disease. 2nd Ed., 1884.
2. MAUDSLEY, Henry: The Physiology and Pathology of Mind. 2nd Ed., 1868, pp.492-516.
3. LEWIS, W. Bevan: op.cit., p.462.
4. Handbook for the Instruction of Attendants on the Insane. Boston, 1885, pp.103-6.
5. SANKEY, W.H.O.: Do the Public Asylums of England? p.467.

of Mental Science' in 1874,⁽¹⁾ dealt under this heading with the removal of patients to asylums, the practice of "non-restraint", the plentiful supply of food and last but not least, the value of exercise in the open air.

So intangible was the term that it could be extended into virtually any aspect of the relationship between asylum staff and pauper inmates, and it is not surprising, bearing in mind the class-difference between these two, that this whole conglomeration of practices and attitudes often took on a distinctly paternalist, not to say didactic quality. No superintendent would have excluded from his understanding of the term "moral treatment" such things as the discipline of the asylum routine, or the religious observance every Sunday in the asylum chapel and the suitably uplifting spiritual material which inmates were encouraged to read,⁽²⁾ or the games of cricket in the grounds⁽³⁾ or the "treats" such as outings, dances and picnics on the lawn.⁽⁴⁾

But here we encounter another side to what was now known as "moral treatment". In its original sense it was, as we have seen, essentially the imposition of an outward discipline designed to produce self-control and conformity with "normal" behaviour. The abandonment of physical restraint was only ever intended by its early proponents to be a preliminary, a pre-condition essential for this moral action of mind upon mind. Indeed its action could often be unmistakably punitive and harsh.⁽⁵⁾ The release of the madman from his chains signalled the release of equally

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1. BUCKNILL, J.C. and D.H. TUKE: extract from "A Textbook of Psychological Medicine". 3rd Ed., in Journal of Mental Science, XX, 90, 1874, pp.224-235.
 2. General Rules for the Government of the County Lunatic Asylum at Lancaster. 1878.
 3. HUNTER, R. and Ida MACALPINE: Psychiatry for the Poor. 1974.
 4. ibid.
 5. WALK, A.: Some Aspects of Moral Treatment of the Insane up to 1854. Journal of Mental Science, C, 1954, pp.807-837.

powerful moral strictures, of punishment and guilt, with which to keep him chained from within. Perhaps this seems too scathing, but outside the Quaker homogeneity of the Retreat the demands of the moral therapist may not have been the desires of the patient, and it was a therapy specifically designed to facilitate the requirements of the therapist. It was, moreover, not confined to dealing with the insane, but was applied also in prison reform, educational establishments, and other institutional regimes where a population was required to come to order, to be either claimed or reclaimed for society. Since the lunatic asylum had grown out of this societal response to deviant 'types' so it preserved to an extent this original formulation of "moral treatment" in its function, beneath the humanitarian gloss. The implications of this ran through the whole of asylum therapy. The obverse of "comforts", "indulgencies" and "embellishments" was control, authority and punishment.

Not that mental physicians regarded it at all in that light. For them, everything which they were doing was simply seen as part of their enlightened campaign against "disease". The rhetoric of progress, of enlightenment through "science" (the intimate association between these two things being demonstrable in the very concept of "disease") lay as a cloak around their whole activity. Moreover, "moral treatment" itself had been eulogised in terms of "humanitarianism" and the reform of the "individual", and the fact that similar terms were used on either side of a social-individual division - both as a defence of persons' humanity from social abuse and as a defence of society against "harmful" individuals, using methods designed to change the humanity of those individuals rather than defend it - obscured the contradictions which existed. Asylum medical staff were not, after all, social philosophers (though one or two tried their hands at it) and they were not able to transcend any of its essential values. In the event, they merely followed the line of greatest social acceptability.

What could be more natural, for example, than to extend what Bevan Lewis called "individualising the patient" into the common institutional practice of solitary confinement? Under the euphemistic term "seclusion" patients would be placed in single cells when they were disruptive in their behaviour. These were the padded rooms which were standard in every asylum before more efficient chemical means of quietening such people were discovered. It is understandable that in asylums, where the frenzied and maniacal were placed along with others whose behaviour led them to be called "insane", such methods would have to be resorted to. It can be argued that the padded cell was the logical conclusion of the principle of isolation from society - of "individualisation" - for such people. In an asylum, however, where everyone was supposedly "diseased", it was all too easy for nice distinctions between sane and insane behaviour to be lost sight of, and for this "understandable" necessity to shade off into simple control of all kinds of difficult behaviour whatever its cause. T.O. Wood noted in 1872 that

"In one asylum the cases secluded were one in six, and in another they amounted to one in 1455." (1)

which suggests a considerable degree of variation between asylums that can only be accounted for by the seclusion in many of those who elsewhere would not have been regarded as maniacal and in need of "treatment", but perhaps as merely awkward. In any case, this "treatment" was as often as not simply a method of shutting away a person's behavioural problems. (2) The flexibility of response which enabled seclusion to be regarded both as treatment and as a euphemism for punishment comes across clearly from J.A. Campbell's recommendations on its use, published in the 'Journal of Mental Science' in 1886. (3) He outlines four circumstances in which it is

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1. WOOD, T.O.: on the abolition of seclusion. Journal of Mental Science, XVIII, 81, 1872, p.59.
 2. ibid.
 3. CAMPBELL, J.A.: Remarks on the Use and Abuse of Seclusion. Journal of Mental Science, XXXII, 139, 1886, p.351.

advised, first, "from the curative point of view", secondly, as a protection for the patient from harming himself, thirdly, for the safety of others, and lastly,

"as a disciplinary agent, in patients who combine with their insanity much inherent wickedness".

The padded cell was one of the methods in the hands of asylum medical staff which, ostensibly "curative" (which, given that they did not "cure", a fact recognised throughout medical literature, should probably be interpreted as meaning "excusable on the grounds of the patient's disease") could also be used as a formidable battery for keeping all its inmates in check. Mental physicians were aware of the dilemma.

"We would observe that the facilities which seclusion holds out to the hard and indolent attendants for getting rid of and neglecting troublesome patients under violent attacks of mania, instead of taking pains to sooth their irritated feelings, and work off this excitement by exercise and change of scene, render it liable to considerable abuse".⁽¹⁾

Yet half a century later, such methods were still in use in ways that can only be regarded as punitive. Montagu Lomax⁽²⁾ recorded how one patient, apparently deluded that he must fight everyone in order to save his own life, was ordered by the medical superintendent into a pitch-dark cell for three months, with only one hour's exercise each day. Other methods in the doctors' battery of force included physical restraint, using wrist-straps,⁽³⁾ one reason given for its use being, according to records at Nottingham asylum, to prevent "self-abuse"; the cold wet sheet, in which patients were tightly packed for several hours, unable to move arms or legs or rise from the supine position; and the method of force-feeding. This last practice was grotesque in the extreme. Joseph Rogers, a workhouse medical officer who also practiced in the local asylum, described the process.

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1. COMMISSIONERS IN LUNACY: Eighth Annual Report, 1854, p.43.
 2. LOMAX, Montagu: op.cit.
 3. Ninth Annual Report of the Nottingham Borough Council, 1888.

"I sent for the stomach-pump and some of the strongest of the pauper inmates, that (the patient) might be fed by artificial means. It took four to take him out of bed, secure him in a chair, and to assist me to get his mouth open, when I made the dreadful discovery that all his teeth had recently been broken away in the forcible efforts that had been made to feed him. After a most desperate struggle I administered some beef-tea, arrowroot and wine". (1)

With resources such as these at their disposal, doctors could threaten inmates with their use unless certain behavioural standards were kept, quite irrespective of whether such behaviour was considered "morbid" or not. Indeed, the distinction withered away under the general regime of control. Not even the use of drugs obviated this attitude by asylum staff towards their patients. J.F. Stephen,⁽²⁾ the criminal law historian whose friend ran an asylum, noted that hyoscyamine was used as a threat to obtain a modification of behaviour, since its effects were such that "a maniacal or perverse lunatic will exercise all the self-control of which he is capable" in order to avoid it. Lomax observed that croton-oil was used in the same way, since,

"the bowels, after a strong croton purge, may be opened ten or twenty times. Often, there is severe griping as well, and the patient may be violently sick". (3)

J.C. Bucknill was anxious to deny that such techniques constituted any kind of punishment, though he did not deny that punishment was necessary on occasions.

"The only punishment which I have permitted myself to use, is the degradation in class of a patient, for some course of conduct which I have felt warranted in deeming more or less capable of suppression, under the exercise of a presumably unimpaired power of self-control". (4)

W. Griesinger, the German mental physician, toyed with no such fine

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1. ROGERS, Joseph: Reminiscences of a Workhouse Medical Officer, 1889, p.141.
 2. STEPHEN, J.F.: A History of the Criminal Law of England, Vol.II, 1883.
 3. LOMAX, Montagu: op.cit.
 4. BUCKNILL, J.C.: "Elements of Psychological Medicine", by David NOBLE. Asylum Journal, I, 3, 1854, p.44.

distinctions. Threats and punishments were an acknowledged part of his curative regimes, as part of "moral treatment" in its original sense.

Ointments and tartar-emetic, he claimed,

"are chiefly useful in a moral aspect, as the continued acute pain, which constantly forces itself upon the consciousness, breaks the chain of morbid ideas, and prevents the mind dwelling on them". (1)

Shower-baths served a similar purpose.

"The strong shower-bath should scarcely be employed as a means of cure, but rather as a means of punishment auxiliary to moral treatment".

But as Harrington Tuke pointed out, such methods would not be regarded as proper "moral treatment" in England. At least, not for "gentlemen".

"I am of opinion that a patient of equal rank in life with his medical attendant, perhaps even in a much higher social position, can never be benefitted by any penal measure that steps beyond the limits of moral control". (2)

For paupers, of course, the story was different.

"In a public asylum, or where patients are massed together in corridors and common sleeping rooms, it is of importance for the comfort of others, that noisy or mischievous lunatics should be controlled, and the shower bath, if graduated, is a certainly mild punishment, and may do good besides, in relieving the congestion of the brain, that may have been the cause of mental excitement".

If Harrington Tuke could not quite allow himself to admit to outright punitive methods of control without adding a medical afterthought about "congestion of the brain", J.F. Stephen, with no professional image to maintain, had no qualms.

"Unquestionably, a great deal of pain and discomfort is inflicted upon patients in consequence of their acts, and it would be extremely difficult to say how much of this pain is of a remedial, how much of a penal character". (3)

What could pass for "remedial" was made clear by Stephen when noting how, in his friend's asylum, the cold douche was used to attempt to force an

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1. GRIESINGER, W.: op.cit., pp.473-6.
 2. TUKE, Harrington: op.cit., pp.546-7.
 3. STEPHEN, J.F.: op.cit.

"improvement" in behaviour. It did not cure, he observed, but it did disguise the evidence of the disease and compelled patients not to act upon their insanity. The distinction between "diseased" and wilful behaviour, so precise in the text-book writers' theoretical constructions, is here seen as the irrelevance which, in practice, it always was. An extract from "a County Lunatic Asylum", published in the 'Journal of Psychological Medicine' in 1857, shows how "remedial" and how "penal" treatment actually was in at least one asylum.

"A.B. Violent; broke six panes of glass. Ordered eight leeches to the head. F.G. Kicked one of the attendants. A blister to be applied to the nape of the neck; to be dressed, as an additional punishment, with turpentine ointment. G.W. Tore his clothes. An emetic to be administered. F.H. Soiled his bed. Ordered to be cupped. P.T. Shook his fist in the face of the medical superintendent, and used threatening language. Calomel and jalop to be given. A.J. Destroyed his bed-clothes. Ordered a good dose of opium". (1)

According to Lomax,⁽²⁾ some of whose observations of asylum life we have noted above, things were still much the same over fifty years later.

Yet along with these disciplinary measures there was also much kindness, at least, in intention. Bucknill and Tuke had urged that

"the most inflexible firmness must be combined with never-failing kindness and gentleness and sympathy; the patient is to be brought to habitual self-control, by habitual indulgence". (3)

No doubt many of the staff were genuinely kind. Rachel Grant-Smith⁽⁴⁾ evidently encountered a very helpful person in Nurse Stuart in an asylum soon after the turn of the century. But kindly acts or examples of compassionate treatment are rare in the medical literature. Too often, one suspects, the kindness was nothing more than smiles and professional reassurance. No doubt it was often considered a kindness by doctors to

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1. WINSLOW, Forbes: op.cit., p.26 (footnote)
 2. LOMAX, Montagu: op.cit.
 3. BUCKNILL, J.C. and D.H. TUKE: op.cit.
 4. GRANT-SMITH, Rachel: The Experiences of an Asylum Patient, 1922, pp.94-5.

compel a more appropriate or reasonable behaviour from patients who would need to recover their "sanity" if they were ever to regain their employment and their independence. It would not do to expect professional men to take too personal an interest in the lower classes in the nineteenth century, especially as they saw themselves not as the human equals of their patients but as elevated "men of science" with a somewhat aloof sense of duty in their scientific mission to cure "disease". Yet "disease", as we have seen, was a term overlain with humane values respecting the individual, fuelled by disgust at his brutal treatment in former times. Now all that was left of that humanitarian passion was conflated with the business of regulating whole asylum populations and devalued into mere "sympathy" and "kindness". In the event, they simply took it for granted that the humane thing was to enforce, as gently as reasonable, upon their pauper charges what they considered was "best" for them. This response, involving on the one hand material benefits in the form of acceptable diet and general care, and on the other *hand various* assumptions about the expectations of the lower classes by the professional middle-class, can be referred to as the "benign response", that is, the sum total of the response of mental physicians as a self-conscious group to their patients.

This response was contained, quite literally, within the asylum, which enfolded it within its own routines and structures. So much did mental physicians regard the asylum as the sine qua non of treatment that it was almost regarded as being a curative treatment in itself. Thus David Skae, writing in the North British Review in 1862,

"Early removal to an asylum has been proved to be the most provident means of treatment, as being the readiest mode of obtaining a cure of the disease". (1)

1. SKAE, David: Lunacy Legislation. North.Brit.Rev., XXXVI, May 1862, p.475.

But the asylum was also clearly a place of restraint, in that its inmates were held by law and not allowed beyond its walls (except under occasional supervision). Furthermore, the asylum imposed a definite lifestyle upon its inhabitants; the regulated, disciplined lifestyle of a total institution.

In a very real sense, the asylum was the treatment, the total response of all society to the "insane". As Sankey put it,

"The treatment depends so greatly upon the regulation of the ordinary occupations and pursuits of the patient, and the facilities for these, upon the architectural management of the building, that the form of the edifice, and the disposition of its offices, becomes of paramount importance to the medical attendant". (1)

Indeed, the architectural design could facilitate or frustrate that steady supervision of inmates which constituted the controlling aspect of "moral treatment", as well as render the well-being of patients more or less acceptable. Arlidge criticised the common 'corridor'-type asylum which was everywhere before the 1870s on the grounds that such a design generated boredom as well as poor discipline, for

"there is ever the same long gallery for (inmates) to parade in, with many doors on one side and the row of peculiarly constructed, safe, and it may be guarded windows, on the other, the same space, the same air, and the same objects, by day and by night. Where access to their rooms is permitted by day, the torpid and indolent, the melancholic, the morose and the mischievous will find occasion and inducement to indulge in their several humours; opportunity is afforded them to elude the eye of the attendant, to indulge in reverie, and to cherish their morbid sentiments". (2)

Arlidge concluded succinctly that,

"The asylum building is the machine through and by which the superintendent is to work out and develop (sic) his system of moral management, it is an instrument of cure, of the adequacy, utility, and perfectness of which he must be the best judge". (3)

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1. SANKEY, W.H.O.: Do the Public Asylums of England? op.cit., p.467.
 2. ARLIDGE, J.T.: On the Construction of Public Lunatic Asylums. Journal of Mental Science, 24, 1858, p.199.
 3. ibid., pp.188-9.

In thus coming to accept the fait accompli of the asylum's existence as an essential part of the actual cure, doctors conflated the existing ambiguity in their attitude to patients with the requirements of administering an enclosed, largely self-supporting institution. It was easy for Griesinger to extol the virtues of asylums by a single passage which moves, without any sense of self-contradiction, from describing them as havens for unfortunate people wracked with insanity where they might find peace and freedom, to a portrayal of them as the vehicles of an all-pervading, overbearing, authoritarian discipline. The passage is worth quoting in full. "Here", he writes,

"a patient can find everything that his misfortunes require: a physician well acquainted with the treatment of cases similar to his own, skilful attendants who, as well as all about him, know how to treat him suitably to the circumstances of his case; an asylum where his eccentric behaviour is concealed from over-officious eyes, where the necessary surveillance is unobtrusively accorded him, and where he has usually a far greater amount of freedom than he could possibly have under any other circumstances. Here he can weep or give vent to his rage by himself, if necessary; but generally speaking, his restless habits, and the noisy expression of his maniacal impulses, are mutually controlled by the example of other patients, and by the ruling spirit of peace and order, he is brought by his own accord into the quiet routine of the house, and little more direct coercion is necessary to overcome any opposition that may arise than the singular feeling of utter powerlessness to resist the overwhelming authority that prevails over everything". (1)

But it was more than the ever-watchful eye of the medical superintendent, informed at all times by the attendants who kept guard in the wards, that constituted the authoritatorial control of the asylum's machinery. The asylum was also a place of "occupation", that is to say, of organised labour of an industrial kind. It was a process which contained a strongly didactic value, paralleling the rehabilitatory labour of the prisons, the disciplinary labour of the workhouse and the formalised labour of the school.

1. GRIESINGER, W.: op.cit., pp.467-8.

Joseph Lalor, of the Richmond Asylum, Dublin, said that,

"a lunatic asylum, whether large or small, should, I think, be conducted, as far as moral training is concerned, on the same principles as a school, chiefly of an industrial character", (1)

and Charles Mercier stated, unequivocally,

"It should be made plain to every patient that the way out of the asylum lies through the workshop, and that the first step to his discharge is to get into regular employment". (2)

Much of this labour was in fact supplied by the necessary work needed to keep the asylum itself in order. Patients were engaged in cleaning windows and fittings, scraping out the boilers,⁽³⁾ working in the laundry, on the attached farm-land⁽⁴⁾ or indeed anywhere that labour, as opposed to skilled work performed by employed artisans, was needed. Often, the work was of a kind suited merely to keeping patients occupied. Here again, the asylum provided a plentiful supply of things to do. Demented and "idiotic" patients could be kept busy scrubbing floors. Patients in the habit of tearing their clothes could be given cast-off clothing which they were allowed to tear into small pieces, which could then be used to stuff cushions. Other patients could be engaged in rolling up strips of paper for putting into pillows.⁽⁵⁾ Demented men could even be

"made up into large parties of fifteen or twenty or more, and set to pull a horse-roller to which sufficient ropes have been attached to give them a hand-hold". (6)

Lomax records the regular use of such patients for this kind of work, and also for cleaning out earth-closets and taking the soil to the farm.⁽⁷⁾

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1. LALOR, Joseph: Observations on the Size and Construction of Lunatic Asylums. Journal of Mental Science, VII, 35, 1860, p.108.
 2. MERCIER, Charles: Lunatic Asylums, their Organisation and Management. 1894, pp.85-6.
 3. ibid., p.10 and p.18.
 4. HUNTER, R. and Ida MACALPINE: Psychiatry for the Poor. 1974.
 5. MERCIER, Charles; op.cit., p.94.
 6. ibid., p.95.
 7. LOMAX, Montagu: op.cit.

The rewards for work of this kind were not according to any idea of market value for labour, but were subsumed into the asylum's rehabilita- tory regime. Money was not usually given at all. The usual reward was extra rations or some other privilege. Thus, by denying beer to those patients who would not work, the medical staff were able to provide strong inducements to engage in some kind of labour.⁽¹⁾ A further development of this system was the use of token money with which tobacco, snuff, writing-paper, jam, cakes, chocolate, ribbons, scents, pencils and many other things vital to patients in an enclosed *institutional environ- ment* could be purchased. The possibility of thereby inducing required patient behaviour by a combination of the "stick" and the "carrot" did not go unnoticed. The token system, wrote Mercier,

"would supply a disciplinary agent of the most direct and effectual, and of the least harmful character; for it would enable fines to be imposed upon patients for miscon- duct, a punishment that they would feel keenly, and that would be without the manifest objections of the punish- ments now in use".⁽²⁾

But industrial employment was not the only mechanism which the asylum provided for turning lunatics into rational human beings. Amusements, entertainments, and other aspects of their regime were also a vital part of the asylum-as-cure approach to insanity. These could be as numerous as the medical superintendent could devise and as varied as seemed in accord- ance with decency. Games, both indoor and outdoor, were advocated, and other sports, such as donkey and three-legged races were not uncommon. At the West Riding Asylum an annual fete was held in the spacious grounds at which several hundred patients were present.⁽³⁾ Other entertainments might include a "magic lantern" show, a theatrical performance by the

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1. MERCIER, Charles: op.cit., p.64.
 2. ibid., p.87.
 3. Report of the West Riding Lunatic Asylum, July 1872. (Wakefield P.R.O. C85 123).

patients and staff or a fancy dress ball.⁽¹⁾ It was even possible for selected patients to go out with attendants on a countryside ramble. In 1890, there were twice-weekly rambles involving 70 to 80 patients at the West Riding Asylum.⁽²⁾

There is no doubt that these entertainments provided a much-needed levity and could afford patients a good deal of simple fun. That the medical staff recognised the value of them is to their credit, and Mercier made the point that they were part of the treatment, and not to be confused with privileges for work. Nevertheless, there was scope here for providing some additional reward for showing acceptable behaviour. Griesinger⁽³⁾ suggested that the amount of freedom which a patient should be allowed should depend upon his power of "self-control". Taken in conjunction with the existence of obviously punitive machinery such as threats of harsh physical treatment and solitary confinement, these pleasurable activities could become part of an overall punishment-reward system, being more freely available to those showing more "self-control". Even the day-to-day running of individual wards could become part of such a system, for undoubtedly some wards were better to be in than others. Whether medical superintendents actually employed a system of ward-hierarchies - graded by the quality of life available in each and allotted according to "good behaviour" - is uncertain. Rachel Grant-Smith encountered something of the sort when she found herself in Drayton House.⁽⁴⁾ Placed first of all in a most unpleasant ward under an apparently callous nurse, she was later transferred to another, more kindly, ward. When she complained about the loss of a brooch, however, accusing the attendants of theft and behaving "badly" she found herself sent back again to her old ward. From this one account we

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1. ibid., January 1888.
 2. ibid., September 1890.
 3. GRIESINGER, W.: op.cit., p.468.
 4. GRANT-SMITH, Rachel: op.cit., pp.94-6.

can draw no firm conclusions, but the means for such a system were undoubtedly there. In these ways, the machinery of the asylum could be used to induce in the inmates some correspondence in their behaviour with that which mental physicians took as "normal" in persons of the lower classes. All this was done with the best of benign intentions, but the process was clearly one which retained the outlines of that authoritarian response to the insane which first took on the term "moral treatment", just as it relied upon its institutional context for its efficacy.

Yet for all its ideological heritage the lunatic asylum still maintained a pragmatic and vital function. Quite simply, it had to provide a reasonable home for its inmates. Indeed, it could be argued that this purely supportive function was ultimately a more important one than all the attempts at "cure" as such, since probably half the asylum's inmates never re-emerged into the outside world, while the other half spent often years of their lives inside them before their eventual discharge. When we consider that a great many of the "insane" had been so designated because they had been found unacceptable by the outside world, or were people who could not cope with it, this provision of basic care and hopefully tolerable accommodation can be seen as a matter of some significance. Perhaps precisely because this function was not necessarily seen as "treatment" it became the field in which the professional "kindness" and "sympathy" of the mental physician had its strongest effect.

When Arlidge attacked the corridor-style asylum (above) he did so not only on the grounds that it hindered efficient supervision of patients but also because it was an arrangement most unlike the domesticity of an English home. "From whatever point of view the 'ward-system' be regarded", he said,

"there is in it an evident absence of all those domestic and social conditions and provisions, which give a charm to the homes of the poorest". (1)

1. ARLIDGE, J.T.: op.cit., p.192.

Considerable attention was paid to the internal domestic arrangements of asylums in order that they should not be as bleak as might otherwise be the case. This attention was limited by financial restrictions as well as by what was possible in a place where people of such unpredictable character were living. Clearly, some things were usable by the suicidal as a means of killing themselves, so there were no glass objects, knives, ropes or cords or any other such device within easy reach of patients. The difficult behaviour of other patients created problems, too. The violent, the incontinent and those liable to epileptic fits might easily damage articles or harm themselves or others with them. Nevertheless, care was taken that windows should be large and plentiful and that they might allow in sufficient fresh air without providing an easy escape route. It was advised that the walls be painted in bright colours with plenty of variety, that there should be ample decoration in the form of pictures and flowering plants of various kinds. It was recommended that the furniture be solid and comfortable, with attractive mahogany or pitch-pine tables and lots of cushions on the chairs.

How far any of this was actually put into practice remains a vexed question. It was easy enough for medical officers to speak of the luxury in which pauper patients lived, but we must remember that the closest point of comparison would have been the pauper workhouse, a miserable enough standard that would have made any improvement into a luxury. But over the years of the later nineteenth century there was some material improvement in asylum conditions and mental physicians were quick to employ better furnishings where possible. In 1891, Burdett observed that,

"more objects of interest, and more comfortable, home-like articles are to be met with now than would have been thought necessary, or possible, twenty years ago". (1)

1. BURDETT, Henry C.: Hospitals and Asylums of the World; their origin, history, construction, administration, management and legislation. Vol.II, 1891, p.41.

Given that such articles had to be paid for out of the local poor rates, whose guardian councils only began to show some alteration in their habitual parsimony during the 1880s, we should give some credit to the medical profession in insisting on the importance of ordinary domestic arrangements against the tide of ratepayers' attitudes to paupers in general.

At some point, these general arrangements for the well-being of the asylum inmates blended into that area of patient welfare that passed under the term "nursing". In Florence Nightingale's "Notes on Nursing", which was much praised by Bucknill in the 'Journal of Mental Science',⁽¹⁾ much emphasis was given by her to the importance in general hospitals of fresh air and sunlight (never direct), as well as comfortable beds that provided good sleep, nutritious food and scrupulous cleanliness. Care for patients' physical comforts should be given by a body of trained people. In the asylum that meant the male and female attendants who, since the abolition of mechanical restraint as a normal measure, had adopted the role of supervisors and personal assistants to the insane. Their help was always regarded as crucial by the mental physicians. "Nothing in connection with the treatment of the insane", said the Commissioners in Lunacy in their 15th Annual Report, 1861,

"has a more direct and immediate effect, for good or ill, upon their condition and comfort, than the fact of their being under the charge of good or bad attendants". (2)

G.F. Blandford, in his lectures to medical students, said about patients with acute mania that

"Good attendants will not only feed a patient - they will also nurse him. A man or woman in this condition is to be looked upon essentially as a sick person, and not as a mere violent and noisy lunatic to be allowed to run about, or to be shut in a padded room and occasionally looked at and fed". (3)

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1. BUCKNILL, J.C.: "Notes on Nursing" by Florence Nightingale. Journal of Mental Science, VI, 34, 1860.
 2. COMMISSIONERS IN LUNACY: Fifteenth Annual Report, 1861, p.15.
 3. BLANDFORD, G.F.: Insanity and its Treatment - lectures on the treatment, medical and legal, of Insane Patients, 1871, p.231.

In 1885 a 'Handbook for the Instruction of Attendants on the Insane' was published, which, in addition to the general duties already referred to concerning treatment, outlined the attendants' duties as cleaning and tidying, airing bed-clothes, checking patients' clothing for cleanliness, dressing and undressing patients, serving food and keeping a constant watch on their behaviour. (1)

Regrettably, the quality of recruits rarely seems to have matched the high expectations which doctors had of them. The Commissioners in Lunacy, on conducting a survey of medical superintendents' attitudes to their attendants, said that, if asked, most of the superintendents would describe them as

"coarse, harsh, passionate, indifferent, untrustworthy, intemperate; as having no higher conception of their office than that of gaoler and as having no better or kinder or humane bond with them than that of watching and warding and ruling them". (2)

We must remember that attendants and nurses were commonly drawn from the ranks of farm labourers and domestic servants (3) and that a distinct class alienation existed between them and their employers, yet, with little systematic training before 1890, (4) it is very unlikely that the doctors' ideals for the nursing care of their insane patients could have been adequately realised, (see Chapter 6 for a fuller treatment of this).

But it is Blandford's reference to the "lunatic" as a "sick person" which is really the key to the strictly "medical" approach to insanity in the nineteenth century. A person who is "sick" required, as W.T. Gairdner pointed out, (5) a sound diet, comfortable circumstances,

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1. Handbook for the Instruction of Attendants on the Insane. Boston, 1886, pp.101-2.
 2. COMMISSIONERS IN LUNACY: Fifteenth Annual Report, 1861, p.44.
 3. A Descriptive Notice of the Sussex Lunatic Asylum, Hayward's Heath. Journal of Mental Science, VII, 33, 1860, p.257.
 4. WALK, A.: A History of Mental Nursing. Journal of Mental Science, CVII, 1961, pp.1-17.
 5. GAIRDNER, W.T.: op.cit.

sympathetic treatment and a generally supportive regime. As for "cure", Nature must be allowed to take her course. Medicines could help, but only by being directed at the overall regime. Those most generally used, as we have seen, were given to encourage natural functions - sleep, digestion and a relatively peaceful mind. These things, added to good food and pleasant surroundings, were the substance of the supportive regime which, outside of their assumed role as social educators, was essentially all that mental physicians as medical men were able to provide.

This is not to belittle the importance of the "medical" aspect of what was commonly called "psychological medicine". If the term meant anything beyond the programme of social readjustment (one may use the terms "moral control" or "social control" with the same material significance) which has been outlined above, it could be no more than that which late nineteenth century medical knowledge and practice could allow. The value of this medicine is often overestimated even today. Too often its development is presented in the context of a struggle between an enlightened body of doctors and recalcitrant authorities, particularly the Poor Law Board, under whose auspices most popular medicine was made available. Certainly the Poor Law authorities were notoriously anxious to avoid any superfluous expense, yet what could doctors actually offer that could justify the presentation of the relationship between them as a triumphant crusade by "enlightened" scientists with "far-seeing demands" against "obscurantism" and "apathy", as one well-known historian has it?⁽¹⁾

We need to avoid seeing nineteenth century medical practitioners merely as embryonic counterparts of the formidable profession which we know today, aware of some future destiny, hindered in their "far-seeing demands" by antiquated administrative systems. They, too, were children of their

1. HODGKINSON, Ruth: Poor Law Medical Officers of England, 1834-1871. Journal Hist. Med., XI, 1956.

time. Their knowledge was in fact very limited, their range of treatments even more so and their professional ambitions confined to immediate objectives. To provide just one illustration, yet one of great significance in the medical profession's later stature, we may consider the development of "germ-theory", from the concept of transmissive "particles" to the identification in 1882 of the bacillus responsible for tuberculosis. It is true that the 1860s might be described as the "era of the particle".⁽¹⁾ By this time, Darwin's "gemmules" and Spencer's "physiological units" - hypothetical concepts both - had been added to the pioneering work of William Farr, and before long the researches of L.S. Beale, B.W. Richardson and J.B. Sanderson had made particles, or "germs" a challenging new medical concept.

But historians tend to attach too much weight to the origins of ideas and too little to their social flowering. The 1870s marked only the beginnings of an empirical understanding of disease. The alternative views, "spontaneous generation" - by which "sundry (disease) poisons are constantly being generated de novo by the material conditions which surround us"⁽²⁾ - and the so-called "miasmatic" view, the belief that diseases were caused by the "miasma" which arose from filth and bad air, were still dominant, and remained so in practical medicine, both general and "psychological". When an outbreak of "asylum dysentery" occurred at the Wadsley Asylum, Sheffield, in 1876, the superintendent, Dr. Samuel Mitchell, gave his opinion that it was caused by "the foul air from imperfect ventilation of closets".⁽³⁾ Even Florence Nightingale rejected

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1. CRELLIN, J.K.: The Dawn of Germ Theory - Particles, Infection and Biology. in POYNTER, F.N.L., Medicine and Science in the 1860s. 1968.
 2. BUDD, William: Letter to the BMJ, 1864, ii, p.356.
 3. THORPE, F.T.: A History of Middlewood Psychiatric Hospital. Sheffield, 1972, p.15.

the idea that diseases were directly contagious preferring the "miasmatic" view,⁽¹⁾ and as late as 1885 the British government denied that an outbreak of cholera in Egypt had been spread by contagious germs.⁽²⁾ In any case, it is questionable how valuable the disease-paradigm arising from the discovery of bacterial infection was in the practical operation of everyday medical treatment. Apart from during periods of epidemic - against which hospital medicine was never effective in the nineteenth century - few hospital patients' illnesses could actually be described by this paradigm. Ivan Illich⁽³⁾ points out that even today most hospital populations suffer from several imprecise or indefinable disablements which it is the job of doctors to describe in terms of medical paradigms. Probably few patients in non-epidemic times could be adequately assisted by the new concept of "germ-theory".

This is not to underestimate the ultimate importance of these developments, but rather to emphasise the social nature of the work of the general medical practitioner. Patients entered hospitals and workhouse infirmaries seeking relief from a wide range of physical impairments which could not necessarily be organised around any "cause" and doctors were bound to respond to these impairments using whatever means were available. This meant that in effect they adopted the social criteria of "sickness" and "health" which were provided by the cultural environment in which they worked. This made medicine an enterprise bounded by cultural values rather than by objective, "scientific" criteria, whatever the contemporary outlook of positivism made of it. According to Dr. H.W. Acland, Regius Professor of Medicine at Oxford, "health" meant

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1. WOODHAM-SMITH, Cecil: Florence Nightingale, 1820-1910. 1950.
 2. ACKERKNECHT, E.H.: Anti-Contagionism between 1821 and 1867. Bull. Hist.Med., 22, 1948, p.582.
 3. ILLICH, Ivan: Limits to Medicine - Medical Nemesis: the Expropriation of Health. 1976.

"that condition of the individuals of a nation which enables (them) to discharge rightly their respective functions". (1)

Indeed, social and even moral values frequently provided the "cause" around which actual physical impairments were seen to cohere, as, for example, in the supposed "disease of masturbation".⁽²⁾ Even without resort to value-laden concepts of disease, the actual practice of medicine was necessarily bounded by the common-sense dictates of apparent human need and by doctors' judgements as to the severity of those needs. Thus doctors were engaged in a moral and social enterprise which had as its de facto conscious direction the ordinary "benign" concerns of people for their suffering neighbours. This process was contained within the wider social enterprise of providing support and accommodation to those who, by reason of being "sick" could not support themselves. Both these functions were part of the actual nature of general medical provision, and both these and the social concern that individuals should "discharge rightly their respective functions" are clearly paralleled in "psychological" medical provision.

More specifically, we can deduce the actual nature of "medicine" in general practice from the following extract from the 'Lancet' for 1865, which was part of a major attack on workhouse medicine following the scandals of Daly and Gibson.

"The workhouse hospital system is a disgrace to our civilisation. Compare it with that of our public hospitals. In the latter there is everything provided which can ensure the well-being of the sick inmate: the constant care of skilled nurses; the administration of all the remedies which may be useful, irrespective of cost; sustenance by food of the most appropriate, nutritious, and, if necessary, tempting kind; the daily attendance of the most highly qualified medical attendants; the care of a body of students as dressers and clerks, ever on the alert to watch and report the change of symptoms, ever vigilant to observe the

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1. quoted in BRANDS, Jeanne: Doctors and the State, 1871-1900.
 2. ENGELHARDT, H.T.: The Disease of Masturbation. Bull.Hist.Med., 48, 1974.

attentions of the physician to the patient, and to note the results, the intervention of lay visitors and lay readers" (1)

It falls into three categories: nursing, "remedies" (note the vagueness of this term) and good food. This is followed by rhetoric to assure the readership what a well-organised and caring institution the medical profession was. The eight remedies suggested by the editorship of the 'Lancet' following their enquiry into the state of the workhouse sick ward at Bethnal Green, London, provides a similar insight. They were:

- 1) the removal of all able-bodied paupers and children from the workhouse to reduce overcrowding;
- 2) paid nurses, in the proportion of one to fifty patients;
- 3) extra windows;
- 4) better ventilation;
- 5) more waterclosets;
- 6) baths and wash-places;
- 7) more nutritious food, better cooked (and not steamed);
- 8) additional medical officers and a dispenser. (2)

Hodgkinson in her study of Poor Law doctors before 1871, makes the same point, but fails to recognise this as the central function of medicine:

"it was not always treatment and medicines the sick poor needed but nourishment". (3)

In view of the nature of medicine at this time it is worth asking whether there is any real difference. The "medicines" were mostly opium, calomel, antimony and sarsaparilla, but one cannot really conceive of such preparations acting in any fundamentally different way from good food itself. The actual conflation of the two can be seen following the action of an overseer at a Shropshire workhouse who, in 1871, refused extra meat to a woman suffer-

1. The 'Lancet', 15th April 1865, p.410.
2. The 'Lancet', 27th January 1866, p.105.
3. HODGKINSON, Ruth: op.cit., p.307.

ing from inflammation of the womb, contrary to the Medical Officer's recommendation, on grounds of expense. The response of the 'British Medical Journal' was to elevate extra meat to the status of medicine, and the decision to provide it to a matter of specialist ability.

".... we think that the discretion of the medical officer to order nourishment necessary on medical grounds should be so far absolute as not to be interfered with by subordinate officers, whose means of judgment must be inferior to his own". (1)

This view was recognised by Parliament in the 1885 Medical Relief Disqualification (Removal) Act, which took away the powers of Poor Law guardians to refuse extra rations to paupers ordered on "medical" grounds by a doctor.

Yet here we come to the heart of the medical achievement, for if special treatment is to be given to some paupers and not to others, there has to be an acceptable criterion for distinguishing the two. That criterion was forced into significance by the doctors, who relied upon it when ordering any kind of treatment on "medical grounds". This was that such treatment was necessary for the "sick". As Freidson has pointed out, (2) the "sick" is actually a social category embracing persons who deviate from accepted norms (in this case, that of providing one's own support) for reasons for which they cannot be held responsible. As a category it is given legitimacy by doctors, thereby becoming a form of "non-responsible, legitimated deviance". Because of the existence of such a category as a social fact it becomes possible to channel benign energies through the medical profession towards the individuals so categorised to an extent not otherwise possible, at least, not at administrative levels of society. In the nineteenth century doctors were in the process of giving concrete reality to this category, raising it to an important level in

1. BMJ, I, 1871, p.135.

2. FREIDSON, E.: The Profession of Medicine - a study of the sociology of applied knowledge. 1970.

poor law administration and expanding it in accordance with popular concern and their own professional interests. In effect, they could, by diagnosing illness, try to avoid for their pauper patients the harshest effects of the workhouse regime and the 1834 Poor Law which created it. This is not to say that those so defined were not in need of special attention - no doubt we may judge that they were - simply that without the labelling process by doctors such attention would have been less forthcoming within the workings of poor law administration.

This differential perception of the subjects of that administration (and pauper lunatics were also supported out of poor rates,) was an important development by doctors, but it also had the most important consequence of helping to resolve two conflicting attitudes to social administration: on the one hand the view that every man should be self-reliant and not be eligible to support from the State except under the deterrent conditions of the workhouse; and on the other, that some degree of support should be given without penalty to the less fortunate of those who were unable to support themselves. By concretising the concept of "sickness" the doctors were able to legitimate a benign response to some individuals without challenging basic social structures. Indeed, with the removal of this contentious group of "sick" those structures could be made even firmer, (as was the case with "able-bodied" paupers, including the elderly, for some time after 1870).

With this parallel history of general medicine in mind, we may return to Blandford's description of the "lunatic" as a "sick person". Clearly, the same process of concretisation of social category can be recognised here. Blandford is arguing that the insane, too, are worthy of preferential treatment over and above the lot of the ordinary "able-bodied" pauper. Along with this must go the general supportive regime of "medical" aid, whose nature was essentially no different in "psychological" medicine

than in the general medicine which we have been examining. In a sense, we have come full circle. The asylum, so commonly justified by doctors as merely the place where proper medical treatment for insanity could be provided, can now be seen as the real medicine, to which the drugs and other systems, electrical or hydraulic, were simply aids.

But therein lies the peculiar paradox of the mental physicians' dealings with those labelled "insane". Despite the continuity of the "medical" response, the asylum was a very different place from the infirmary or voluntary hospital. For these latter institutions were chiefly the creation of the medical profession itself but the mental asylum was established at a time when the profession had still to contest much ground in order to persuade the public of its competence in this area. The impetus behind the creation of asylums, as we saw in the Introduction and as Scull, Fears, Mellett, Donnelly and others have shown,⁽¹⁾ owed far more to the general reform movement of the early nineteenth century which embraced prisons, workhouses, schools, orphanages, factories and other such institutions designed to create regularity and order within a particular, socially problematic, population. That impetus, expressed as a desire to segregate and reform certain individuals for the protection of society, remained throughout the nineteenth century and sustained the logic of the mental asylum's existence as a place of legal detention, no matter how hard mental physicians sought to portray it otherwise.* The truth is, that just

* They certainly tried very hard. They blamed "legal complexities" for the asylum's poor curative performance and indulged in endless debates on the merits of "large" versus "small" asylums. The Asylum, as an ideal, was never in doubt, however, a fact which Tuke constantly insisted upon. "We should be able to regard the asylums of the land", he asserted, as if to ward off any doubts on the matter, "as one vast Temple of Health, in which the priests of Esculapius, rivalling the Egyptians and Greeks of old, are constantly ministering, and are sacrificing their time and talents on the altar of Psyche. See Ch. 7, below.

1. SCULL, Andrew T.: op.cit; FEARS, Michael: op.cit; MELLETT, D.J.: Government, Society and Mental Illness. Ph.D. thesis, Cambridge, 1979; DONNELLY, M.J.: Perceptions of Lunacy in Early Nineteenth Century Britain. Ph.D. thesis, Birkbeck, 1976; IGNATIEFF, Michael: op.cit. See also FOUCAULT, M.: Madness and Civilisation: a History of Insanity in the Age of Reason. 1967.

as by defining "insanity" in theoretic terms, mental physicians were simply recasting into their own "scientific" terminology the specific value-judgements passed by society upon some of its less acceptable members, so by accepting the mental asylum as the only possible centre of all their therapeutic ambitions they were reworking into their own ideology the social fait accompli of the lunatic's rejection from general society and relegation to an enclosed institution. Thus, just as general medicine avoided its implied challenge to existing social structures by elevating a special category of "sick" people within those structures, so "psychological" medicine affirmed in its ideology the socially-structured isolation of the "insane" from the rest of society. Moreover, although this affirmation co-existed with that other, "benign", view of the "insane" person as simply "sick", thereby worthy of special attention, a view which inevitably implies acceptance of the individual concerned, this latter came virtually to nothing, the tension between the two views, and the philosophical interplay between the needs of the individual and the requirements of society involved in all this, never being recognised as such in the nineteenth century. Social demands were simply taken as a fixed measure, and the whole work of rehabilitation, or "cure", was conceived in individual-organic terms. Thus we are bound to see "psychological medicine" as having its existence, its very rationale, within existing social structures and attitudes, and it was from this socially conservative basis that it attempted its benign responses.

How benign were those responses in any case? How great a contribution to a compassionate psychiatry can nineteenth century mental physicians claim? These are the questions which will be addressed in the remainder of this thesis. Here, we shall simply make one important observation concerning the overcrowded conditions in asylums and the attitudes of medical men to populations which quite commonly consisted of

several hundred and often over a thousand inmates. Most of the time the patients were dealt with, not as individuals, but as a single mass. As Mercier put it,

"Great individuality of treatment is not to be attained so long as the structure of the asylums provides only for the treatment of the insane in bulk". (1)

This treatment in bulk was reflected in the way mental physicians spoke and wrote about their patients. It was unusual for patients to be referred to as individuals. Mostly the expressions used show that the doctors regarded them as types:

"The dull swain with clouted shoon but frequently finds his way into the asylum",

says Hack Tuke, (2) and Andrew Wynter seems happy enough to characterise the majority of patients as "drivelling idiots" and "raving maniacs". (3) No wonder, then, that S.A.K. Strahan, assistant medical officer at Northamptonshire Asylum, could remark,

"which of us having a friend suffering from mental disorder which we considered curable would think of placing him in the ward of an asylum with sixty or eighty other patients, most of them chronic maniacs and gibbering imbeciles?" (4)

Not only does the terminology betray a tendency to lump the insane together as a type, but there seems to be over all a derisory tone at odds with the mental physicians' insistence on their "kindness" and "humanitarianism", though this is perhaps only to be expected in language directed across a class barrier. This does serve to suggest, however, that not even in personal interaction between doctor and patient (such as it was) was the effect of the lunatic's socially-structured rejection from "normal" society

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1. MERCIER, Charles: op.cit., p.3.
 2. TUKE, D.H.: Insanity in Ancient and Modern Life, with chapters on its prevention. 1878, p.98.
 3. WYNTER, Andrew: op.cit., pp.214-5.
 4. STRAHAN, S.A.K.: How Can the Medical Spirit be Best Kept up in Asylums for the Insane? Journal of Mental Science, XXXII, 139, 1886, p.347.

overcome. The doctors were all too often merely reflecting in their own outlook the pre-medical attitudes of society toward the "mad", to the detriment of even their own declared medical intentions. But this must be examined more closely when we consider the medical staff and their world.

We come to see 'psychiatry' - or, 'treatment of the insane' - in the late nineteenth century, finally, as a continuation of existing social arrangements, involving no new values, but hinting in a way as yet unrecognised at a new significance of the individual as arbiter of his own condition of 'normality'. This significance did not surface until well into our own century, but it was latent as a kind of subterranean tension between the benign responses towards the suffering individual and the dominative responses towards the individual as social deviant. The amalgam of these responses before 1900 was the activity of the asylum as we have analysed it. It cannot be denied that late nineteenth century 'psychiatry' was essentially a process of social re-education, with all the implications of class-domination which this suggests. An assessment of the validity of this re-educative response depends on how one assesses that society. The value of it to the patients must in the last resort depend upon their own assessment of the place in society to which they were to be, in theory at least, reinstated.

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P A R T B

PSYCHOLOGICAL MEDICINE IN PRACTICE

CHAPTER 4: RAW MATERIAL: A RECONSTRUCTION OF ASYLUM
FUNCTION FROM MEDICAL DOCUMENTATION

Our study of late nineteenth century psychological medicine has so far been conducted at the level of medical theory, using firstly an examination of conceptions of insanity and its recognition and secondly an examination of ideas about its cure. This presents us with a picture of psychological medicine at its most mythologised; that is to say, from a point of view in which the medical perspective is followed exclusively and so acquires an impression of fact, whilst actually representing only the particular approaches of the medical profession. In this section we will look at the practical effects of mental physicians' efforts and so hope to correct this perspective with harder evidence drawn from the experience of the patients. This will be done analytically, by the use of asylum documents, and then descriptively, by drawing upon government reports, medical writings and autobiographical material.

This chapter deals with the results of an analytical study of asylum records. The asylums chosen for this study represent three varied institutions in one large geographical area. They are the West Riding asylum at Wakefield, the Wadsley asylum at Sheffield and the Mapperley asylum in Nottingham. The areas covered by these asylums are diverse and include agricultural, textile, mining and steel-making regions as well as a varied range of domestic situations from small rural villages to large industrial towns. It was felt that this would provide a reasonable guide to the county asylum's general performance.

In addition, each of the three asylums possessed different features which could be compared. The West Riding asylum was a long-established institution founded in 1818. It was only the sixth county asylum to come into existence and had already seen important innovations by the start of our period. Its first medical superintendent was William Charles Ellis, a

prominent figure in the "non-restraint" and "moral treatment" debates of the early nineteenth century,⁽¹⁾ and the asylum continued a reputation for innovative ideas.⁽²⁾ Wadsley asylum was opened in 1872 and was originally an overspill establishment designed to relieve the pressure upon the West Riding asylum. It quickly began to function quite independently and soon grew to a size approaching that of the institution at Wakefield.⁽³⁾ It is interesting not only in this respect but also in that its records show a number of privately paying patients living alongside those supported on the poor rates, whose experiences can be contrasted. Mapperley asylum is of interest because of its relatively small size. It housed between 300 and 400 inmates and can thus be compared in its performance with the other, more typical, institutions.⁽⁴⁾

The records relating to the nineteenth century are by no means consistently to be found in all asylums. Time and the workings of local authorities have ensured that some have been lost and others misplaced. The West Riding documents are very well preserved, though divided up arbitrarily between the Wakefield public record office and the museum at what is now Stanley Royd Hospital. At Wadsley, now Middlewood, the survival-rate of documents is more patchy. All the existing records were, at the time of researching, contained in an attic. Not all the material seems to have survived and there is a much broken record of events from the asylum's opening until 1900 when, suddenly, documentation improves. Medical case-notes were few and not expansive but fortunately a complete set of admission

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1. See Chapters 1 and 2 on this debate. For more on Ellis, see HUNTER, Richard and Ida MacALPINE: Three Hundred Years of Psychiatry, 1535-1860. 1963.
 2. ASHWORTH, A.I: Stanley Royd Hospital, Wakefield, One Hundred and Fifty Years; a History. Wakefield, 1975, pp.24-35.
 3. THORPE, F.T: A History of Middlewood Psychiatric Hospital. Sheffield, 1972.
 4. See BELL, Joyce et al: Mapperley Hospital Centenary, 1880-1980. [Nottingham, 1980.]

registers still remained. Other evidence concerning the asylum's early years, including the quarterly reports of its medical superintendent, were placed for safe keeping in the vault of a Sheffield bank, the precise details of which, however, appear to have been lost. The Mapperley records are patchiest of all, at least, in the years from its opening in 1880 up to 1900.

It was therefore decided to make a study of the admission registers for each of the three asylums, these being the best surviving documentary evidence in these particular cases. They contain, in separate columns, the following information on each new inmate:

admission number;
 date of admission;
 name;
 sex;
 age;
 marital status;
 occupation;
 place of previous abode;
 parish chargeable;
 by whose authority sent;
 name of doctor signing admission;
 form of disorder;
 supposed cause;
 bodily condition;
 whether idiotic;
 whether epileptic;
 date of discharge or death.

The registers are written in longhand and are very nearly complete, although several gaps occur in specific information. There are some errors in the

entries which are apparent, suggesting that there are others which pass unnoticed. There is evidence that some registers, at least, were copied up from other documents - consistency of handwriting over twenty or thirty years, in the case of some entries, suggests this possibility - which implies that scope for clerical errors existed (quite apart from the author's own in copying them down). The information available is thus not as exhaustive or reliable as it might be.

This prompts the question of how precise an indicator of asylum functioning this evidence can be. The question is an important one since information of this kind must necessarily be communicated in statistical form. This tends to lend a false precision to the results of any survey. Any given number is, by definition, exact, yet it may well have been derived from the quantification of less than perfect source material. Proportional figures and averages drawn upon this kind of quantification are particularly susceptible to this false appearance of precision.

It is essential to understand at the outset, therefore, that this survey is in no way intended as a definitive statistical profile of asylum performance. I have attempted no precise calculation of numerical information derived from initial quantification since this precision can only, in the light of the foregoing observations, be false. Neither have I attempted a comparative study with the outside population. Apart from difficulties in defining which outside population would be the appropriate one for comparison, the job would be better performed by a demographer than by myself. My modest talents rise only to providing a starting block from which such comparative analysis can begin. The information presented here therefore serves only as a guide to the events which took place inside the asylum walls, yet it is probably as close to some of those events as we shall ever get.

a) PATIENT CAREER PROFILES

There are several ways in which the statistics of asylum inmates can be construed. An obvious parallel is the study of general hospital populations such as that conducted by Robert Pinker.⁽¹⁾ In his study, Pinker calculates bed-provision, bed-occupancy and average length of stay as the most significant factors in assessing the availability of medical relief to those reliant on such hospitals. To do this he draws on five sources; the Bristowe and Holmes enquiry, Fleetwood Buckle's survey of 1863, Low's survey in "The Charities of London", 1862, and two enquiries into the number of sick persons in metropolitan workhouses in 1866 and 1868.

However, lunatic asylums performed a significantly different function from that of the general hospitals which Pinker investigates. His survey took the validity of such medical provision as formed the basis of his enquiry as already assumed. By contrast, the validity of asylum provision in the treatment of insanity is precisely the subject of this investigation. It has been preferred, therefore, not to enquire into the availability of accommodation, whose constant expansion throughout this period was, and remains, a problematic phenomenon. Length of stay, on the other hand, is a vital consideration, but there, because the average length of stay of patients in asylums was considerably longer than those of hospitals, a difficulty arises over the source of information used to do this. Annual counts of total populations may give reliable results where the turnover is in the region of one month, as in the material which Pinker examines, but where patients often remain for several years this source becomes complicated by a high incidence of multiple counting. To overcome this problem, it was decided to use as a basis of the enquiry the total of patients admitted during each of certain specified years. The

1. PINKER, Robert: English Hospital Statistics, 1861 - 1938. 1966.

'careers' of each patient have then been individually followed through, with the results as shown in the tables. In addition to length of stay, recovery-rates, mortality, and the incidence of two specific diseases (the only diseases which can be given such specific treatment from the records), epilepsy and general paralysis of the insane have also been analysed. All this information (except for the latter category) has been calculated independently for male and female patients, as well as aggregated for the total population.

The selection of years for the study of patient intake has of necessity been arbitrary. An initial pilot survey suggested that little difference was to be found between years, so that there did not seem to be any clear feature on which to focus attention. The years chosen have consequently reflected convenience more than anything else. The admission years selected were 1860, 1870, 1880 and 1890. In the case of Wadsley asylum, which opened in 1872, only the years 1880 and 1890 were used. However, Wadsley's privately paying patients were included separately in the survey. As their number was small, a single sample of all admissions in this category from 1880 - 1889, inclusive, was used. For Mapperley, which opened in 1880, it was necessary to use 1881, the first complete year of its operation. Also, since not all the nineteenth century records were complete, 1891, rather than 1890, was used.

These anomalies actually matter less than they seem. The consistency shown in all these records - within years as well as between them - indicate a dreary sameness of normal function. The fluctuations which do occur on a smaller scale are not of great overall significance. Clearly, actual usage had its variations, its ups and downs, but these were minor and should be regarded as a part of practical functioning rather than a deviation from some statistical norm.

The total population figures which were used in each case were as follows:

	<u>FEMALE</u>	<u>MALE</u>	<u>TOTAL</u>
<u>WEST RIDING</u>			
1860	158	167	325
1870	258	189	447
1880	224	228	452
1890	192	208	400
<u>WADSLEY</u>			
1880	280	188	468
1890	208	199	407
1880-9 (Private)	154	110	264
<u>MAPPERLEY</u>			
1881	45	52	97
1891	59	77	136

(i) Recovery-Rates

Once admitted, the patient must either be discharged or die in the asylum. Those discharged were listed under one of three headings; "recovered", "relieved" and "not improved". It should be realised that these categories are open to wide interpretation. In particular, the category "recovered" (this was used rather than "cured") need not indicate permanent return to "normality". We may cite J.C. Steele in this context, writing on the discharges from Guy's Hospital, London:

"With reference to the class designated "cured" or "well", it is well-known to those accustomed to hospital practice, that the meaning intended to be conveyed is not an absolute and permanent recovery from disease in all cases, but that it includes a very large number of cases where a restoration of temporary health is the utmost that can be expected" (1)

The point can be underlined by citing one or two cases which were discharged

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1. STEELE, J.C: Numerical Analysis of the Patients Treated in Guy's Hospital for the last seven years, from 1854 to 1861. Journal of the Statistical Society, 24, Sept. 1861, p.376.

as "recovered" from Wadsley asylum. A 36-year-old labourer was admitted on 10th May 1883 and discharged on 9th June the same year as "recovered". He was described as suffering from

"Dementia with General Paralysis. He is confused and unable to answer questions rationally and has a defective memory. Feeble bodily health from the General Paralysis".

Similarly, a 35-year-old housewife, admitted on 16th February 1883, was described as suffering from

"Mania, having delusions to the effect that she has been transformed into a pack of cards and often becoming incoherent".

She was discharged "recovered" after only 22 days. We may suspect that here a manic period may have passed into normal behaviour, but whether this remained permanent must remain the object of some doubt.

Even harder to ascertain is the meaning of the category "relieved".

To cite Steele again:

"The same remark is equally applicable to the division, "relieved".... Under this latter heading are included a large, perhaps the greater portion of patients whose classification might, with equal propriety, have been inserted into the category of incurable cases, were it not for the fact that they had received benefit from their temporary residence, and were discharged much better in health than they were at the date of their admission". (1)

Herbert Major, superintendent at the West Riding asylum, reported to the Commissioners in Lunacy in 1882 that

"I continue in my endeavours to discharge as relieved those patients whose condition and circumstances render the procedure in my opinion practicable and right, and as a rule these cases have apparently done well". (2)

The distinction between "recovered" and "relieved" appears to rest on a judgement made by the medical superintendent. According to Bevan Lewis, who succeeded Herbert Major three years later, many patients were then

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1. ibid.
 2. Quarterly Meeting of the West Riding Lunatic Asylum, 26th October, 1882. Wakefield PRO, C85 126.

being discharged "relieved" and sent into the care of "friends or to the Union Workhouse".⁽¹⁾ This trend was to some extent accelerated by the need "to reduce the overcrowding in our Wards",⁽²⁾ a need which must, therefore, have resulted in an expansion of the "relieved" label.

How this differed from the category of "not improved" is likewise unclear. The Registers do not usually contain a record of where discharged patients were then sent, but from time to time whole batches of patients from other asylums were entered in one sequence in the "admissions" column. Thus on 31st July, 1880, a batch of twenty female patients from the Lincoln Asylum were admitted to Wadsley. Most of them were discharged "not improved" on 8th February 1882, together with a further seven female patients admitted earlier, also from Lincoln. It seems likely that many such batches consisted of chronic, long-stay cases. All the twenty-seven patients from Lincoln, for example were entered as suffering from "dementia", and of the four who were not discharged with the others, three remained at Wadsley for over ten years. However, it is by no means certain that these were the only patients to be so treated. Of the twelve female patients admitted from Birmingham to Wadsley on 23rd November 1880, eleven were discharged after a year and two months and one after only ten months. The six male patients admitted from Carlisle the same year were all discharged after two years. All these patients were discharged as "not improved". The evidence suggests that this sort of "moving-on" of patients was not uncommon⁽³⁾ and the high probability is that they were all entered as "not improved". Thus the distinction between this category and "relieved"

1. ibid, 30th April, 1885. Wakefield PRO, C85 110.

2. ibid.

3. STALLARD, J.H.: Pauper Lunatics and their Treatment, (a Paper read at the Meeting, at Bristol, of the National Association for the Promotion of Social Science, October 4th, 1869). 1870. pp.4-5. Also, GRANT-SMITH, Rachel: The Experience of an Asylum Patient. 1922, p.72.

becomes clear. Far from being true "medical" descriptions, they merely indicate the post-asylum destination of discharged patients, the "relieved" going into unofficial care and those "not improved" simply being transferred to another asylum.

A further complication is the officially recognised but unofficially ignored category of patients with previous asylum history. The Registers do contain a column headed "Date of Previous Admissions", but these were rarely filled in. There can be little doubt that several patients did return, some on many different occasions, but without an analysis of every name throughout the entire series of registers it would be impossible to assess how many of these there were. No doubt the same difficulty prevented the asylum clerk from similar paper-work (it is interesting that Mapperley, the smallest of the asylums studied, does have fairly regular entries under "readmissions"), so that patients were probably entered in the "Previous Admissions" column only if they themselves made this known, otherwise most asylum authorities preferred to treat each new patient as a first admission.

The final category of "died" requires no explanation. Death in the asylum was a regular part of everyday existence. Its frequency embarrassed the Commissioners in Lunacy, who took care to calculate the mortality-rate on a different basis from that of discharge-rates, thereby making it appear only one third of its true value. Whereas the latter were based on a proportion of total admissions for one year, death-rates were generally calculated as a proportion of the total asylum population, a figure roughly three times as great as that for the annual intake. This distortion has been avoided here by referring in all cases only to admissions in each specified year. The rates of discharge and death as shown in the following tables:

<u>Table I</u>	-	<u>Wadsley;</u>
<u>Table II</u>	-	<u>Wakefield (West Riding);</u>
<u>Table III</u>	-	<u>Nottingham (Mapperley).</u>

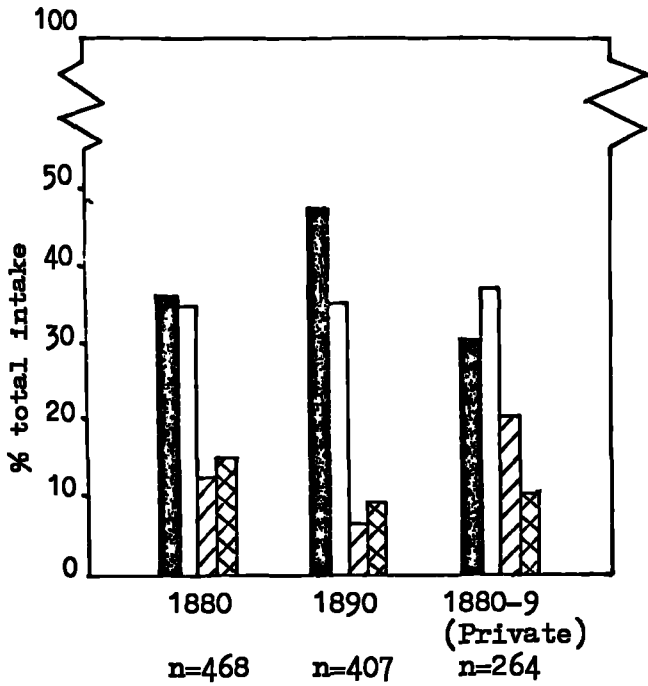


TABLE I: Deaths and Discharges, Wadsley Asylum.

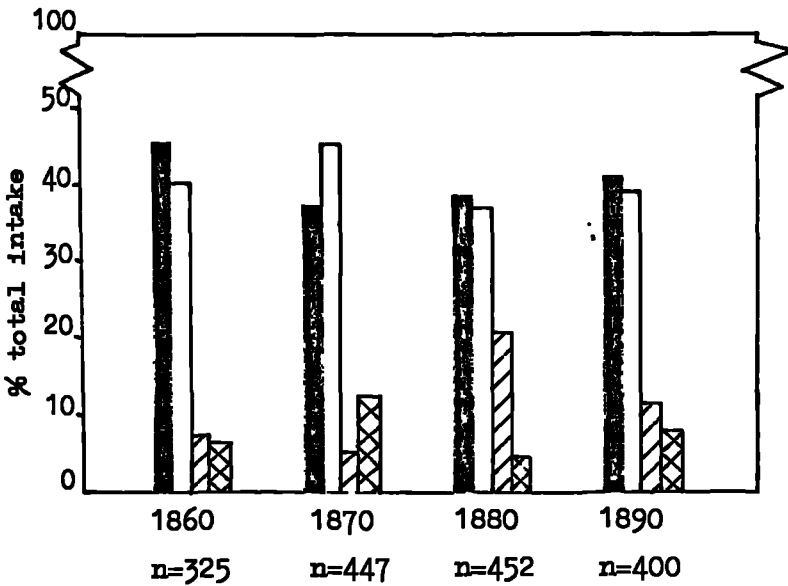
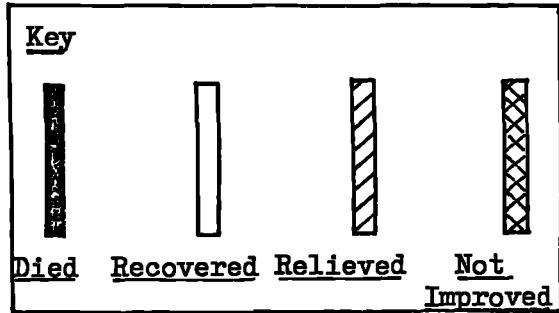


TABLE II: Deaths and Discharges, West Riding Asylum

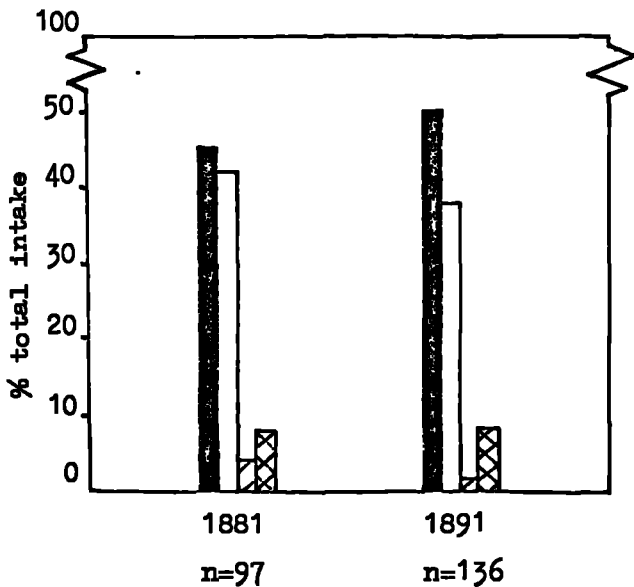


TABLE III: Deaths and Discharges, Mapperley Asylum

It will be seen at once that around two fifths of each year's intake eventually die without leaving the asylum. The rate of "recovery" is on the whole about the same, or perhaps slightly lower. The rest were presumably moved on to some other form of care or perhaps discharged without ever really gaining effective relief from their original difficulties. This picture, despite local fluctuations, is depressingly persistent throughout the whole period 1860-1900. When we consider the overall picture broken down into sexes, an interesting variation is found.

[See Table IV - Wadsley;
Table V - Wakefield (West Riding);
Table VI - Nottingham (Mapperley).]

The female death-rate is consistently lower than the male in a ratio of something like 5 : 7. The proportions of those discharged "relieved" or "not improved", however, shows little difference.

This calls for some comment. This differential mortality rate has already been observed by Santos and Stainbrook in their pioneering study of mental nursing in 1949.⁽¹⁾ They attribute this to the superior nursing qualities of female, as opposed to male, attendants. This thesis seems inherently unlikely, particularly as female attendants came increasingly to be employed in male wards during the century without apparently affecting the mortality-rate. A more likely explanation may lie in the nature of those conditions which resulted in female admissions. A considerable proportion of them were attributed at the time to circumstances surrounding childbirth and lactation, much emphasis on which is given in all the textbooks on female insanity. A condition commonly found is "puerperal insanity", or "melancholia following childbirth". This condition may have close correspondencies with the modern term "post-natal depression", which

1. SANTOS, E. and E. STAINBROOK: A History of Psychiatric Nursing in the Nineteenth Century. Journal of the Hist. of Med. and Allied Sciences, IV, 1949.

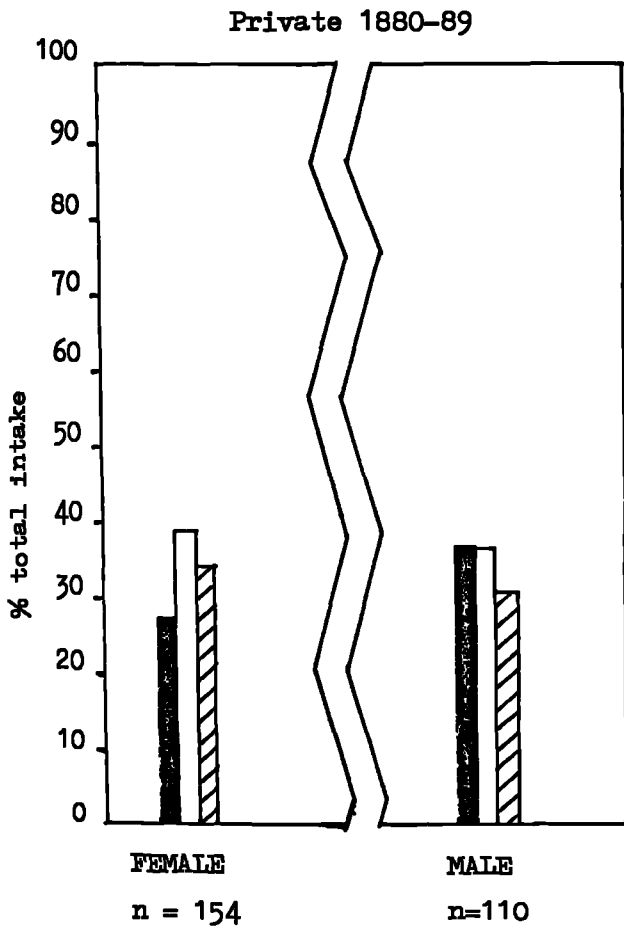
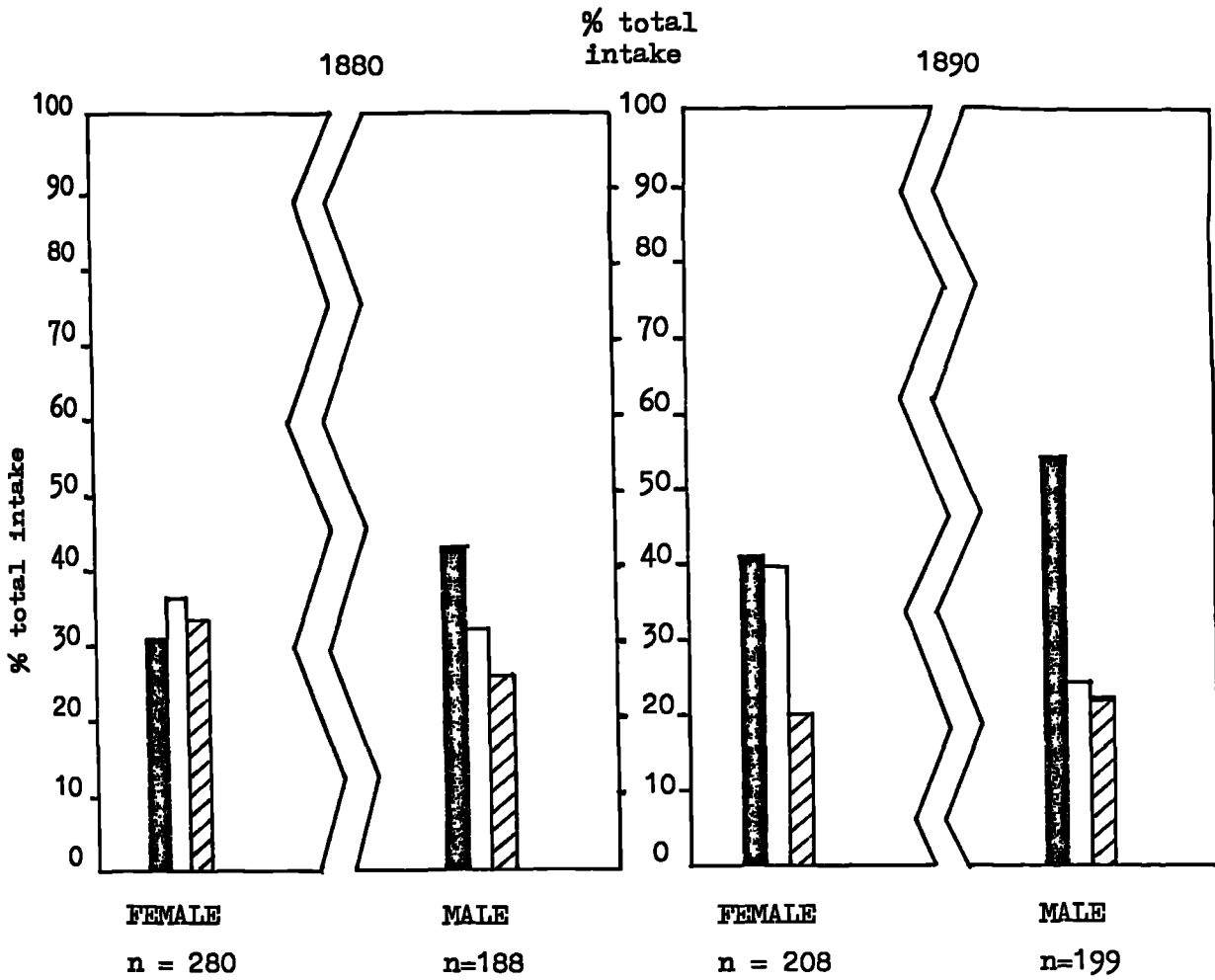


TABLE IV: Deaths and Discharges Distinguished According to Sex.
Wadsley Asylum.

Died Recovered Relieved and Not Improved

TABLE V: Deaths and Discharges Distinguished by Sex.
West Riding Asylum.

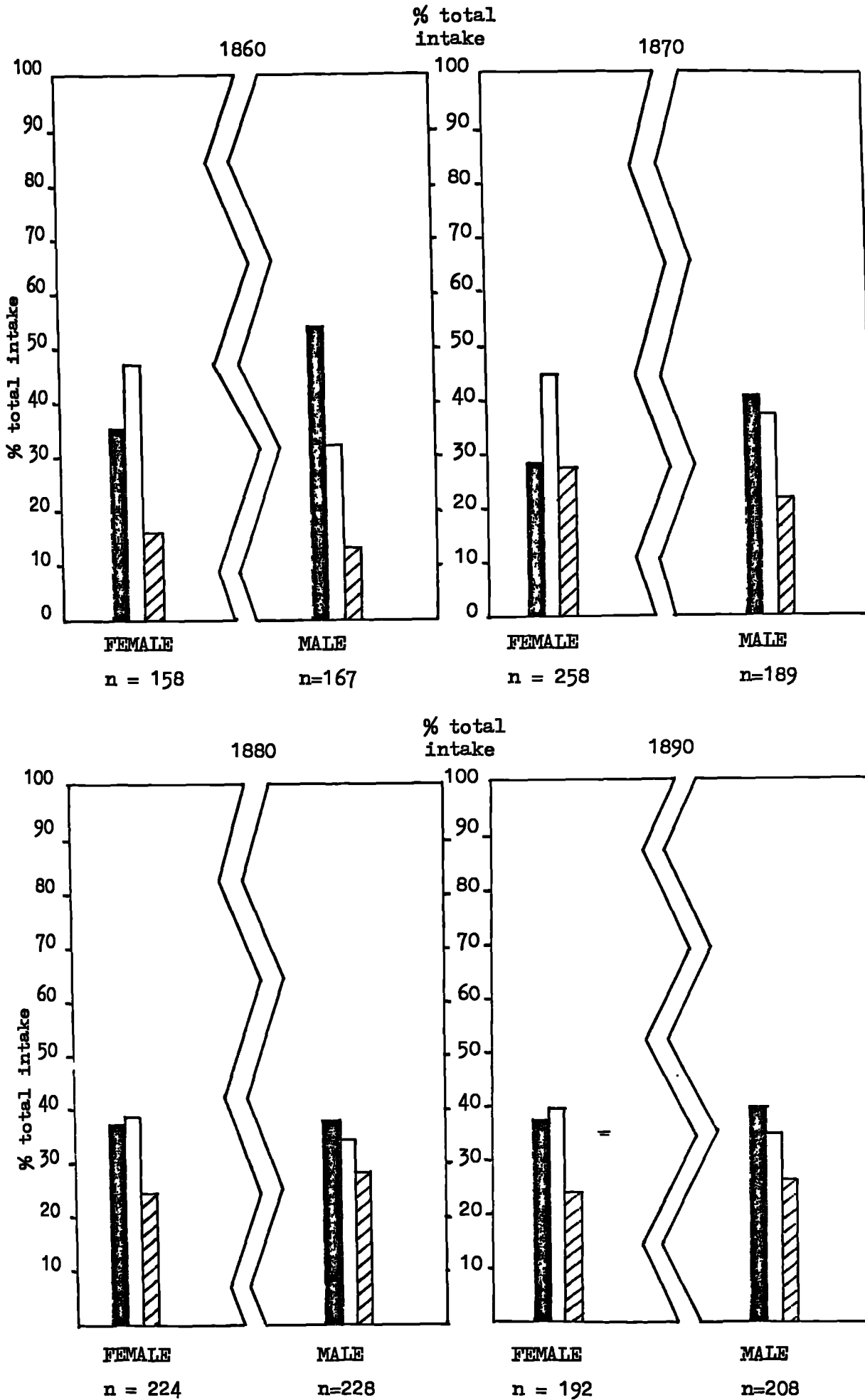
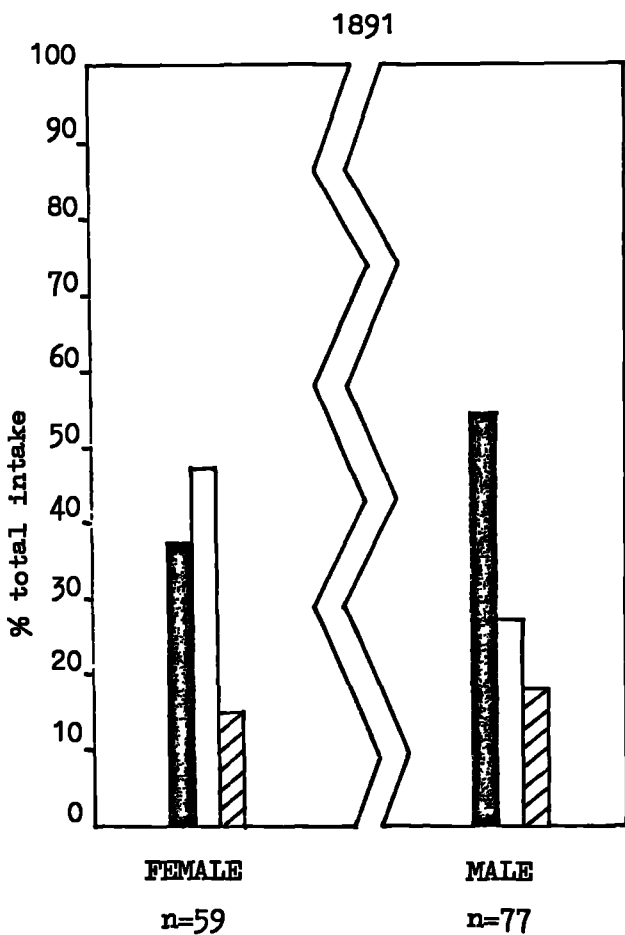
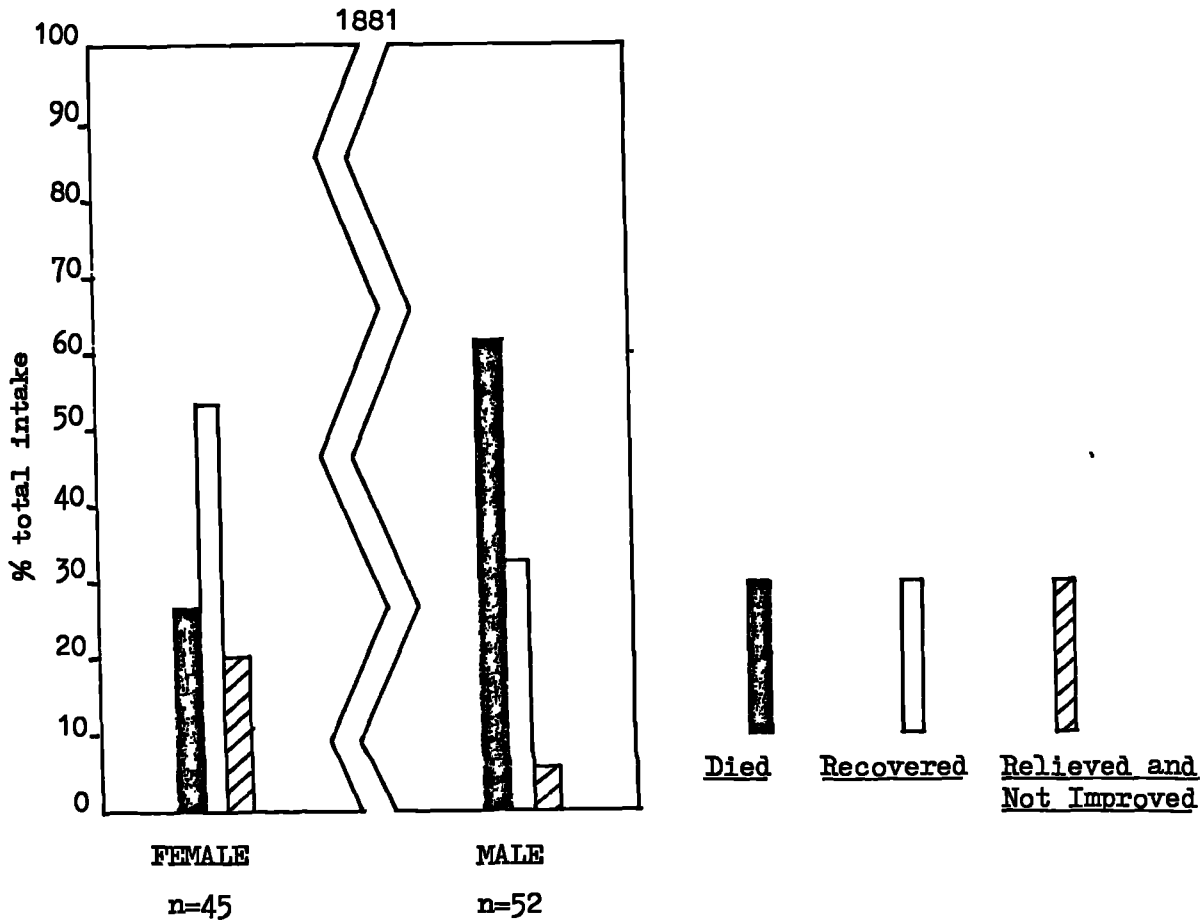


TABLE VI: Deaths and Discharges Distinguished According to Sex.
Mapperley Asylum.



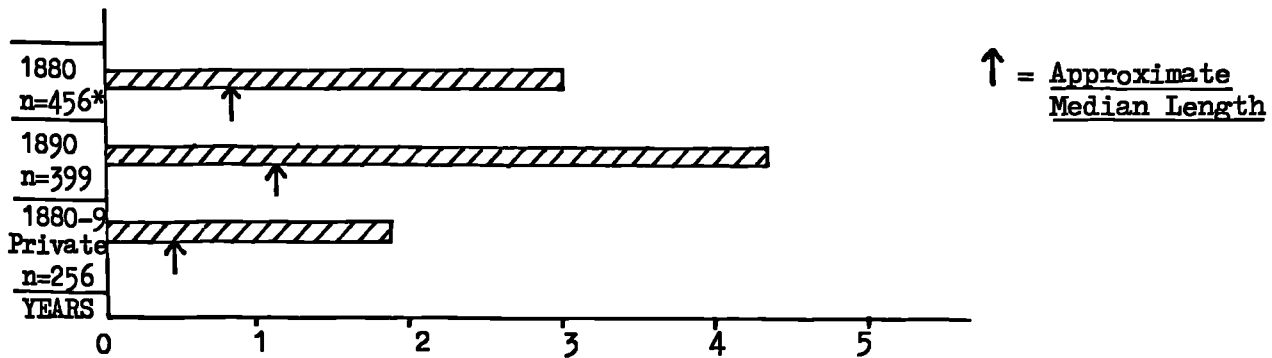
generally leads to spontaneous remission. It is not unlikely that a significantly higher proportion of women were suffering from such conditions which cured themselves than were men, and this would account for the lower death-rate and higher rate of "recovery". On the other hand, it is possible that conditions in female wards (the sexes were always strictly segregated) were more favourable than in male wards, or the nature of their employment less harmful. In this context, it is worth noting that Mapperley, despite its much smaller size, and therefore one might assume more favourable conditions, shows precisely the same pattern as Wadsley and the West Riding. On balance, the nature of the female admissions seems most likely to account for the difference in outcome between women and men, but there are grave doubts, as we shall see later, that the lower mortality-rate led to earlier discharge.

(ii) Length of Stay

Before we consider the pattern of mortality in greater detail, we must examine the length of time which patients generally spent in the asylum before death or discharge. Unlike general hospitals, where patients remained on average only a few weeks, lunatic asylums acted as long-term residences where patients were retained by law for some considerable time. It would be misleading to infer too much from averages, but a comparison with hospital figures shows how very different was the shape of the typical patient's career in the asylum.

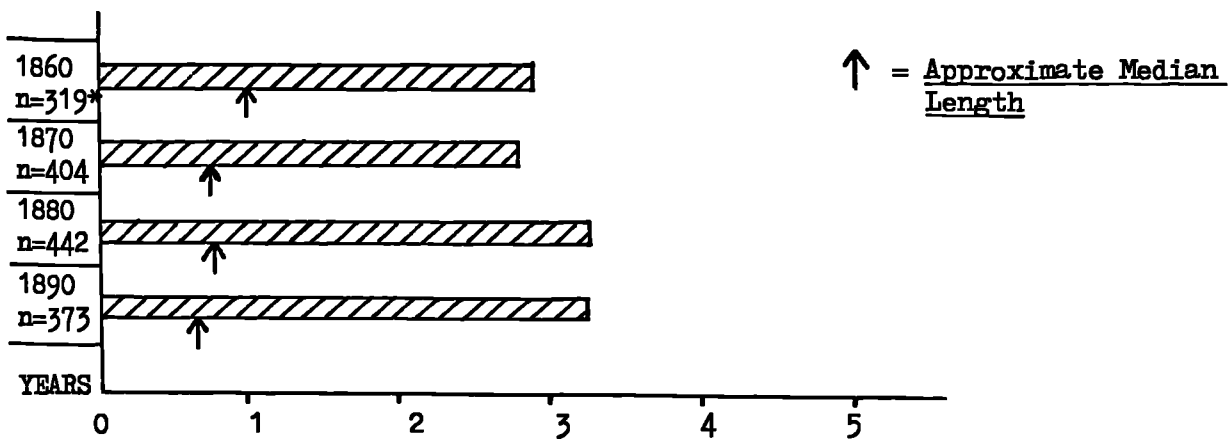
The mean length of stay is shown in Tables VII, VIII and IX. The small arrow indicates the approximate median. The very different figures for these two averages will be discussed in a moment. A clear consistency emerges with the mean length of stay at around three years. Apparent departures from this pattern, as in Wadsley's 1890 intake and Mapperley's admissions, can be explained by the unusually high proportion of long-stay

TABLE VII: Mean and Median Lengths of Stay, Wadsley Asylum.



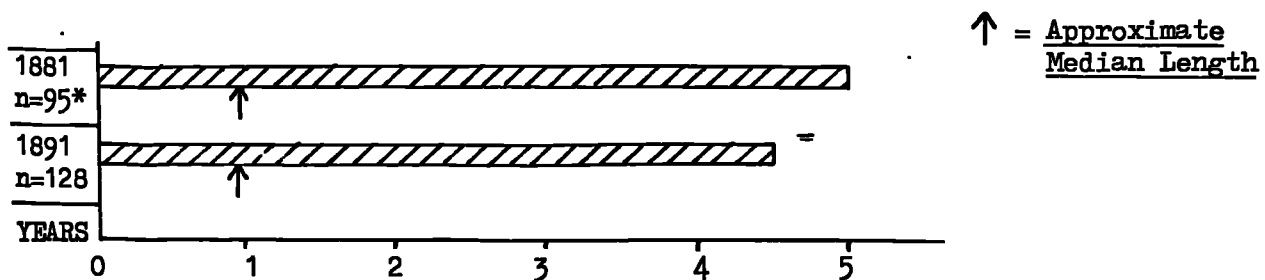
* N.B. The figures for population size given here are different from those in Table I. This is because of gaps in the original admissions registers.

TABLE VIII: Mean and Median Lengths of Stay, West Riding Asylum.



* N.B. The figures for population size given here are different from those in Table II. This is because of gaps in the original admissions registers.

TABLE IX: Mean and Median Lengths of Stay, Mapperley Asylum.



* N.B. The figures for population size given here are different from those in Table III. This is because of gaps in the original admissions registers.

patients which these admissions contained. In 1890, for example, Wadsley received 34 eventual long-stay patients from other asylums out of a total of 407. These particular admissions increase the mean length of stay by five months. Yet even allowing for this, the 1890 figure is a high one. Mapperley, too, received many long-stay patients (256 patients were transferred as soon as the asylum opened in August 1880, many of them chronics) which similarly boosted the mean figures.

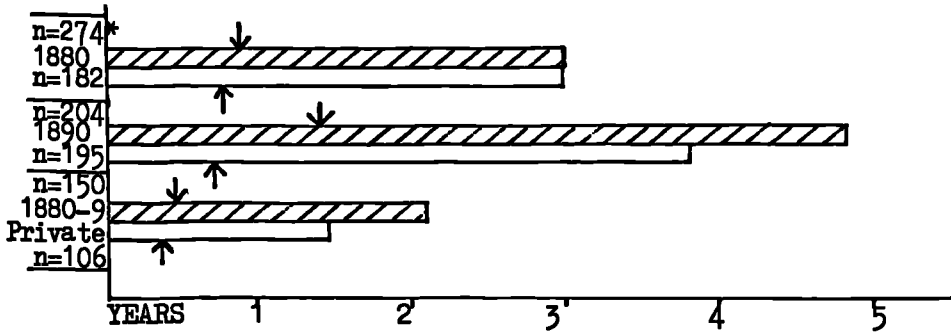
It is when we look at the median figures that a more striking consistency is found. In virtually all cases, the median lies at slightly under one year. This is as true for Mapperley, with its excessive mean lengths, as for Wadsley or the West Riding. Clearly, once we are able to discount the inflation of length-of-stay figures due to chronics simply remaining to die of old age, the asylum gave a fairly consistent performance. Even despite the relatively small numbers upon which this survey is based (and particularly Mapperley's small population) this consistency remains. When the figures are broken down into sexes another interesting consistency is found.

[See Table X - Wadsley;
Table XI - Wakefield (West Riding);
Table XII - Nottingham (Mapperley).]

In almost all cases (West Riding's 1860 intake being the one exception) the median length of stay for males is slightly less than the female figure. In the case of Mapperley's 1881 intake this trend is exaggerated, but the absolute figures involved are very low. These figures suggest a serious challenge to the commonplace belief that asylums merely collected unwanted humanity and kept them for an indefinite time.⁽¹⁾ Even so, a year is by no means a trivial amount of time to be spent inside an institution.

1. for example, see SCULL, Andrew T: Museums of Madness, the Social Organisation of Insanity in Nineteenth Century England. 1979. Chap. VI.

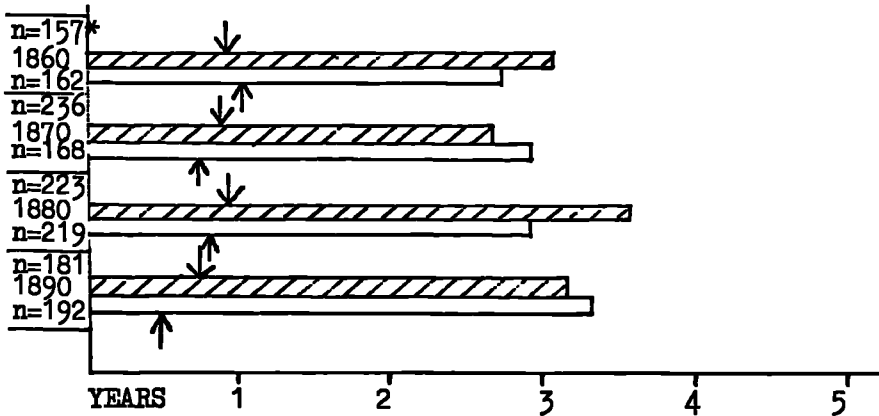
TABLE X: Mean and Median Lengths of Stay - Female/Male, Wadsley Asylum.



* N.B. The figures for population size given here are different from those in Table IV. This is because of gaps in the original admissions registers.

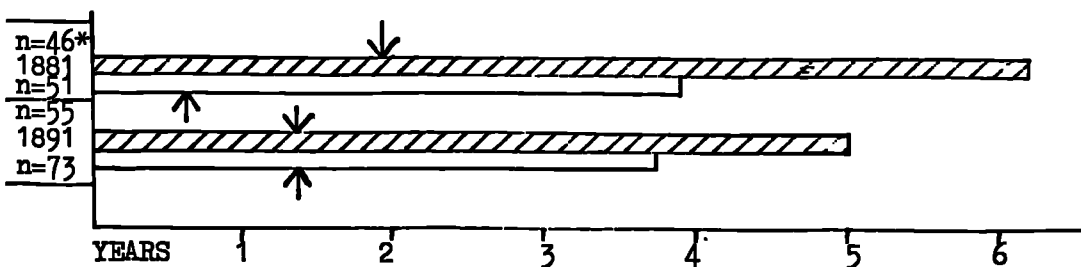
 Female  Male ↓ = Approximate Median (Female)
 ↑ = Approximate Median (Male)

TABLE XI: Mean and Median Lengths of Stay - Female/Male, West Riding Asylum.



* N.B. The figures for population size given here are different from those in Table V. This is because of gaps in the original admissions registers.

TABLE XII: Mean and Median Lengths of Stay - Female/Male, Mapperley Asylum.



* N.B. The figures for population size given here are different from those in Table VI. This is because of gaps in the original admissions registers.

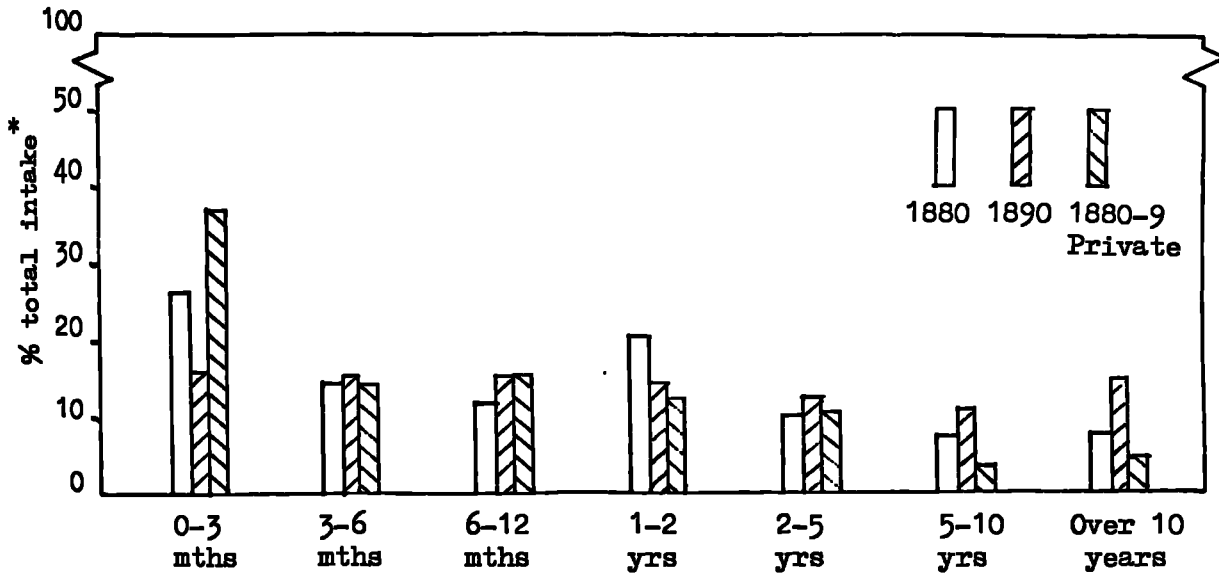
The position becomes clearer when the length-of-stay figures are broken down into seven divisions.

∟ See Table XIII - Wadsley;
Table XIV - Wakefield (West Riding);
Table XV - Nottingham (Mapperley). ∟

It can be seen that a significant proportion of inmates remain for less than three months and that the notion of inmates being retained indefinitely is simply not true. What is true is that some kind of regular assessment was taking place even amongst the longest stay patients, since many of them were discharged in some cases after twenty or thirty years. Clearly, on admission, a patient could look forward to a period of stay from a few weeks to many years, and it has not been possible to discover any factor in the records which might have indicated at the outset how long the period might actually be.

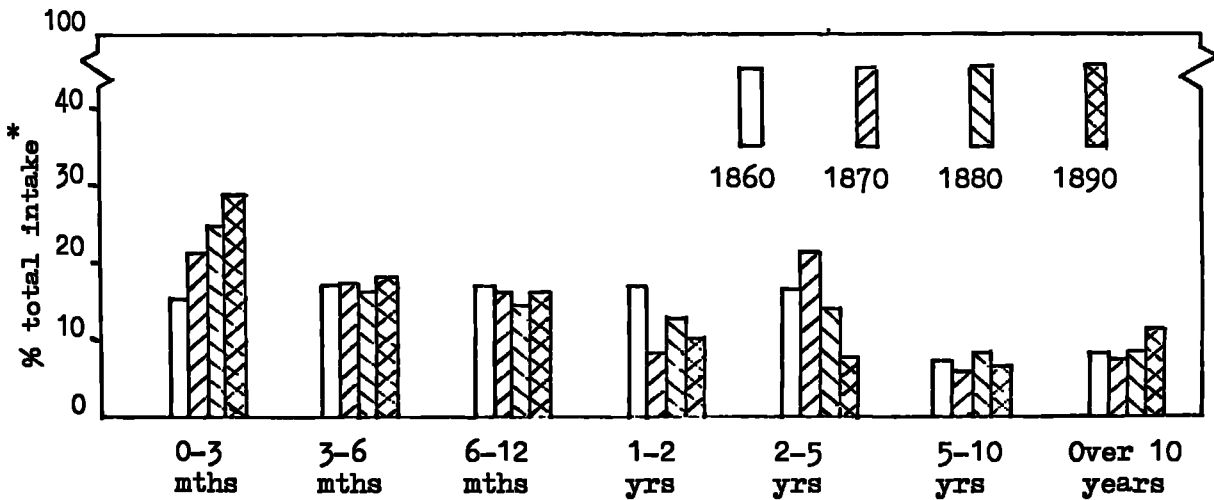
Two points deserve mention. There is a noticeable improvement in the proportion of patients discharged in under three months at Wakefield which is paralleled by a drop in the Wadsley figures for this category between 1880 and 1890. This suggests that Wakefield asylum was following a policy of speeding up "turn-over", probably with an eye on the constant pressure upon asylum accommodation. Some were undoubtedly transferred to Wadsley (and were noted down in Wadsley's Admission Registers) probably within a few weeks, while others were put back in the outside world more quickly. It seems most unlikely, in view of the previous chapter on available treatment, that this reflected any real improvement in the patients' condition. Probably the procedure had its origins in administrative necessity, which prompted a more hasty approach to patient care at Wakefield. Interestingly, the rise in the '0-3 month' category is matched by a fall in the '2-5 year' category. It seems possible that a funnelling through process was occurring, with a gap appearing at somewhere around the five-year mark, beyond which were only chronic patients, who could not have been speeded up or discharged at all.

TABLE XIII: Patient Career Profiles, Wadsley Asylum.



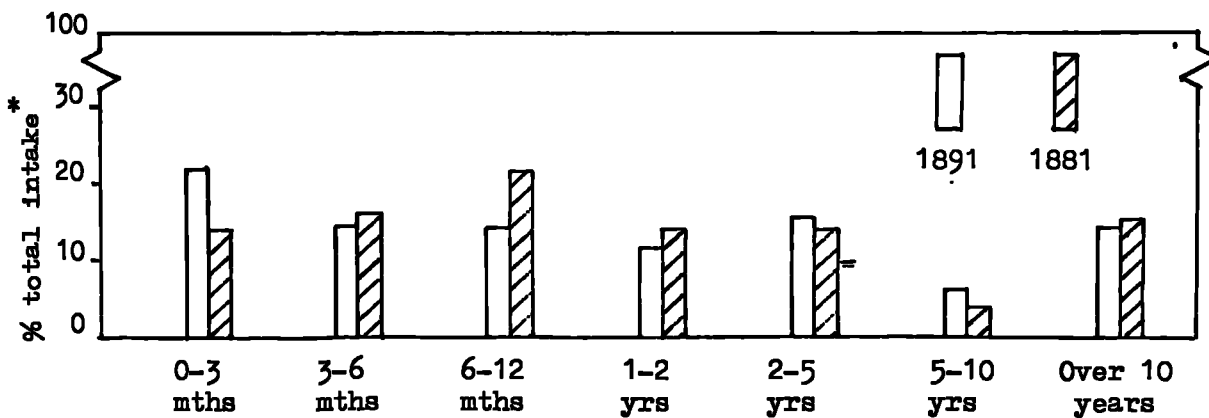
* see Table I for population figures.

TABLE XIV: Patient Career Profiles, West Riding Asylum.



* see Table II for population figures.

TABLE XV: Patient Career Profiles, Mapperley Asylum.



* see Table III for population figures.

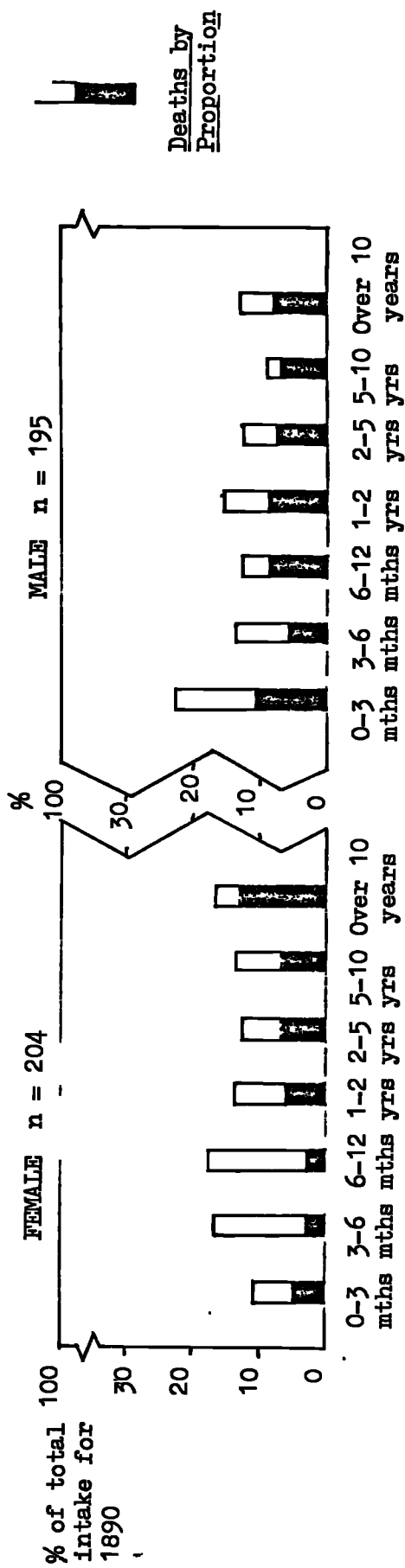
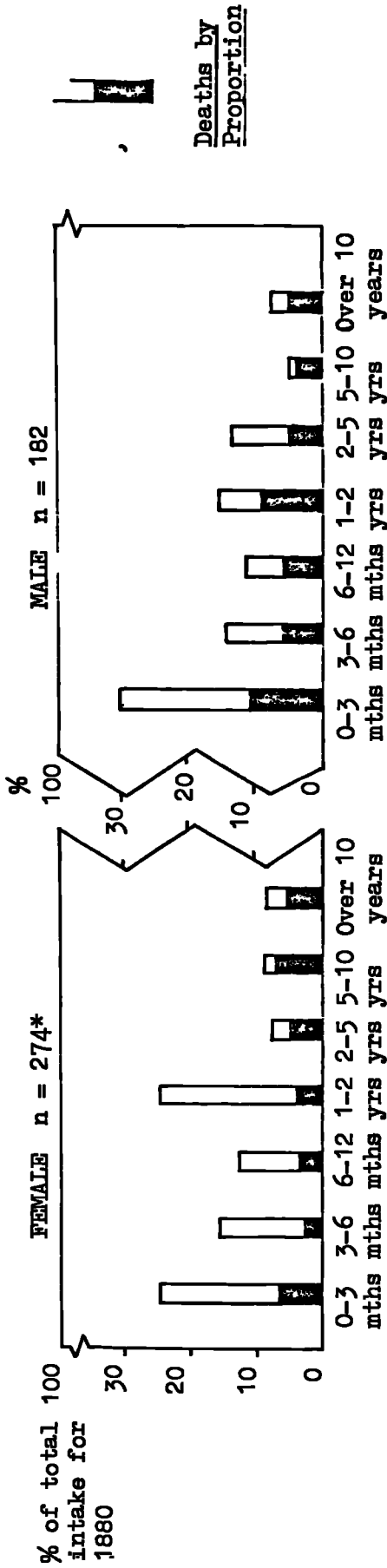
The second point of interest concerns the "private patient" category at Wadsley. There were only a few of these - between 3% - 4% of the annual intake - and so cannot, perhaps, be taken as typical. Their position in the asylum must have been anomalous. They were supported privately, invariably by their immediate families, and were certified by two doctors instead of the usual one, in accordance with the requirements of the 1845 Act. Apart from this difference, it is hard to imagine how they might have benefitted from this. Neither does this help to explain why their average length of stay (in both mean and median) was only half that of the other patients. The most noticeable difference occurs in the '0-3 month' category, in which private-patient releases were very high. The probable explanation is that the patients' families removed them as their finances ran low (which the procedure for private patients under the 1845 Act allowed them to do). Alternatively, they may have been removed only from the status of 'private' patient and transferred to 'pauper' status within the same asylum. The records are not clear on this point, but we should beware of reading the figures for private patients as the result of a superior 'medical' provision. Indeed, this particular anomaly must raise questions concerning the purely non-medical forces which shaped patients' career profiles.

When we distinguish these length-of-stay tables by sex we find a certain degree of variation in the pattern between male and female profiles.

┌ See Table XVI - Wadsley;
Table XVII - Wakefield (West Riding);
Table XVIII - Nottingham (Mapperley). ┘

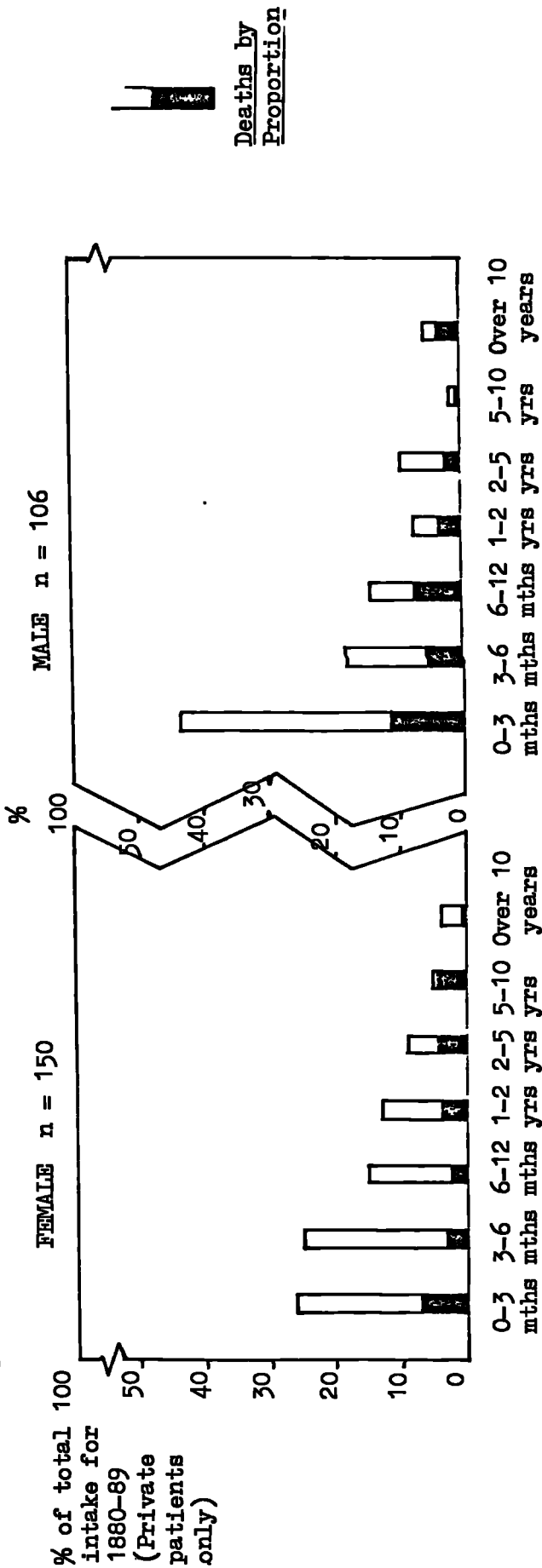
The much lower rate of discharge amongst female private patients at Wadsley as opposed to the male, may reflect their lesser economic importance amongst that social class which might have been expected to be the class most likely to pay privately. Yet it is only a slight exaggeration of a trend which is suggested by some of the tables referring to pauper patients.

TABLE XVI: Patient Career Profiles - Distinguished by Sex, Wadswley Asylum.



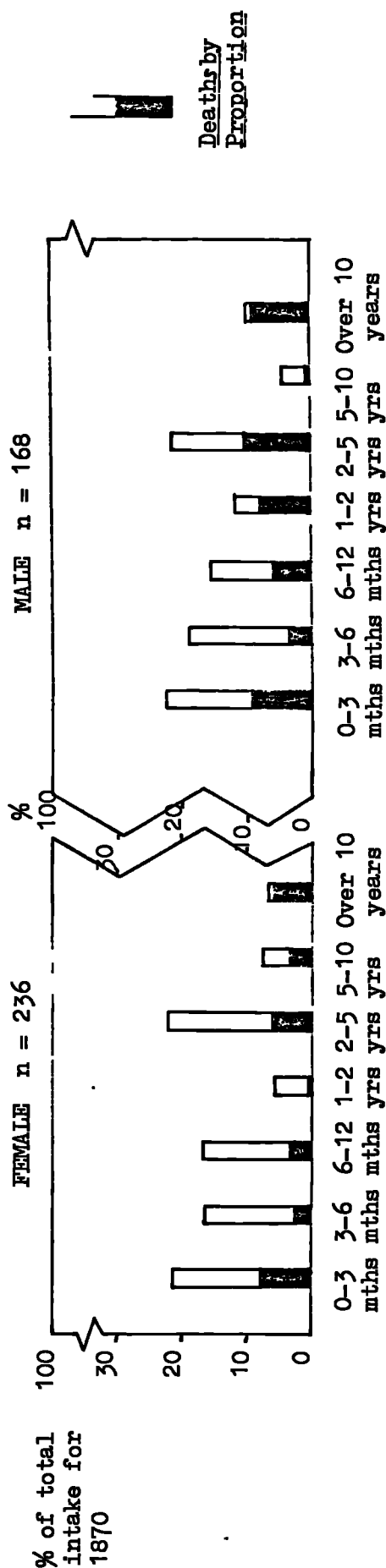
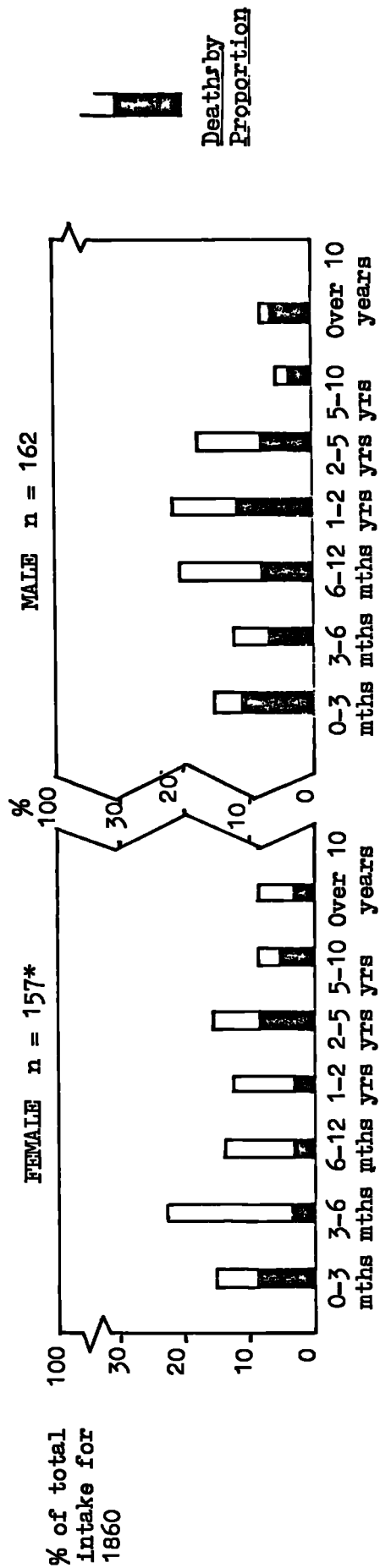
continued over

TABLE XVI - continued



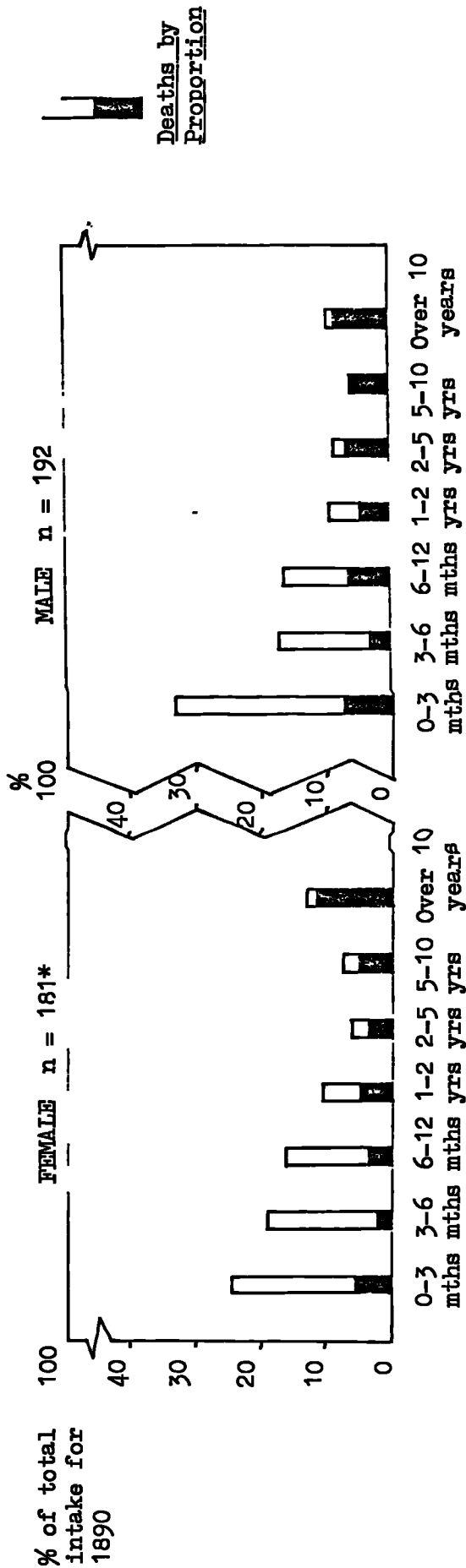
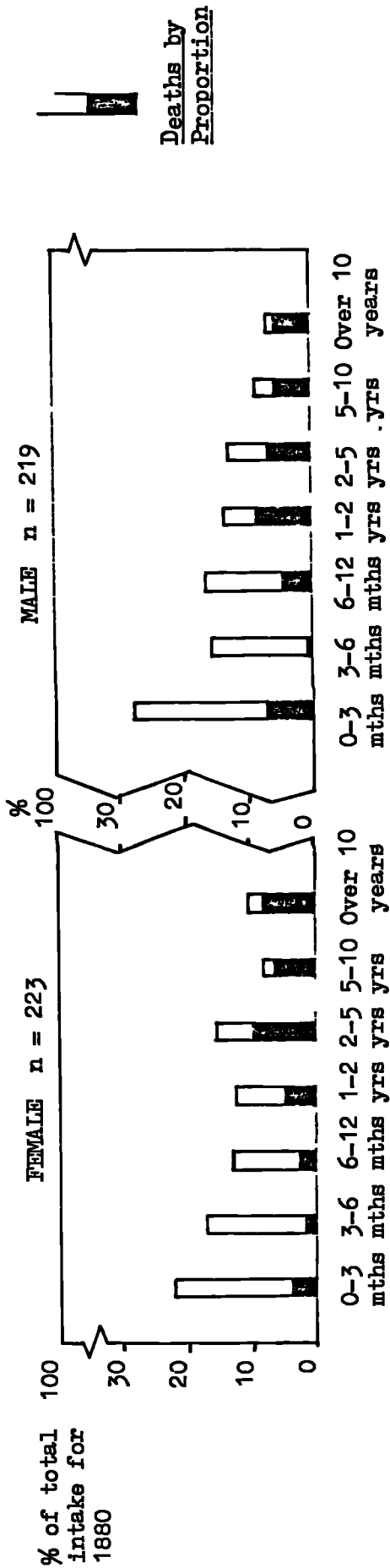
* N.B. The figures for population size given here are different from those in Table IV. This is because of gaps in the original admissions registers.

TABLE XVII: Patient Career Profiles - Distinguished by Sex, West Riding Asylum.



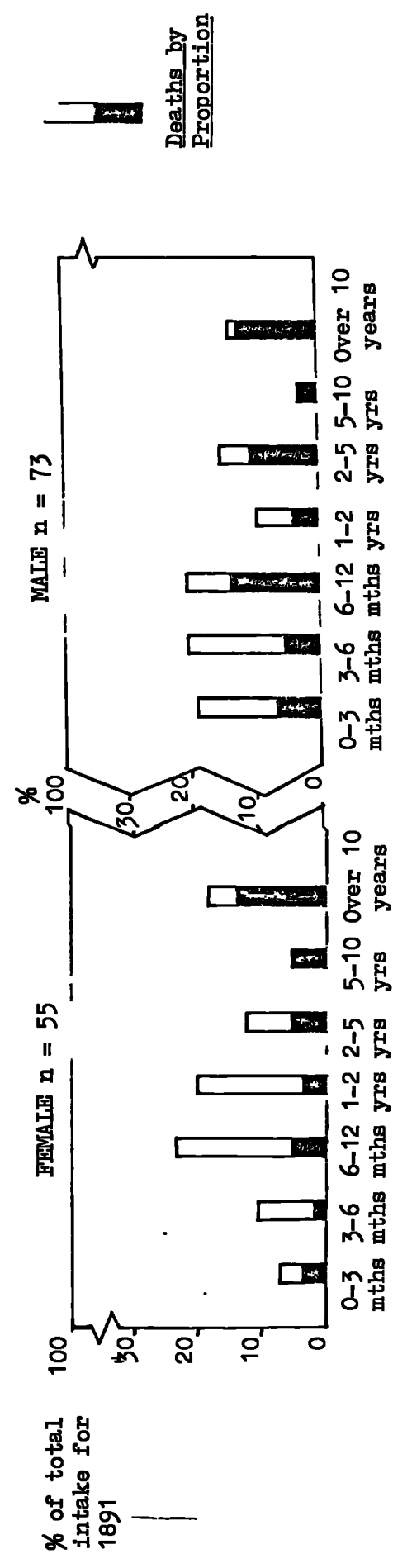
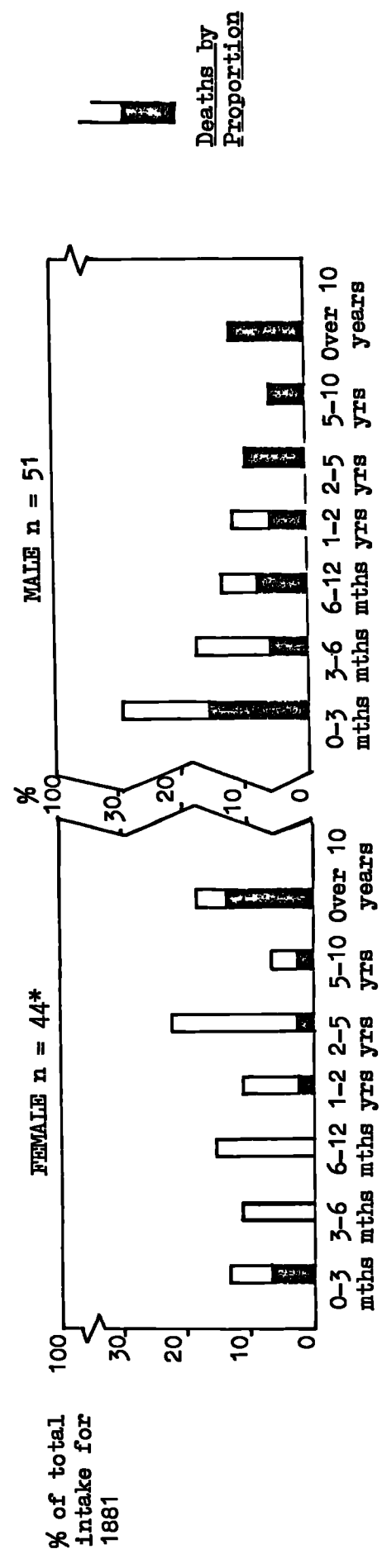
continued over

TABLE XVII - continued



* N.B. The figures for population size given here are different from those in Table V. This is because of gaps in the original admissions registers.

TABLE XVIII: Patient Career Profiles - Distinguished by Sex, Mapperley Asylum.



* N.B. The figures for population size given here are different from those in Table VI. This is because of gaps in the original admissions registers.

(iii) Mortality Pattern

We now need to look at how mortality and length-of-stay interrelated, that is, at the pattern of mortality amongst the asylum inmates. This is shown on the same tables, as the black portions of the columns. At once a pattern emerges. The absolute rate of mortality as a proportion of total intake is high amongst those in the '0-3 month' category, falling suddenly in the '3-6 month' group and then rising steadily. (N.B. The apparent rise in the '1-2 year' category is an artifact of the tables themselves, the first year of stay being represented by three columns and the second year by only one). The second peak we would expect, since the longer the length of stay the greater the likelihood of death and, more significantly, the higher the proportion of patients who were destined to remain until death in any case - the "lifera" of the institution. But the high initial peak comes as a surprise. It suggests that a large number of patients were being admitted who were suffering from physical ailments which were to prove fatal. Moreover, there seems no difference in this respect between female and male admissions. The only alternative explanation would be that patients were contracting serious disease upon entry to the asylum, but this would not adequately account for the concentration of deaths amongst recent admissions.

We have here a clue to one of the more obscure facts in mental history, namely the reasons for which people were referred to lunatic asylums. We have already considered the nature of "mental disease" as defined by the theoreticians and the criteria for diagnosis in this period and found them inadequate for an assessment of whether the patient required treatment in an asylum. Beneath these theoretical, or "medicalised" explanations, however, there lay practical realities. Faced with people of varying description of differing circumstances, the certifying doctors applied practical, rule-of-thumb criteria for their decisions. What those

criteria were remains largely obscure, but the pattern of mortality here described does suggest one possibility - a need for constant supervision. It may well have been that patients at the end of a terminal illness became sufficiently unmanageable that a hard-worked family found themselves unable to care for him or her. If this unmanageability was accompanied by any kind of mental symptom - incoherence, instability or senility - then ground was afforded for removal to an asylum as an "insane person". The same would also apply if the patient was an inmate in a workhouse. Indeed, the asylum may have acted as a human 'waste-disposal' depot for the local Board of Guardians. Something of this sort, at least, appears to have happened to a 35-year-old bricklayer admitted to Wadsley on 17th October 1892, suffering from

"Mania. He has been very restless, is now incoherent, much confused and quite unable to give any information respecting himself. In very feeble bodily health with heart disease and is in rather poor bodily condition".

He died 23 days later.

This conclusion is given added weight by J.T. Arlidge in his "State of Lunacy", published in 1859. There he says that several of the 1854 admissions

"were in advanced stages of bodily disease Others were in advanced stages of dropsy, phthisis and general paralysis". (1)

In his report to the Committee of Visitors on 27th July, 1882,

Herbert Major noted that

"one Benjamin Metcalfe was received with broken ribs, heart disease, and bronchitis. He died suddenly, the inquest found, from heart disease, bronchitis and disease of the kidneys". (2)

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1. ARLIDGE, J.T: On the State of Lunacy and the Legal Provision for the Insane, with observations on the construction and organisation of asylums. 1859. p.94.
 2. Quarterly Meeting of the West Riding Lunatic Asylum, 27th July 1882.
Wakefield PRO, C85 126.

His successor, Bevan Lewis, reported in 1885 that

"the character of the male Admissions this quarter has been most unsatisfactory, embracing as they do many confirmed epileptics, several paralytic and senile cases sent here in the last stage of their malady to die shortly after admission.

Several of these cases might judiciously have been treated at the Union Workhouse or even by their friends at home". (1)

Many of these patients had already been inmates of workhouses before their admission to the lunatic asylum. Dr. Boyd, of the Somerset county asylum, described how a man with dropsy, generally broken down and epileptic, had been sent to the local workhouse.

"He was disappointed at not being admitted into a general hospital, became violent, and was sent as a patient here". (2)

Evidently, almost any awkward behaviour could be construed as an act of insanity if it suited the relieving officer or the poor law doctor. A 70-year-old paralysed woman was "troublesome" in the workhouse and so was sent to the asylum.⁽³⁾ But generally such patients seem to have been certified when, as Dr. Boyd continued, they

"are in a diseased and feeble state of bodily health, and require more nurse-tending than they receive in the workhouse".

In such circumstances any mental peculiarity was an adequate justification.

As J.C. Bucknill commented,

"patients are sent suffering from serious and troublesome bodily disease, whose mental condition would never have been considered a sufficient cause for removal, had it existed alone". (4)

It was enough for Arlidge to remark that asylums were becoming "mere auxiliaries to workhouses",⁽⁵⁾ and it would appear that they largely remained so during the century, as far as these patients were concerned.

1. ibid, 29th January 1885. Wakefield PRO, C85 126.
2. quoted in ARLIDGE, J.T: op.cit, p.91.
3. ibid, p.91.
4. ibid, p.96.
5. ibid, p.92.

Thus the pattern of mortality which we have traced is a graphic representation of this common dumping of the sick and dying poor upon an institutionalised 'waste-disposal' point, under the convenient heading of "insanity".

This pre-existing disease must be distinguished from diseases contracted during the patients stay in the asylum. Causes of death in the asylum were set out each quarter in the superintendent's Report to the Committee of Visitors. At Wakefield, in the relevant years of this study, the causes listed were as follows:

<u>1860</u>	TB	-	31
	General Paralysis	-	24
	Diseased Brain	-	14
	Diseases of Heart, Lungs and Kidneys	-	5
	Exhaustion	-	6
	Apoplexy	-	5
	Epilepsy	-	4
	Bronchitis	-	3
	Others	-	54
	<hr/> TOTAL	-	<hr/> 146
 <u>1870</u>	Brain Disease	-	33
	TB	-	28
	General Paralysis	-	24
	Pneumonia	-	9
	Ulceration of Intestines	-	3
	Senile Decay	-	3
	Apoplexy	-	2
	Epilepsy	-	2
	Exhaustion	-	2
	Others	-	81
	<hr/> TOTAL	-	<hr/> 187
 <u>1880</u>	General Paralysis	-	28
	Phthisis (TB)	-	16
	Cerebral Atrophy	-	12
	Bronchitis	-	6
	Pneumonia	-	7
	Apoplexy	-	5
	Heart Disease	-	5
	Acute Mania	-	3
	Others	-	43
	<hr/> TOTAL	-	<hr/> 125

<u>1890</u>	General Paralysis	-	44
	Cerebral Atrophy	-	27
	Phthisis (TB)	-	20
	Pneumonia	-	15
	Epilepsy	-	14
	Bronchitis	-	10
	Heart Disease	-	8
	Others	-	20
	<hr/>		
	TOTAL	-	158
	<hr/>		

The most common cause of death appears to have been general paralysis, (a form of syphilis) and the next most common, tuberculosis. Notice that, apart from senile decay, the only cause which can be related to clear "mental" conditions was exhaustion following attacks of manic excitement. We do not know how long each of these patients had been in the asylum before death, so we do not know if they included people admitted with these diseases, but we do know that contagious disease was a hazard in the asylum.⁽¹⁾ In this connection, we should note the apparent reduction in the overall proportion of deaths shown in the tables during the 1870s. Whether this merely reflects the falling mortality-rate of the period in general or whether some other local cause is responsible is not clear. Certainly, there is nothing in the Reports of the superintendents which draws attention to such a feature, though there is evidence of improved health amongst the patients. Crichton Browne, in his quarterly report to the Committee of Visitors on 23rd July 1872, made the first observation of this improvement at the Wakefield asylum.

"The health of the patients has been unusually good - not a single case of any infectious, contagious or epidemic diseases having presented itself. The Asylum has not been so free from sickness for more than twenty years past, as in the first half of the present year". (2)

Probably, the non-recurrence of such diseases was an important factor in the lowering of the death-rate in the 1870s.

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1. HUNTER, Richard and Ida MacALPINE: Psychiatry for the Poor, 1974.
 2. Quarterly Meeting of the West Riding Lunatic Asylum, 23rd July, 1872. Wakefield PRO, C85 124.

(iv) The Problem of Chronic Patients

All these figures, as has been stated, are only a very imprecise measure of asylum function. Small groups of a particularly marked character could, and did, cause the statistical inference of them to vary significantly. Probably the single most important such group is that of chronic or 'long-stay' patients. These were people who appear to have lived in institutions for much of their lives and who generally remained in these circumstances until death. Even here, however, one cannot generalise, for several 'long-stay' patients did leave the asylum alive, though whether to another institution or to a friend or relative is not known. We might question, in this situation, whether a patient of this kind would have any outside friends or relatives, in which case it would appear that many chronic patients were moved on even late in their lives to die in a strange institution.

The presence of chronic patients has a clear impact upon the overall performance of the asylum as measured in statistics. An illustration of this can be taken from Wadsley in 1873, the first full year of its operation. When it opened, it at once received several batches of patients from other institutions. In all, there were 89 such transfers out of a total intake of 263, and the date of their original committal, together with the date of their transfer to Wadsley, are all recorded. There is a very high correlation between such a background and a long stay at Wadsley, which is as one would expect, since the removal from one asylum to another would not have altered the mental condition of the patient in itself. If we examine the mean length-of-stay figures for Wadsley for that year we can note the following figures:

	<u>Length of stay (mean)</u>
First admissions only:	3 years 9 months
All admissions, including transfers:	5 years 2 months

	<u>Length of stay (mean)</u>
Pre-Wadsley careers of transfers	7 years 8 months
Total stay in both institutions for transfers:	8 years 0 months

It is evident that Wadsley opened with a large influx of chronic patients, constituting about one third of the total number of inmates. Of this group of chronic patients, 65 (73.0%) died in the asylum, whilst only 79 (45.4%) of the first admissions were to die there. This is clear evidence that the transfers were made for administrative, not therapeutic, reasons, since no change in their condition resulted from the change in institution, although their presence in the asylum could alter its apparent achievement. Beneath such appearances, however, nothing really changed. The death-rate for Wadsley's first admissions in 1873 was more or less typical. At Mapperley, although the great influx of chronic patients from elsewhere affected the mean length of stay, the typicality of the median length suggests the usual asylum performance; no worse for the presence of chronics, and no better for being a small asylum.

Medical superintendents were well aware of this problem which came with the admission of chronic patients. They raised the death-rate and gave the asylum a poorer reputation, which the superintendents resisted. The result was probably that chronic patients came to be regarded as very much the scum in the lowly social strata that constituted the "insane". As Bevan Lewis reported to the Committee of Visitors in 1894,

"The nature of the cases admitted during the past few months has been most disheartening. For the most part they are hopelessly demented chronic cases or the incurable class of the General Paralytics. With such admissions it would appear almost impossible to maintain the usual reputable Recovery rates for the current year". (1)

1. Quarterly Meeting of the West Riding Lunatic Asylum, 21st June 1894.
Wakefield PRO, C85 127.

Seven years earlier, he was making the same complaint, reporting that

"the worst forms of Delusional Insanity, usually Alcoholic in origin, and of Epileptic and Congenital Imbecility have prevailed to a most discouraging extent". (1)

This body of chronic, 'long-stay' patients remains one of the more distinctive features of the aggregate patient profile, not least in extending the mean length of stay, and their presence must have added to some extent to the profound pessimism evident throughout the period of this study.

(v) Age of Inmates

An examination of the median age of new admissions to each of the asylums studied reveals no particularly surprising feature. The ages, together with the total age-range was as follows.

	<u>TOTAL</u>	<u>FEMALE</u>	<u>MALE</u>	<u>TOTAL AGE-RANGE</u>
<u>Wakefield</u>				
1860	40.2	40.8	39.9	15 - 78
1870	37.7	36.5	38.7	6 - 75
1880	37.5	37.8	36.5	8 - 74
1890	39.3	39.9	38.2	10 - 77
<u>Wadsley</u>				
1880	39.9	40.0	39.8	6 - 77
1890	39.2	38.2	40.7	10 - 79
1880 - 89 (Private)	39.2	38.5	39.8	15 - 77
<u>Nottingham (Mapperley)</u>				
1881	37.1	35.3	39.0	7 - 75
1891	43.6	44.0	43.5	14 - 89

It perhaps needs pointing out that the number of children admitted was very small and that the effective lower end of the age-range was around 15 or 16. Two small anomalies need explaining. The unusual figures for Mapperley no doubt reflect the small sample from which these results were

1. ibid., 27th October, 1887. Wakefield PRO, C85 126.

drawn. The dip in median age in Wakefield perhaps reflects a shift in the median age of the total population as younger men and women were attracted to the town in the wake of the mining boom, with its subsequent employment opportunities. Without comparative figures for the entire catchment area population - which I have not attempted - this must remain mere speculation. There is no difference whatever between the median ages of private patients at Wadsley, as opposed to pauper patients. It seems unlikely that a criterion for admission can be found which depends upon the particular age of the potential inmate. It may be significant that the median age of female admissions is towards the end of the child-bearing period. We have already observed the higher rate of "recovery" amongst females and speculated that this may have been due to the incidence of birth-related conditions, which tend to be spontaneously remissive. If this were so we would expect a median age further into the child-bearing period, but it appears this does not occur. As ever, we have too little information to interpret from and the field is still wide open for further research along these lines.

One other set of figures may be useful here. I have taken the median age of the total inmate population at Wakefield (as distinct from admissions only) for the years 1861 and 1881, using the records of the Census Enumerator. They are:

	<u>TOTAL</u>	<u>FEMALE</u>	<u>MALE</u>	<u>TOTAL AGE-RANGE</u>
1861	41.3	41.7	40.7	11 - 81
1881	42.6	41.8	42.3	11 - 77

When we compare these with the figures for admissions in 1860 and 1880 respectively we find a slight increase of about 1 year over 1860 admissions but about 5 years for 1880 admissions. If it was the case that patients tended to remain for protracted periods in the asylum, particularly into old age (the familiar "long-stay" patients), so that total populations inevitably grew in size, then this would be revealed by a higher median age

of the whole population as distinct from fresh admissions. The 1860/1 figures do not show this to any significant degree, but the 1880/1 figures do show a significant increase in median age for the whole population. We can probably see here the build-up of older patients in the asylum; a phenomenon which seems to have gathered pace as the century wore on, providing one cause of the constant increase in asylum populations.

(vi) Children in the Asylum

Throughout this period there was a steady proportion of people labelled "idiot". Some of these were children under the age of fifteen. They, like the other patients labelled idiots, were to become one segment of the chronic population. They were the only children in the asylum and they deserve some special mention. The numbers admitted are as follows:

	<u>Wakefield</u>	<u>Wadsley</u>
1860	-	
1870	3	
1880	1	5
1890	5	6

The youngest of these was six years old. Fifteen of those above died in the asylum, after living within its walls for periods varying from two months (in the case of one 13-year-old) to seventeen and a half years (a 14-year-old admission). The remaining 5 children were discharged "not improved" after one month to eleven years. Almost certainly they were moved on to another asylum, and then perhaps to another, until they eventually died. It would be interesting to know how they came to be separated from their families, if they were orphans, and how they were treated in the asylum. This, however, seems to be a part of the lunatic asylum's untold story.

(vii) Conclusion

From what we have been able to glean from the available records, the lunatic asylum emerges as an eclectic institution, admitting a diverse range of problematic individuals. Two particular problem areas we have been able to define with some clarity - the sick and dying poor and the demented or permanently incapacitated. What appears to collect them together, more importantly than any behavioural aberration which they may have displayed, seems to be a common inability to find adequate care and supervision in any other place. What of the rest of the asylum population? What social functions was the lunatic asylum performing here, beneath its rhetoric of "mental disease"? Another area we have touched on - that of the syphilitic. This and one further area - epilepsy - will be considered later. But before leaving this particular body of individual statistics and moving on to less precise records, we need to recognise the inadequacy of all these figures if we are to see the asylum population as real human problems. Half of the inmates were there for up to a year. The rest for well over. What did the asylum return in exchange for such a loss of freedom? Was anyone ever really "cured"? Or was the greatest benefit to those who were spared the responsibility of coping with so many awkward, sick and unmanageable people? It may have been, bearing in mind the 'benign' impulse outlined in the previous chapter, that inmates did receive better care than they would have done outside, yet this can only be a serious indictment of contemporary society, for the asylum was the temporary prison of half its inmates and the graveyard of the rest.

b) THE ORIGIN OF INMATES

The asylum admission registers note three factors in the origin of their patients, the listed place of previous abode, the Poor Law union to which inmates were chargeable under the financial provisions of the govern-

ing Lunacy Acts, and the former occupation of the patient. Only the second and third of these were tabulated.

The importance attached to the information listed under the heading "Union Chargeable" in the admission registers comes as no surprise. The source of income in respect of each inmate was a major priority in asylum administration without which it would clearly have been unable to function. Each Poor Law union supplied the necessary finance on which the daily care and maintenance of patients was dependent. It does not, however, tell us anything about the patients themselves, their problems or their treatment.

The tabulated information on inmates' previous occupations has more potential. Unfortunately we run into difficulties if we attempt to extract conclusions from it without a thorough demographic study of the catchment areas from which each asylum drew its population. A break-down of occupation and geographical location would be a major enterprise in itself and it was felt that such a venture should be taken independently of the present study rather than attempted in a necessarily limited and unsatisfactory way within it.

This does not preclude the possibility of making some observations in this area drawn from the asylum records themselves. These are of necessity cursory, since the records themselves are brief in this respect. Clearly medical men of the time were little concerned with extrapolating ideas on insanity from information on former employments, but we can allow ourselves some speculations of our own.

∟ See Table XLX - Wakefield (1870);
Table XX - Wakefield (1890);
Table XXI - Nottingham (1890). ∟

TABLE XIX

Showing the Previous Occupation of Patients Admitted
to the West Riding Asylum During the Year 1870

MEN					
Accountant	1	Grocers	4	Potters	2
Barber	1	Groom	1	Puddlers	2
Barman	1	Horse Dealer	1	Quarryman	2
Blacksmiths	2	Innkeeper	1	Rag Dealers	2
Blade Forger	1	Jewish Minister	1	Saw Maker	1
Boiler Maker	1	Joiners	2	Schoolmaster	1
Bookseller	1	Labourers	27	Ship Carpenter	1
Brickmaker	1	Lawyer's Clerk	1	Shoemakers	11
Butchers	6	Maltsters	2	Show Man	1
Butler	1	Masons	5	Soldier	1
Cab Driver	1	Mechanics	3	Solicitors	3
Clerks	3	Mill Hands	12	Smith, Engine	1
Coachman	1	Millstone Builder	1	Stocking Weaver	1
Colliers	7	Nail Maker	1	Stuff Manufacturer	1
Confectioner	1	Omnibus Conductor	1	Tailors	11
Currier	1	Painters	2	Tea Dealer	1
Cutlers	5	Pianist	1	Tinners	2
Dyers	2	Pipe Maker	1	Warehouseman	6
Farmers	2	Plasterer	1	Wheelwrights	2
File Cutter	1	Plate Rubber	1	Weavers	9
Founder in Glass House	1	Plumber	1	No occupation	9
Gardeners	2	Pointsman on Railway	1	Unknown	1
Greengrocer	1	Printers	2		
		Porters	2		
				TOTAL	190

WOMEN					
Baker	1	Huckster	1	Seamstresses	3
Book-folder	1	Lodging-House Keepers	2	Servants	39
Charwomen	12	Milliner	1	Shopwomen	2
Factory Hands	26	Nurses	2	Staymakers	2
Dress Makers	7	Pearl Buttonmaker	1	Washerwomen	4
Farm Servant	1	Rag Dealer	1	Weavers	17
Governess	1	Rag Pickers	2	No occupation	11
Hawkers	2	Saw Rubber	1	Not known	8
Housekeepers	5	School Mistresses	2		
Housewives	102			TOTAL	257

SOURCE: Report of the Medical Superintendent, West Riding
Asylum, 1870. Wakefield Public Record Office,
C85 109

TABLE XX

Showing the Previous Occupation of Patients Admitted
to the West Riding Asylum During the Year 1890

MEN					
Baker	1	Fitters	2	Rag Grinder	1
Basket Maker	1	Flag Maker	1	Shoemakers	2
Blacksmiths	2	Forgeman	1	Shop Assistants	2
Blanket Piecer	1	Gas Stoker	1	Shuttle Maker	1
Blanket Raiser	1	Gentleman	1	Slater	1
Boot Rivetters	2	Glass Painter	1	Soldier	1
Book-keeper	1	Grocer	1	Spinners	2
Brass Finisher	1	Hand Loom Weaver	1	Stone Delver	1
Bricklayer	1	Hawkers	2	Stone Masons	4
Butcher	1	Iron Moulder	1	Tailors	8
Clerks	7	Joiners	2	Teamsters	3
Cloggers	2	Labourers	57	Timekeeper	1
Cloth Dressers	2	Mason	1	Tinner	1
Cloth Finishers	2	Mechanics	5	Tinplate Worker	1
Cloth Weaver	1	Millhands	5	Tramps	2
Clothes Dealer	1	Millwright	1	Woolcomber	1
Coach Painter	1	Miners	3	Woolsorters	4
Coal Miners	6	Model Maker	1	Working Jeweller	1
Cooper	1	Painters	2	No occupation	21
Drayman	1	Pedlar	1	Not known	4
Dyers	2	Plumbers	2		
Engine Firers	2	Policeman	1		
Farmer	1	Porter	1		
Farm Labourers	7	Power Loom Tuners	2		
Fettler	1	Power Loom Weavers	2		
				TOTAL	209
WOMEN					
Agricultural		Machinists	2	Spoon Cupper	1
Workwoman	1	Millhands	9	Tailoresses	3
Cap Finisher	1	Milliners	2	Teacher	1
Charwomen	5	Nurse	1	Twister	1
Cloth Burler	1	Power Loom Weavers	3	Umbrella Repairer	1
Currier	1	Prostitutes	2	Warper	1
Domestics	22	Rag Sorters	3	Weavers	9
Dressmakers	5	Schoolgirl	1	Woolcomber	1
Hawkers	2	Seamstress	1	No occupation	18
Housewives	61	Servants	7	Not known	2
Houseworkers	13	Setter	1		
Housekeepers	7	Shoefitter	1		
Lace Makers	2	Shopkeepers	2		
				TOTAL	194

SOURCE: Report of the Medical Superintendent, West Riding
Asylum, 1890. Wakefield Public Record Office,
C85 111

TABLE XXI

Showing the Previous Occupation of Patients Admitted
to Mapperley Hospital During the Year 1890

MEN					
Bobbin Maker	1	Instrument Maker	1	Schoolmaster	1
Bookbinder	1	Jewellers	1	Sculptor	1
Brush Makers	1	Labourers	24.	Shoemaker	1
Carpenters	3	Lace Makers	7	Smiths	2
Chair Makers	2	Leather Dressers	2	Soldiers	2
Clerks	6	Lithographer	1	Station Master	1
Coachman	1	Lodging-House		Stationer	1
Coal Agent	1	Keeper	1	Stoker	1
Colliers	4	Mattress Maker	1	Stonemasons	2
Commercial		Milk Seller	1	Surveyor	1
Traveller	1	Miller	1	Tailor	1
Designer	1	Musician	1	Ticket Collector	1
Engineers	2	Muslin Printer	1	Tin Worker	1
Fitter	1	Organ Grinder	1	Town Crier	1
Gardener	1	Plasterers	2	Warehouseman	1
Gas Fitter	1	Police Inspector	1	Warper	1
Grocers	2	Polisher	1	No occupation	10
Groom	1	Printers	2		
Hawkers	5	Railway Clerk	1		
Hosiery	2	Sailor	1		
				TOTAL	117

WOMEN					
Barmaid	1	Lady's Maid	1	Prostitute	1
Charwomen	2	Laundress	1	Rag Sorter	1
Cigar Maker	1	Lodging-House		Schoolmistress	1
Cooks	2	Keeper	1	Seamstresses	4
Dressmaker	1	Mantle Maker	1	Servants	19
Governesses	2	Midwife	1	Tailoress	1
Hawker	1	Milliner	1	Winder	1
Hosiery	4	Needlewomen	3	No occupation	25
Housework	35	Nurses	2		
Lace Makers	18	Paper Maker	1		
				TOTAL	133

SOURCE: Report of the Superintendent, Mapperley Asylum,
1891. Mapperley Hospital Library.

When we examine the tables of information we find a broad spectrum of the working class, from skilled craftsmen to labourers. In 1890 at Wakefield, there was even a "gentleman" and two "tramps". In 1870 we find a "pianist" and three school-teachers, and even doctors have turned up in the books as pauper patients. But overwhelmingly, the inmates were drawn from apparently all walks of working life. By far the largest classes were those of "labourer" and "domestic servant". In the latter case the meaning is clear enough, but precisely what kinds of work the former implied needs some slight elaboration. Obviously, there were many unskilled workers among this group, which must have included seasonal and casual workers, but the records appear only to be interested in occupations that could clearly be linked with a trade. Consequently, the undistinguished "labourer" group probably represents merely those who could not be so defined, the labour reserve of the local economy. This is borne out by the occupational spectrum of those admitted as private patients at Wadsley in the 1880s, whose families had sufficient income to pay their medical fees, at least, for a while. Among the 256 admitted only two were identified as "labourers". However, 58 were listed as having "no occupation", though probably not all were so much self-supporting as kept by family or friends.

Among the women the corresponding anomalous group is that of "housewife", somewhere between a third and half of the total female intake. This, of course, refers to women who performed industrial labour in their own homes, rather than to the modern use of the term, (though in a sense there is not such a great difference). The other large group is that of "servant", or "domestic". If this table represents the occupational spread amongst the population in general, then around one sixth of the female population were in domestic service. From such a general spread of occupations it seems unlikely that any useful conclusions could be drawn from a medical geography, however, without at least a more thorough survey

of the local economy, population and other factors.

c) "HAVING SLEPT IN HULL ON A DAMP BED"* - TYPES AND CAUSES OF INSANITY

It was observed at the conclusion to the first part of this chapter, that there were two types of 'problem' which were probably being referred to the lunatic asylum - the sick and dying poor, and the demented or permanently incapacitated. What other problems in human living were similarly referred we cannot tell from the figures presented there. For this last piece of empirical exploration we must turn to the columns in the registers headed "type of insanity" and "supposed cause of insanity", as well as those marked "epileptic" or "idiotic". The quality of this evidence, however, is such that no intelligent attempt can be made at quantification. Even qualitative assessment must be performed with extreme reserve, as the entries are vague to the point of mere description. Nevertheless, some conclusions can be drawn which shed a little more light on the functions which the asylum subserved.

Before we do this it is necessary to abandon any attempt at analysis using medical terminology at its face value. If we had been led to believe that 'psychiatric' nosology had developed to any extent that could account for a wide range of varied conditions (a belief fostered by a whole mass of medical text-books, but which should not have survived our analysis of them in Chapter 2) then the "medical" notations actually used would quickly put us right. Essentially, only three classifications of "insanity" were generally in use; "mania", "melancholia" and "dementia". Occasionally variants of these do occur. A breakdown of admissions at Wakefield in the first quarter of 1870 should give a flavour of current

* An entry in the Wadsley asylum admission register under "supposed cause of insanity". It is not clear which of these two misfortunes was the more responsible.

asylum medical terminology:

Mania	27
Dementia	26
Melancholia	23
Dementia with Excitement	15
Senile Dementia	10
Idiot	4
Monomania of Suspicion	3
Moral Insanity	2
<hr/> TOTAL	<hr/> 130

Later entries are slightly more expansive, but still do not tell us much.

"Acute melancholia; agitated and the subject of delusions;
Chronic melancholia; delusions and ill-formed auditory
hallucinations;
Acutely maniacal; shouting, destructive and incoherent".

These entries, from the register for 1890 at Wadsley, can be compared with the table of "types" published by Mapperley Asylum in the same year in their Annual Report.

[See Table XXII]

It can quickly be seen that the only effective categories were still "Mania", "Melancholia" and "Dementia", with the additional (and in practice not always exclusive) category of "Epilepsy". All the various sub-categories appear to be a mere theoretical elaboration.

The "recoveries" and "deaths" figures in this table must be taken for what they are worth. Without a measure of overall length-of-stay, or indication of whether those appearing in the "recoveries" and "deaths" columns correspond in any way to those under "admissions", the findings are not helpful. In working through the admission registers, it was impossible to detect any correlation between "type of insanity" and likelihood of outcome, or between "type" and length of stay. It appeared that whether a patient, on admission, was to be in the asylum for a few months or many

TABLE XXII

Showing the Form of Mental Disorder on Admission, in the Admissions, Recoveries, and Deaths of the Year 1890, and the Form of Mental Disorder of the Inmates on December 31st, 1890. (Mapperley Asylum).

Form of Mental Disorder	Admissions		Recoveries		Deaths		Remaining in the Asylum Dec. 31st 1890	
	M.	F.	M.	F.	M.	F.	M.	F.
Congenital or Infantile Mental Deficiency								
A with Epilepsy	2	0	2	0	0	0	7	5
B without Epilepsy	5	1	6	0	0	0	18	5
Epilepsy acquired	7	11	18	1	3	1	32	28
General Paralysis of the Insane	20	4	24	0	0	2	17	6
Mania - Acute	5	12	17	8	11	0	3	9
" Chronic	31	40	71	7	12	2	85	106
" Recurrent	0	0	0	0	0	0	0	4
" A Potu	2	2	4	2	4	0	1	0
" Puerperal	0	1	1	0	3	0	0	1
" Senile	1	2	3	0	0	0	0	1
Melancholia - Acute	6	8	14	2	12	0	5	5
" Chronic	10	18	28	7	10	2	16	7
" Recurrent	0	1	1	0	0	0	0	1
" Senile	0	2	2	0	0	0	0	1
Dementia - Primary	0	1	1	0	1	0	0	0
" Secondary	24	25	49	0	0	1	71	79
" Senile	2	3	5	0	0	2	1	5
Organic (i.e. from Tumours, Coarse Brain Diseases, etc.)	1	2	3	0	0	2	1	4
TOTAL	116	133	249	21	35	26	257	287
								544

SOURCE: Report of the Superintendent, Mapperley Asylum, 1891. Mapperley Hospital Library.

years, and whether he or she might die there, could in no way be predicted from the entries in this column.

Yet if "medical" terminology is unusable at face value it is all we have to go on. Fortunately, as has been indicated, what passed for "medical" terminology was commonly a thinly-veiled common-sense description of behaviour, so it can be used if we are careful to read between the lines. If any insight into the nature of patients' real problems and the causes which led them into the asylum is to be gained, therefore, we are forced to examine selected individual records. This introduces three specific biases into the material which cannot be avoided. Firstly, all these examples are drawn from the later, more expansive, entries. Secondly, they are even then very selective, partly because not all cases have any more than a very brief description and partly through the simple need to seek 'typical' examples as far as the author can judge them to be. Thirdly there is a bias of a different kind; the entries are those of medical men seeking to put down what they saw as a clinical account of a type of disease. We are not constrained to use their interpretation, but it does preclude much information that we would have liked to see set down. Indeed, it is more than likely that the doctors themselves were unconsciously selective in their accounts, since not all patients were equally communicative, or their symptoms equally interesting.

With these strong reservations in mind we can proceed to consider some examples which occur in the admission registers, in order to illuminate some of the uses to which the asylum may have been put.

(1) Types of Insanity

The most striking aspect of these records is the extent of stereotyped phrases. These stock descriptions no doubt reflected a certain pre-existing pattern of perception in the minds of the doctors, but their effect

is to obscure more than they reveal. Four actual entries seem to typify those generally found:

- 1) "Melancholia. She is very unhappy, restless, talks incoherently, does not seem to understand her position and has great loss of memory".
(A 53-year-old woman)
- 2) "Melancholia. She is very miserable, unhappy, very restless, and unable to carry on a rational conversation".
(A 26-year-old "housewife")
- 3) "Mania. She is vacant, incoherent, utterly unable to understand the simplest questions and is restless, and at times inclined to be excited".
(A 71-year-old "housewife")
- 4) "Mania. He is irrational in his conversation, restless at times and is quite unable to comprehend his present position and surroundings".
(A 27-year-old millhand)

All except for the first case eventually recovered. (Cases of "dementia", did not usually receive such full description. Probably it was not considered worthwhile). They tell us little about the patients as people, or even as examples of mental disorder (and here a modern psychiatrist must beware of reading back his own experience onto these examples) but they can lead us to deduce what were the key factors in deciding upon the existence of "mental disease", and so of the need for asylum treatment, simply because they were so typical. Those key factors appear to have been:

- a) coherence of speech (or rather, lack of it);
- b) ability to comprehend surroundings;
- c) restlessness.

What these add up to is an inability to be receptive to other people. If speech is incoherent then understanding of the patient by others is lost. Ordinary communication breaks down. This is emphasised by a failure to respond to those 'clues' that inform our behaviour - knowing where we are, who we are, what we are. The patient cannot be 'reached' by these non-linguistic signals. Finally, the behaviour of the patient is not in accordance with what these signals, linguistic and non-linguistic, indicate, and so appears unmanageable.

Whether this condition existed before admission we cannot tell. Once inside the asylum these three characteristics can be seen in a more specific light, however, as part of a relationship with the doctors. In the end, these "medical" entries appear to be determined by the patients' responsiveness to the staff. A person who is difficult to manage, especially if conversation is difficult or impossible, is readily accepted as "insane". Such rule-of-thumb procedure is far removed from the elaborate diagnoses of the text-book theorists, but one suspects it is rather closer to actual 'psychiatric' practice, then and today. In short, so-called "medical" descriptions were the practical responses of the doctors to difficult people, irrespective of the true nature of their problems. Indeed, there seems no attempt to comprehend people's problems at their, or at any, level. Neither do any of the writers of the day suggest any such approach is of any value. There is, in consequence, a certain irony in the description, "unable to comprehend his present position and surroundings", but we must not push our criticism too far. Mental physicians were men of "science". Their intention was to cure, not to comprehend.

Despite this, people's own problems were real enough, and it is clear that asylums were being used for various reasons, whatever the mental physicians made of it. There is no doubt that many of those admitted were deeply disturbed, however one interprets the nature of the problem. Comments against some of the entries leave no question of that. A 44-year old labourer from Sheffield was admitted in 1890 suffering from

"mania. He is sullen suspicious, has hallucinations of hearing, saying that he is constantly hearing humming sounds which threaten to do all sorts of things to him, and drown or throw him out of the window. He admits having been excited and violent, says it was due to these humming sounds".

He died in the asylum after nearly four years. A 34-year-old silver-plate polisher, also from Sheffield, was likewise admitted with

"mania. He says that men who call themselves champions of the world have abused him and plotted against him;

he hears their voices abusing him at night and they throw foul smelling material about which tastes and smells like rotten eggs".

He also died in the asylum, after more than twenty-seven years.

The term "mania" was apparently often connected with delusions. The nature of these delusions is more a study for a present-day psychiatrist than for a social historian, but it is unlikely to reveal much of value in itself. One study of delusions in the nineteenth century⁽¹⁾ concludes that nothing can be gained from them as far as the historian is concerned since

"delusions, specifically, are incompatible with reality".

We must content ourselves with accepting them as facts of life.

A 27-year-old Doncaster schoolteacher was admitted with

"mania with delusions, saying that she has been chloroformed for experiment to see how long she could live dead, that the bread was poisoned with Lime. She is very irrational, memory defective".

Happily she was discharged after three months as "relieved". A similar concern with chloroform was shown by a 79-year-old woman, also from Doncaster. She was described as having,

"mania. She has delusions of suspicion chiefly to the effect that her daughter along with two men used to come to her house at nights and chloroform her and then rob her. She further fancies that she has been acted on by unseen Agencies and has had ulcers formed on her throat which she spits out".

After three months she died in the asylum.

In view of her age and her death so soon after entering the asylum it seems more than probable that this woman was in a dying condition and experiencing accompanying hallucinations. If this was the case it is interesting that the entry should contain such a detailed account of her delusions and no mention of any physical ailment. Possibly she was routed to the asylum because of these delusions and treated for these

1. BURNHAM, John C.: Psychotic Delusions as a Key to Historical Cultures. Tasmania, 1830-1940. J.Soc.Hist., XIII, pp.368-383.

specifically, this being, after all, the mental physicians' speciality.

But hallucination must have been only a facilitating factor, for the asylum was here clearly the final resort of an old and dying woman.

There were other patients who were quite obviously in a terminal condition.

"Melancholia, being depressed, dazed and unable to answer any questions about himself. He is very restless and requires to be assisted to his food. Feeble bodily health, he is but sparcely nourished".

Thus a 60-year-old chimney-sweep, admitted in July 1883 and dying six months later. Similarly, a 35-year-old bricklayer, seems to have found his way into the asylum as a last resort. He was admitted in October 1883 with

"mania. He has been very restless, is now incoherent, much confused and quite unable to give any information respecting himself. In very feeble bodily health with heart disease and is in rather poor bodily condition".

He died after only 23 days.

Another problem which the asylum commonly encountered was that of the suicidal patient. A significant number of inmates seem to be sent to the asylum after attempts at killing themselves. Of course, whether their real difficulties were in any way appreciated by their being handled as "insane" is debatable, but there was a clear problem here. Firstly, suicide and attempted suicide were criminal offences. Anyone who survived such an attempt would have to face prosecution and imprisonment unless, of course, they could be found "insane" and therefore not criminally responsible in law. Interestingly, such cases remain in the asylum for a comparatively short time (well below the median) which may suggest that it may have been used as a shield against criminal prosecution. In the second place, of course, there was clearly felt to be an obligation on everyone's part to protect the life of those who seemed determined to do away with themselves, and asylum routines took very careful precautions in these cases. Again, one doubts the relevance of the "medical" response, but there clearly was a problem.

A 38-year-old labourer was admitted in September 1892 with

"Melancholia, he is in a dull, depressed condition, admits having attempted to drown himself and says he is not worth living and might drown himself if he got the chance".

He was discharged "recovered" after five months. Another attempted suicide was that of a 54-year-old "housewife" admitted in the same year.

She was entered in the register as suffering from

"melancholia. She is very depressed, fully admits having attempted to hang herself, is with difficulty induced to enter into conversation and as yet taken little interest in her surroundings".

She was discharged after four months. Other similar cases are held in the asylum for between three weeks and five months. Curiously, all are entered as "insane" and presumably regarded as such, and no attempt seems to have been made to enquire into the causes of the suicide attempts.

Surely some such cause would have been entered in at least one or two cases.

Perhaps no "satisfactory" reason was unearthed, but doctors were evidently "medicalising" rather more obvious problems, and in the process leaving out of account any understanding from the patient's point of view, even when there is disagreement and grounds for a non-medical explanation. The entry for a 36-year-old "laundress" is a case in point. She was admitted in 1893 with

"melancholia. She admits having recently attempted to strangle herself saying that she has been without food for some time and greatly exhausted from a long tramp. She answers questions fairly well and denies most of the facts mentioned in the certificate".

She was nevertheless held for twelve weeks before being discharged "recovered".

Not just attempted suicide but severe distress also could lead people to the asylum. Some, perhaps, were suffering from malnutrition. The registers list "bodily condition", which is generally given either as "fair" or as "feeble". Amongst the "feeble" ones are these;

"Melancholia, being very low spirited and very restless and can scarcely be induced to reply".
(A 53-year-old "housewife")

"Mania, having been very restless and noisy from admission until yesterday and now being unable to answer the most simple questions on recent events correctly. Feeble health and sparcely nourished".
(A 41-year-old "housewife")

Both were discharged "recovered" after two months. One hesitates to describe asylum food as "wholesome" yet it was better than a workhouse diet and conditions were more favourable than under the care of the Guardians, and it is not impossible that this provision of food and rest was all that some patients really needed. Time after time, one finds "feeble health" and "sparcely nourished" in the records, often with a suggestion of a hallucinatory or other such disorder. Might not the provision of basic (and regular) nutrition have been a major function of the asylum? It was, after all, crucially important in the improvement of Poor Law medicine outside the asylum.⁽¹⁾

There is also a possibility that awkward relatives may have been 'dumped' on the asylum, and their actions sanctioned by the staff through the easy rhetoric of "medical" terminology. Of course, the registers only record these "medical" observations; that was their purpose. But what can one make of these two entries?

"Is at present quite rational in conversation, though maintaining that he has been sent here through his wife who had been drinking and getting excited. He further says that his wife was the cause (in the same way) of having him sent to Lincoln Asylum and keeping him there. He denies all the facts in the certificate".
(Discharged "recovered" after two months)

"Mania. He is confused, unable to give a clear statement about himself, has loss of memory and has no recollection of having recently threatened his wife. He is somewhat restless and requires supervision".
(Discharged "recovered" after two months)

It would be tempting, though no doubt simplistic, to consider these as examples of "abuse", where relatives were avoiding problems or responsibili-

1. See Chapter 3, pp.128-130.

ties by 'locking away' an awkward person. But though we may reject a facile medicalisation, and with it the response of the doctors, it would not be right to talk glibly of controlling deviants by a convenient labelling process. There were problems. The second case actually mentions the incident which probably set the whole social process in motion - the attack on the wife. To these problems the asylum offered some kind of solution, though hardly an adequate one, while the alternative may have been an intolerable living situation for all involved or even criminal proceedings. In the end, however, it is doubtful if either we or the mental physicians have been brought any closer to an appreciation of the problems of patients as they, rather than the doctors, might have expressed them. All the possibilities outlined here are at least conceivable and do not conflict with, even if they cannot be supported by the "medical" evidence. But more importantly, we are forced to recognise that no attempt at empirical research can unearth from an unrecorded past the lives and sufferings of those who fell under the "scientific" gaze of the mental physicians. For that we must be more circumspect.

(ii) The Supposed Cause of Insanity

In our earlier chapter on medical theory we examined the meaning of that part of medical theorising which dealt with the supposed causation of "insanity".⁽¹⁾ There, we considered the intensely value-laden nature of these "causes" and their function as part of the doctors' overall ideology and strategy. Here, we will examine their use in the admission registers and enquire into what may have been behind them.

This question of causation was a perennial one in the medical literature. The Commissioners in Lunacy were anxious to publish the most recent "findings" and the Royal Commissions which enquired into the apparent

1. See Chapter 2, pp.37-42.

increase in lunacy gave much emphasis to such causative factors as "civilisation" and "wear and tear on the nerve-tissue".⁽¹⁾ All asylums issued regular tables of "causes" to which much attention was paid. It seemed as if some discovery might be made if one studied the tables long enough.

∟ See Table XXIII - Wadsley;
Table XXIV - Wakefield (West Riding);
Table XXV - Nottingham (Mapperley). ∟

All one actually discovers is that mental physicians were medicalising some very strange material. Moreover, we find again that tendency for official figures to fall short of actual credibility. According to these tables, those causes which were "unknown" form a reasonably modest section of the total figure. Unfortunately, the registers tell a different story. The actual figures which are recorded at two of the asylums for the relevant years of this study are:

		<u>TOTAL INTAKE</u>	<u>TOTAL "UNKNOWN"</u>
Wadsley	1880	468	345
	1890	407	341
West Riding	1860	325	184
	1870	447	310
	1880	452	303
	1890	400	285

If we look more closely at the tabulated causes we can see how the sleight of hand has been performed. There is a massive total under "hereditary influence" and a very large one under "previous attacks". (The Mapperley total is less enthusiastic about "hereditary" influence, but is at least confident that all causes are known!) But of course, these are both non-causes. To say a thing is caused by a "previous" similar event explains nothing, while to describe it as caused by "heredity" is simply to pass the non-explanation back to a previous generation.

1. e.g. Report of the Select Committee on Lunacy Law, 1878; Special Report on the Alleged Increase in Lunacy, 1897.

TABLE XXIII

Showing the Probable Causes of Insanity in the Patients Admitted into Wadswley Asylum during the period 1881 to 1888 inclusive

CAUSES OF INSANITY	Admissions - Males 1781, Females 2182, Total 3963						% on Total Admissions	% on Admissions, 1889						
	Predisposing		Exciting		Predisposing & Exciting									
	M.	F.	M.	F.	M.	F.			Tot.					
Moral														
Domestic trouble (including loss of relatives and friends)	3	2	5	182	329	511	18	8	26	203	339	542	13.6	8.5
Adverse circumstances (including business anxieties & pecuniary difficulties)	11	14	25	328	206	534	22	6	28	361	226	587	14.8	18.2
Mental anxiety and worry (not included under the above two heads) and over-work	1	-	1	228	119	347	17	5	22	246	124	370	9.3	1.9
Religious excitement	-	3	3	60	76	136	4	3	7	64	82	146	3.6	2.9
Love affairs (including seduction)	-	5	5	14	78	92	-	-	-	14	83	97	2.4	3.6
Fright and nervous shock	1	-	1	54	47	101	-	3	3	55	50	105	2.6	1.4
Physical														
Intemperance in drink	135	32	167	388	123	511	52	7	59	575	162	737	18.5	18.2
Intemperance, sexual	1	1	2	26	46	72	3	1	4	30	48	78	1.9	3.6
Venereal disease	7	1	8	9	7	16	3	1	4	19	9	28	0.7	1.4
Self-abuse, sexual	-	-	-	19	3	22	-	-	-	19	3	22	0.5	0.2
Over-exertion	-	3	3	13	7	20	-	1	1	13	11	24	0.6	2.4
Sunstroke	14	1	15	5	4	9	3	1	4	22	6	28	0.7	0.2
Accident or injury	56	6	62	87	15	102	16	2	18	159	23	182	4.5	6.3
Pregnancy	-	5	5	-	21	21	-	-	-	-	26	26	0.6	0.7
Parturition & the Puerperal state	-	38	38	-	86	86	-	3	3	-	127	127	3.2	4.8
Lactation	-	33	33	-	98	98	-	3	3	-	134	134	3.3	1.2
Uterine & Ovarian disorders	-	2	2	-	105	105	-	1	1	-	108	108	2.7	0.4

Cont. over

Continuation, Table XXXVIII

Puberty	60	17	77	5	30	35	3	1	4	68	48	116	2.9	1.2
Change of life	-	67	67	-	51	51	-	-	-	-	118	118	2.9	1.9
Fevers	-	-	-	5	3	8	-	-	1	6	3	9	0.2	0.0
Privation and Starvation	18	35	53	173	168	341	24	13	24	202	216	418	10.5	5.3
Old age	58	83	141	9	43	52	52	47	52	72	173	245	6.1	8.2
Other Bodily diseases or disorders	84	36	120	191	118	309	33	26	59	308	180	488	12.3	19.2
Previous attacks	377	591	968	-	-	-	-	-	-	377	591	968	24.4	24.5
Hereditary influence ascertained	959	1151	2110	-	-	-	3	3	6	962	1154	2116	53.3	35.7
(direct & collateral)	25	18	43	-	1	1	78	49	127	103	68	171	4.3	5.8
Congenital defect, ascertained	2	-	2	6	-	6	1	-	1	9	-	9	0.2	0.7
Other ascertained causes	77	101	178	69	117	186	-	-	-	205	252	457	11.5	2.6
Unknown														

SOURCE: Report of the Wadsley Asylum Sub-committee on Lunacy Increase, 1889.
Wakefield Public Record Office, C85 50.

TABLE XXIV

Showing the Probable Causes of Insanity in the Patients Admitted into Wakefield Asylum during the period 1881 to 1888 inclusive

CAUSES OF INSANITY	Admissions - Males 1907, Females 1636, Total 3543										% on Total Admissions	% on Admissions 1889		
	Predisposing		Exciting		Predisposing & Exciting		Total		M.	F.			Tot.	
	M.	F.	M.	F.	M.	F.	M.	F.						
Moral														
Domestic trouble (including loss of relatives and friends)	3	2	5	56	165	221	4	1	5	63	168	231	6.5	2.8
Adverse circumstances (including business anxieties & pecuniary difficulties)	9	-	9	158	66	224	7	-	7	174	66	240	6.7	1.6
Mental anxiety & worry (not included under the above two heads) and overwork	5	-	5	38	125	163	2	2	4	45	127	172	4.8	0.4
Religious excitement	-	-	-	26	20	46	-	-	-	26	20	46	1.2	0.9
Love affairs (including seduction)	-	1	1	4	33	37	-	1	1	4	35	39	1.1	-
Fright and nervous shock	1	1	2	11	27	38	-	-	-	12	28	40	1.1	0.4
Physical														
Intemperance in drink	197	24	221	334	109	443	52	4	56	583	137	720	20.3	19.0
Intemperance, sexual	10	-	10	9	-	9	7	-	7	26	-	26	0.7	1.6
Venereal disease	14	2	16	3	-	3	9	-	9	26	2	28	0.7	1.4
Self-abuse, sexual	3	-	3	75	-	75	11	-	11	89	-	89	2.5	5.4
Over-exertion	-	-	-	4	2	6	1	-	1	5	2	7	0.2	-
Sunstroke	9	-	9	7	1	8	5	-	5	21	1	22	0.6	0.2
Accident or injury	21	3	24	38	3	41	27	6	33	86	12	98	2.7	0.8
Pregnancy	-	-	-	-	7	7	-	1	1	-	8	8	0.2	-
Parturition & the Puerperal state	-	10	10	-	110	110	-	2	2	-	122	122	3.3	3.7
Lactation	-	5	5	-	40	40	-	2	2	-	47	47	1.2	0.4

cont. over

1

Continuation, Table XXIV

Uterine and Ovarian disorders	2	2	26	26	3	3	3	31	31	0.8	-
Puberty	1	4	2	2	1	1	1	1	1	0.1	-
Change of life	11	11	79	79	11	11	100	100	2.5	1.1	-
Fevers	-	-	2	3	2	2	2	2	0.1	-	-
Privation and starvation	3	4	27	33	1	1	30	30	1.1	2.1	-
Old age	16	87	10	55	69	111	95	95	7.1	7.5	-
Other bodily diseases or disorders	26	57	101	186	62	97	189	189	9.5	6.3	-
Previous attacks	432	826	-	-	-	-	394	432	23.3	20.1	-
Hereditary influence ascertained (direct & collateral)	667	1309	-	-	2	4	644	669	37.0	41.0	-
Congenital defect, ascertained	35	79	-	1	43	79	88	71	4.4	-	-
Other ascertained causes	28	83	17	39	14	43	96	79	4.9	7.7	-
Unknown	50	123	-	-	-	-	125	103	6.4	-	-

SOURCE: Report of the West Riding Asylum Sub-committee on Lunacy Increase, 1889.
Wakefield Public Record Office, C85 50

TABLE XXV

Showing the Probable Causes of Insanity in the Patients
Admitted to Mapperley Asylum During the Year 1890

CAUSES OF INSANITY	Number of Instances in which each Cause was ascertained											
	Admissions: M. 116, F. 133, T. 249.											
	As pre- dispos- ing Cause			As Exciting Cause			As Pre- dispos- ing or Exciting (where these could not be distin- guished)			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
MORAL:												
Domestic Trouble (including loss of relatives & friends)	0	0	0	2	3	5	0	3	3	2	6	8
Adverse circumstances (including business anxieties & pecuniary difficulties)	2	0	2	1	0	1	3	3	6	6	3	9
Mental Anxiety & Worry (not in- cluded in the above two heads) & overwork	0	1	1	1	1	2	0	3	3	1	5	6
Religious Excitement	0	0	0	1	0	1	1	0	1	2	0	2
Love Affairs (incl. Seduction)	0	0	0	1	0	1	0	0	0	1	0	1
Fright & Shock (Nervous) ..	0	0	0	0	0	0	0	0	0	0	0	0
PHYSICAL:												
Intemperance in Drink	3	0	3	8	3	11	4	4	8	15	7	22
" Sexual	0	0	0	0	0	0	0	0	0	0	0	0
Venereal Disease	0	0	0	0	0	0	0	0	0	0	0	0
Self Abuse (Sexual)	0	0	0	0	0	0	0	0	0	0	0	0
Over-exertion	0	0	0	0	0	0	0	0	0	0	0	0
Sunstroke	1	0	1	0	0	0	2	0	2	3	0	3
Accident and Injury	4	1	5	2	0	2	1	0	1	7	1	8
Pregnancy	0	0	0	0	1	1	0	0	0	0	1	1
Parturition & Puerperal State	0	0	0	0	6	6	0	0	0	0	6	6
Lactation	0	1	1	0	0	0	0	0	0	0	1	1
Uterine & Ovarian Disorders ..	0	0	0	0	0	0	0	0	0	0	0	0
Puberty	0	0	0	1	0	1	0	1	1	1	1	2
Change of Life	0	0	0	0	0	0	0	0	0	0	0	0
Fevers	0	0	0	0	0	0	0	0	0	0	0	0
Privation & Starvation	0	2	2	0	0	0	0	1	1	0	3	3
Old Age	0	4	4	0	0	0	0	1	1	0	5	5
Previous Attacks	21	34	55	0	0	0	0	0	0	21	34	55
Hereditary Influences ascertained	9	8	17	0	0	0	0	0	0	9	8	17
Congenital Defect	6	1	7	0	0	0	0	0	0	6	1	7
Other Bodily Diseases & Disorders	7	3	10	5	3	8	1	2	3	13	8	21
Unknown	0	0	0	0	0	0	0	0	0	46	52	98

SOURCE: Report of the Superintendent, Mapperley Asylum, 1891.
Mapperley Hospital Library.

Next to these transposed "unknown" causes comes a high incidence in "intemperance", while under "moral causes" such things as "domestic trouble", "adverse circumstances" and "mental anxiety and overwork" also rank highly. Of course, the division into "moral" and "physical" is dubious, serving more to focus ideas than to express anything specific. It is fairly clear, for example, that the inclusion of "drink" is not an entirely non-moral judgement, however rationalised.⁽¹⁾ Neither are "self-abuse" or "over-exertion", or, indeed, many of the others. All rely on certain social constants which the doctors, if not always their patients, took for granted.⁽²⁾

This may help to explain why such extraordinary material as that which appears under "cause of insanity" continued to be treated with such respect. Surely we cannot imagine that any serious account of medical etiology is being attempted in entries such as, "worry and anxiety produced by floods of water", "got wet in July", and "having slept in Hull on a damp bed". These are not, admittedly, typical, but do represent the degree of remoteness from the real life of the new admissions which the medical staff adopted. What mundane conception lies behind the more frequent, and laconic, entries like, "grief", "disappointment as a young woman", and "husband out of work"? Perhaps this is to place too much importance upon the value of these particular records, which were, after all, merely required by the existing bureaucratic arrangements. Yet these trivialising comments do appear in major considerations of the nature of "insanity" and, as far as is ascertainable, no other version of the patients' private lives was taken into account. That in itself indicates how "supposed cause of

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1. According to Daniel Hack Tuke, this classification of drink as a "moral" cause is apparently applicable to the upper classes, who wryly refer to a bout of drunkenness as the result of "overstudy". Perhaps we should read "overwork" in this light! See TUKE, D.H: Insanity in Ancient and Modern Life, with chapters on its prevention. 1878, pp.103-4.
 2. See Chapter 2.

insanity" is to be understood, for they depend upon the nature of the patient's behaviour, as seen by a "neutral" observer (for so the mental physicians liked to imagine themselves), and are in reality a description of a set of symptoms rather than any cause. The supposition is that these matters can be treated as phenomena in a "neutral" science in which the human element presented by the new patients, can be entirely divorced from the "scientific" process. Thus "grief" describes, rather than explains, the behaviour of a "melancholic", who is characteristically withdrawn and apparently in a state of deep depression. Its use, which is a rationalisation of a remote observer's perception that already considers the object as "insane", thus pre-empt's any further enquiry into the subject's actual state of mind. Other entries, such as "shock" and "blow on the head 7 months ago", seem equally to be rationalisations made by doctors from their own perceptions, drawing upon the common notion of a "balance of mind" that has been disturbed, rather than any kind of communication from the patient.

This rationalisation of pre-existing value concerns in the minds of the "observers" is demonstrated by the overall consistency of these causation tables. Only certain "causes" appear, and some of them very commonly. We see emotional stress following a domestic tragedy strongly represented. "Religion" and its alleged aberrations feature prominently. "Reverse of fortune" and other matters of financial circumstances are also a common "cause". These three concerns: family, religion, business; all dominate the "moral" causation. We are clearly looking at rationalisations that cohere around the three central pillars of value in late-Victorian middle-class life. Since the patients were drawn almost exclusively from the working-classes the distortions involved could not but have been detrimental to a realistic appraisal of the actual situations involved. This does not, of course, mean that this process renders the entries as non-medical diagnoses. On the contrary, as Fabriga argued,

"Frameworks used to define disease relate to social phenomena". (1)

A whole chapter has been devoted to the process by which social judgements were construed into a medical "science" and need not labour the point here.⁽²⁾ What is being shown here is that even when considered as medical diagnoses these entries really only tell us about the doctors, not about the patients. "

(iii) Causes of Certification?

It is true, of course, that these "supposed causes" were conceived only when the person to whom they referred had already been isolated as a probable "lunatic". They were an effect, not a cause, of that original isolation.

But before we dismiss them from our study of the "medical" records, can we detect from those records any indication of how individuals were first isolated in terms of social value-judgements? It has already been suggested that simple unmanageability may have been a crucial factor in this, but can we be sure that the standard used by the certifying doctors to define what degree of "unmanageability" constituted "insanity" did not vary from one doctor to the next or according to circumstance? Of course, we cannot be sure. But there were two fairly specific diseases which perhaps can provide some sort of answer to this question of the consistency of doctors' diagnoses.

Throughout the period, both epileptics and general paralytics - a variant of syphilis - were admitted into asylums as a matter of routine. Both these diseases are now held to have a purely somatic origin and so would not be expected to vary in their incidence according to changing social evaluations, with the crucial exception of that evaluation as to what degree

1. FABRIGA, H: Concepts of Disease. Persp. in Biol. Med., 15, 1972.
 2. See Chapter 2.

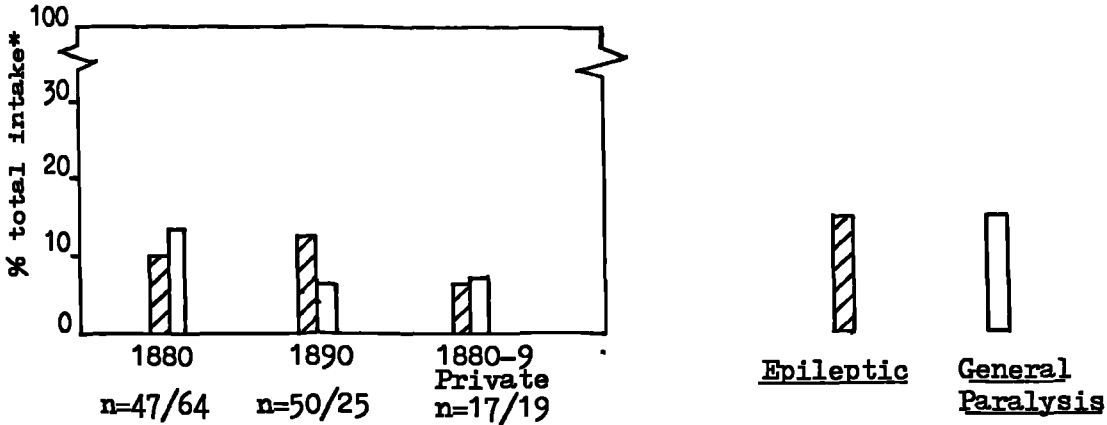
of incapacitation constituted (in this case) "insanity". Assuming a constant occurrence of these diseases, therefore, the admissions under "epilepsy" and "general paralysis" should reflect the consistency of the doctors' evaluation of "unmanageability".

The rates of admission are shown in the following tables.

<u>Table XXVI</u>	-	<u>Wadsley;</u>
<u>Table XXVII</u>	-	<u>Wakefield (West Riding);</u>
<u>Table XXVIII</u>	-	<u>Nottingham (Mapperley).</u>

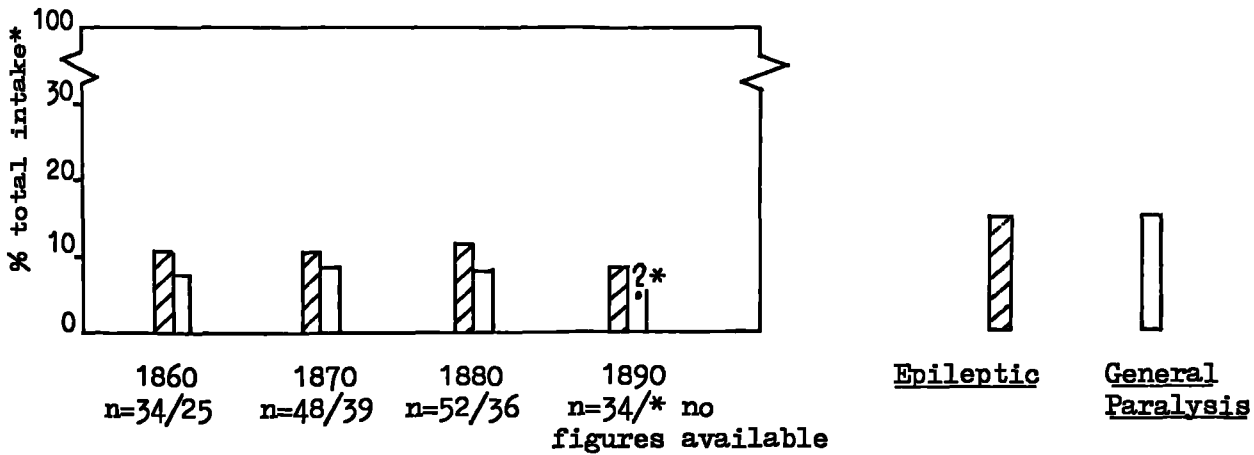
It can be seen that the proportion of epileptics admitted remains at a very constant rate of around 10% - 11%, while that of general paralysis, apart from an unusually high proportion admitted to Wadsley in 1880, and an exaggerated distribution at Nottingham (for which the lower base-rate may be responsible), seems to maintain a steady 7% - 8%. This consistency is reflected within each year as well as between years and shows a very even pattern of admissions. Of course, the consistency of diagnosis shown here relates only to these specific diseases, which were more clearly delineable and so could be better recognised. Whether any consistency existed in other areas of disease is uncertain. Nevertheless, the principles of observation and judgement according to social criteria - the process of construction of the very concept of "disease", according to Fabriga - which first outlined both general paralysis and epilepsy, independently of any somatic base subsequently established, apply just as well to other forms of unmanageability. We may not be able to give assent to the notion that such diagnostic activity as that of the certifying doctors was delineating "real" disease, in the sense of some significant physical discontinuity with a state of "health" (a modern version, just as contingent upon social judgement as those definitions of a century ago), yet it may well have been that the behavioural area which they labelled "insanity" may nevertheless have had a fair consistency about it. In this socially contingent sense, doctors may well have been handling a "real" phenomenon with as much sincerity as they could muster.

TABLE XXVI: Epileptic and General Paralytic Patients, Wadsley Asylum.



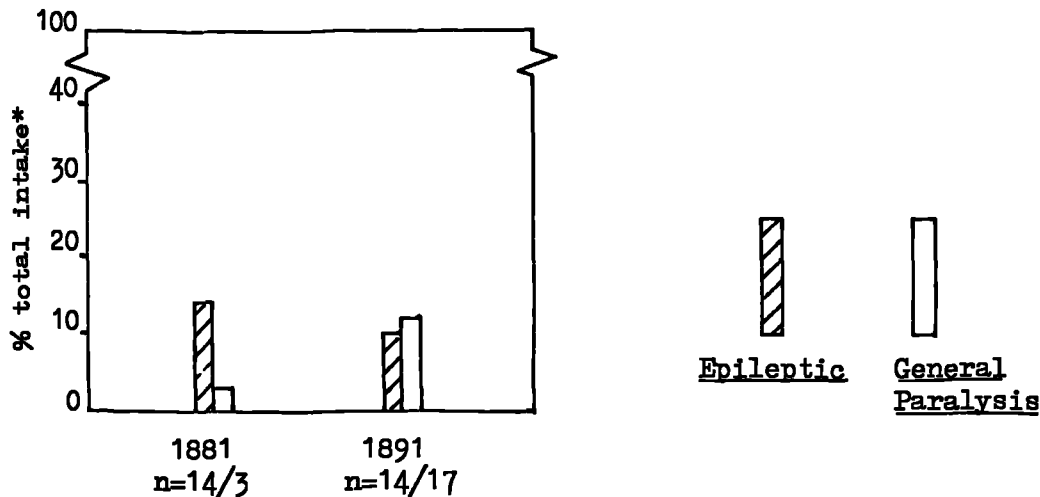
* see Table I for population figures.

TABLE XXVII: Epileptic and General Paralytic Patients, West Riding Asylum.



* see Table II for population figures.

TABLE XXVIII: Epileptic and General Paralytic Patients, Mapperley Asylum.



* see Table III for population figures.

(iv) Conclusion

Enquiry into the conditions and circumstances of people admitted into lunatic asylums is severely hampered by the nature of asylum records. These not only contain only very sketchy information to begin with, but often confuse the issue by slackness of interpretation, despite the copious words involved in their presentation. Furthermore, these records are often only an elaboration of the doctors' perspectives, with little or no bearing on the patients' own points of view. From records such as these there is something to be learnt about professional attitudes and reactions to the problems with which they were confronted, and there is also evidence to illustrate mental physicians' image-building activities (for example, the misleading mortality-rate and the tabulation of unknown causes). Moreover, these records not only form the basis of our actual knowledge of the raw material on which asylums worked; they were also of crucial importance in informing the perceptions of that material which was common amongst the medical profession. Too often the careful quantification of information seems to have acquired a life of its own, obscuring the need to look further afield, as if by endless tabulation of existing material some pattern would emerge: the jig-saw pieces, if thrown in the air often enough, might just fall down in the right combination. This belief was underlined by the three reports of the Association of Medical Officers of Hospitals and Asylums for the Insane in 1865, 1867, and 1869 (the latter after it had changed its name to the Medico-Psychological Association) which recommended the use of a set of sixteen standardised tables of precisely these statistics.⁽¹⁾ Four years later, J.A. Campbell remarked that

1. Report to the Committee appointed at a meeting of the Medico-Psychological Association, held at the Royal College of Physicians, Edinburgh, 1869. Journal of Mental Science, XVI, 74, July 1870, pp.223-232.

"there can be no reasonable doubt that if these tables are accurately kept in the different asylums, they must, from their exactitude, and uniformity, become the material from which the history of insanity in this country will be drawn". (1)

But if our concern is to discover the underlying problems which the doctors called "insanity" then we must disagree with Dr. Campbell. The tables of the different asylums, whether accurately or inaccurately kept, tell us about only one aspect of a whole social process of which the mental physicians were merely a part. The central participants in the process - the patients - have been unable to leave any adequate records of themselves. Essentially, the evidence is all on the doctors' side: it tells us only about the doctors. The story of the inmates remains submerged.

1. CAMPBELL, T.A: Uniformity in Public Asylum Reports. Journal of Mental Science, XIX, 85, 1873, p.68.

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Reference Library.

CHAPTER 5: INSIDE THE WALLS

At the door of the asylum the quiet, well-dressed woman hesitated. Before her stood the unknown: the vast, imposing edifice which was the pauper institution constructed, she was assured, for the care of the mentally sick. Her friends and relatives stood with her outside, urging her in, persuading her of the asylum's beneficial effects. But in herself she was anxious, an intense anxiety which by its hopelessness of expression seemed to separate her from her companions even as she stood amongst them. How had she come to be here? She could not recollect. She clung to her companions with desperate small-talk but their every remark was a subtle pressure pushing her across the threshold.

An attendant emerged and escorted her through the door while her companions smiled assurances from behind. Then she was alone in a gloomy entrance hall. A strange attendant peered at her from the shadows. There was an odd smell. Outside, the friendly voices still chattered and then the heavy door was swung to with a bang. She panicked at that and pleaded with her attendant for one last goodbye.

"Let me speak to them again", she said.

"No," said the attendant, "It is too late". (1)

"The coarse shoutings of the attendants went through me, and the thought, what next they would do with me, obtruded itself upon my mind. I do not recollect that anyone spoke to me, nor did I incline to talk; but walk, walk, walk, was the only vent to my perturbed spirit". (2)

These are two autobiographical accounts from ex-patients of their first experience of a lunatic asylum. The first is from Rachel Grant-Smith who was admitted in 1906 suffering from a protracted depression following the death of her husband. The second comes from an anonymous pamphlet

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1. GRANT-SMITH, Rachel: The Experiences of an Asylum Patient, 1922.
 2. ANON: Life in a Lunatic Asylum; an autobiographical sketch. 1867.

published in 1867. Neither of these patients can be regarded as typical, not only because they both wrote down (and had published) their experiences, but also because both appear to be more educated and come from a more genteel background than most pauper patients. Nevertheless, we have precious little to work on. Most asylum inmates left no trace of their own through their institutional careers. Yet from such autobiographical fragments as do exist⁽¹⁾ we can begin to sketch an outline of some significant moments in asylum life which must have been common to all.

Entering the institution could be a traumatic experience. One might simply appear to be shutting out one's normal familiar life and allowing an unknown force to take over one's very existence. After the first shock of entering the asylum Grant-Smith was shown into a small but "very pretty little bedroom"⁽²⁾ and was brought some "nice tea". Here she was asked some routine questions, presumably for the admissions register, though she did not know and was not told. The room, however, was not hers. When the questions were over she was conducted into a long corridor by a nurse, who told her that she was to be found another room in which to stay.

"I went with this lady upstairs and she proceeded to look into room after room, only to be told by a nurse at the door that there was not a bed. I still remember my desolate feeling, that I was in a place where I counted for so little that there was not even a bedroom ready for me. At the door of one room a nurse with an exceptionally loud piercing voice shouted, 'No, take her away, we don't want her in here'". (3)

Finally she was put into a ward with nine or ten others where the main light was left burning all night.

"The noise at night and the light, and the general surroundings, not only prevented my sleeping, but simply appalled and stunned me, and were very detrimental to my

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1. e.g. "My Experiences in a Lunatic Asylum" by "A Sane Patient", 1879; "Sane in Asylum Walls; a true narrative", by James Scott, 1931. also works by Grant-Smith and Anon, as above.
 2. GRANT-SMITH, Rachel; op.cit., p.64.
 3. ibid., p.65.

health. I was disturbed at night by people being taken to the bath, and what sounded like their being ducked under water, followed by the noise of gasping sobs. The noise was most horrible." (1)

The anonymous autobiographer records that on entering the asylum he was first given a warm bath, then wrapped in cold sheets while he waited to be given his asylum clothes. These consisted of an old check shirt which buttoned at the back, an old jacket and waistcoat and some worn-out corduroys. All these were "hopelessly too big".⁽²⁾ He was then given some thick bread with butter and a pint of tea and conducted into a room containing about twelve other patients who all seemed "strange and startling". The lights were put out at eight o'clock and the first night inside the asylum walls began.

These accounts have been included at this point in order to stress that whatever effect the asylum might have had upon inmates' states of mind, and therefore behaviour, was mediated through subjective experience. This factor should not be left out of account, though naturally it can be given only the vaguest of outlines by the evidence which we have. A greater tangibility can, however, be given to the object of the experience, since it is probable that the emotional impact of at least the initiation into a lunatic asylum described above was more or less common to all new patients.

This impact has much to do with the structured relations within these institutions, which arguably had a great degree of consistency. There is a modern literature on the impact of total institutions upon those who enter them of which Erving Goffman's book "Asylums"⁽³⁾ is the seminal work.

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1. ibid., p.67.
 2. ANON., op.cit., p.13.
 3. GOFFMAN, Erving: Asylums. Essays on the Social Situation of Mental Patients and other Inmates. Penguin Ed., 1968.

Goffman seeks to describe this impact in terms of a new inmate's reactions to that particular set of structural social interactions which he sees as common to all such institutions. In the face of such overwhelming odds, the particularity of the individual counts for very little.

"Persons who become mental-hospital patients vary widely in the kind and degree of illness that a scientist would impute to them, and in the attributes by which laymen would describe them. But once started on the way, they are confronted by some importantly similar circumstances and respond to these in importantly similar ways". (1)

If this view is sound, and if the late nineteenth century lunatic asylum did indeed present "some importantly similar circumstances" to its raw recruits, then these accounts may be considered not untypical, even though the authors themselves were not typical patients. Moreover, even if we dismiss his more individualistic assumptions Goffman's analysis still contains some significant parallels.

"The moral aspects of (the mental patient's) career typically begin with the experience of abandonment, disloyalty and embitterment". (2)

Goffman writes, and this certainly accords with our own examples. Grant-Smith's recollections of abandonment and the easy assurances of her friends by which she was coaxed inside the asylum door give a certain credibility to his further comment that

"Those who suggest the possibility of another's entering a mental hospital are not likely to provide a realistic picture of how in fact it may strike him when he arrives. Often he is told that he will get required medical treatment and a rest, and may well be out in a few months or so". (3)

It would not do to press these parallels too far since we are not concerned here with Goffman but with outlining the internal life of the lunatic asylum and any "importantly similar circumstances" which may be discernible. They do, however, offer the present-day historian, with scant

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1. ibid., p.131.
 2. ibid., p.125.
 3. ibid., p.130.

evidence on which to draw, a counterweight to much of the material culled from medical sources which, besides its bias, also appears dispassionate and impersonal. No attempt at assessing the effectiveness of the asylum in dealing with the problems presented by those labelled "insane" should be made which left the patient's subjectivity and response out of account yet it is the case that this information is generally not documented. What is available is evidence concerning more concrete matters - the arrangement of living quarters, the provision of services, the official rules and regulations that link individuals of different status, and so on - to which only the impression of "life" can be given by the use of those meagre autobiographical sources which do exist. Therefore, we must be always trying to assume that living participation in experience which the notion of "life" implies. If that leads to some Goffmanesque assumptions in the process, then it is a bias of which we should at least be aware.

We have seen⁽¹⁾ that the asylum itself was commonly regarded as "the machine through and by which the superintendent is to work out and develop (sic) his system it is an instrument of cure". If the totality of asylum life was indeed regarded as the cure itself, then we are entitled to study it in detail in order to draw conclusions concerning psychiatric effectiveness at the time. Every detail of the asylum must, by that reckoning, have held a potential significance for the patient. But since, by virtue of being a total institution, the asylum embraced every aspect of its inmates' lives, we need to examine how it effected each inmate as a whole human being, not simply how it may have worked upon his "insane" condition.

Accordingly, the examination will begin with the physical environment of the asylum inmate, the buildings, their furniture and decor and their surroundings. Then aspects of physical health will be considered, from disease to hygiene. Diet will also be included. Following these more

1. See Chapter 3.

concrete considerations the less determinate factors of patients' own expectations and relationships will be attempted, with an emphasis on patient-staff interactions and autonomous patient behaviour. Finally, these aspects will be drawn together in an assessment of the probable impact of asylum existence upon the inmates' lives.

a) THE PHYSICAL ENVIRONMENT

(i) Bricks and Mortar

The distinguished mental physician Andrew Wynter gave the following impression of normal asylum life, which he set down in his book "The Borderlands of Insanity" in 1875.

"When the visitor strolls along the galleries filled with listless patients, the utter absence of any object to afford amusement or occupation strikes him most painfully

(He) sees nothing but groups of patients seated round the fire or lolling about in a dreamy sort of way, perfectly quiet, and only curious about the curiosity of the stranger. This is the class of people that form 90 per cent of the inhabitants of our asylums". (1)

The environment in which this all took place was in most cases a fairly recently-built brick structure, specifically erected under the 1845 Lunacy Act. Some were of older construction, having served as asylums under the earlier, permissive, Act of 1808. In the course of the century the lunatic population grew and new asylums were erected to accommodate them. Asylums were still being opened at the end of the century, so that by 1900 a range of buildings were in use.

Apart from a few older buildings which had been adapted from a previous usage (e.g. the Suffolk and Gloucestershire asylums) the nineteenth century asylum was built according to one of two major patterns.⁽²⁾ The

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1. WYNTER, Andrew: The Borderlands of Insanity and other applied papers. 1875. pp.122-7.
 2. BURDETT, Henry C.: Hospitals and Asylums of the World, their origin, history, construction, administration, management and legislation. Vol.II. 1891.

earlier of these, the so-called "corridor" pattern, was the basic institutional design for many of the mid-century constructions and was used in general hospitals as well as prisons, orphanages and so on. It contained long corridors from which rooms led off on either one or both sides. Its advantages were that a large number of single rooms (or cells) could be built into the structure and supervision was made easy because of the common corridor.⁽¹⁾ The old asylum at Nottingham was of this design and could house 350 patients.

The disadvantages of the "corridor" pattern were bad lighting and poor ventilation. Moreover, in a building dedicated to medicine the effect of long, monotonous corridors was depressing and counter-productive to many mental patients. The famous Colney Hatch asylum, opened in 1851, extended for one third of a mile, with a corridor running the entire length. By 1890 it housed 2,250 people, although it was originally intended for only 1,300. In 1857 Andrew Wynter described it thus:

"Its facade of nearly a third of a mile is broken at intervals by Italian campaniles and cupolas, and the whole aspect of the exterior leads the visitor to expect an interior of commensurate pretensions. He no sooner crosses the threshold, however, than the scene changes. As he passes along the corridor, which runs from end to end of the building, he is oppressed with the gloom; the little light admitted by the loop-holed windows is absorbed by the inky asphalte paving, and coupled with the low vaulting of the ceiling, gives a stifling feeling and a sense of detention as in a prison. The staircases scarcely equal those of a workhouse; plaster there is none, and a coat of paint, or whitewash, does not even conceal the ragged surface of the brickwork. In the wards, a similar state of affairs exists: airy and spacious, they are without a doubt, but of human interest they possess nothing". (2)

It was this lack of human interest which Arlidge criticised in the Journal of Mental Science,⁽³⁾ as being so detrimental to sound

"moral management". Nevertheless, this design was the most common of all

1. Single cells were regarded as essential for the effectiveness of moral treatment, though less so as their availability diminished. See Chapter 3, pp.110-111.
2. WYNTER, Andrew: Lunatic Asylums. Quarterly Review. Vol.101, April 1857, p.364.
3. See Chapter 3, p.116.

and characterised most of the asylums built in pursuance of the 1845 Act.⁽¹⁾

The second major design, which gained popularity especially after Florence Nightingale's advocacy of it to the Social Science Association in 1858,⁽²⁾ was the 'pavilion' style asylum. Here a number of blocks were connected by single-storey closed corridors. The blocks might be arranged in line, in 'V' or 'H' formation or in a horse-shoe. This design had the advantage of superior lighting and ventilation, qualities which Miss Nightingale and the new school of skilled nursing prized greatly, in asylums as in general hospitals.⁽³⁾ It was the surgeon, Charles Hawkins, who first suggested the 'H' formation in his design for Queen Charlotte's Hospital⁽⁴⁾ because of its supposed hygienic nature, and the construction had the approval of the whole medical profession, including the mental physicians.

However, there were drawbacks. Supervision was harder to maintain and required a greater physical effort since in order to move from one block to another one had to descend and ascend sets of stairs. Evacuation in case of fire was similarly a problem. Possibly the most serious drawback was that the new design did not easily lend itself to small rooms but rather to large, barn-like enclosures which lacked individuality, adding weight to what has been called the "treatment of the insane in bulk".⁽⁵⁾

The best example of this type is probably the Leavesden asylum, built in 1870 under the Metropolitan Asylums Act of 1867. It housed 2,000 patients, designated "incurable". All but forty-six of these were held in

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1. BURDETT, Henry C.: op.cit., p.vii.
 2. MILLMAN, Michael: The Influence of the Social Science Association on Hospital Planning in Victorian England. Medical History, XVIII, 1974, pp.122-137.
 3. NIGHTINGALE, Florence: Notes on Nursing. 1859.
 4. DUNCUM, Barbara: The Development of Hospital Design and Planning in F.N.L. POYNTER, The Evolution of Hospitals in Britain. 1964.
 5. MERCIER, Charles: Lunatic Asylums - their Organisation and Management. 1894, p.3.

thirteen T-shaped blocks, six for men and seven for women. The attendants' rooms were on the ground floor, lit by overhead windows of toughened glass, and also on their floor were the day-rooms, 105' x 36', with bay-windows facing south-west. On the floor above there were some more attendants' rooms together with clothing stores, WCs, offices, workshops and kitchens. This type approaches most closely to the "warehouses for the mad" which some writers have referred to.⁽¹⁾

With the full development of the 'pavilion' style the blocks became single units of supervision, each with its own facilities, including lavatories, store rooms, baths, sculleries and a few single rooms.

"The attendant in charge can therefore be held responsible for everything occurring within it, for he is not subject to interference by other persons passing through on their way to or from other parts of the building".⁽²⁾

Along with these changes in basic pattern came a shift in the style of dormitory provision. As we saw, the earlier, 'corridor' style incorporated a large proportion of single and small-sized rooms. These were lost as the "bulk" effect of 'pavilion' accommodation became more widespread. Here, patients were far more likely to sleep in large, crowded wards, with questionable effects upon their being treated as individuals.

In the early days of the working of the 1845 Act, when individual treatment was still a living ideal, single rooms were regarded as being of major importance in the regime of "moral treatment". Even so, they were by no means universal when it came to actual asylum design. John Conolly, who led the movement towards the abandonment of all mechanical restraints earlier in the century, complained that the extent of single-room provision

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1. e.g. Andrew T. SCULL: Museums of Madness, 1979; Vieda SKULTANS, English Madness, 1979.
 2. COBBOLD, C.S.W.: Design for a Public Asylum for 310 Patients, allowing for extension of Accommodation up to 450 beds. Journal of Mental Science, XXXI, 136, 1886, p.470.

was not adequate.

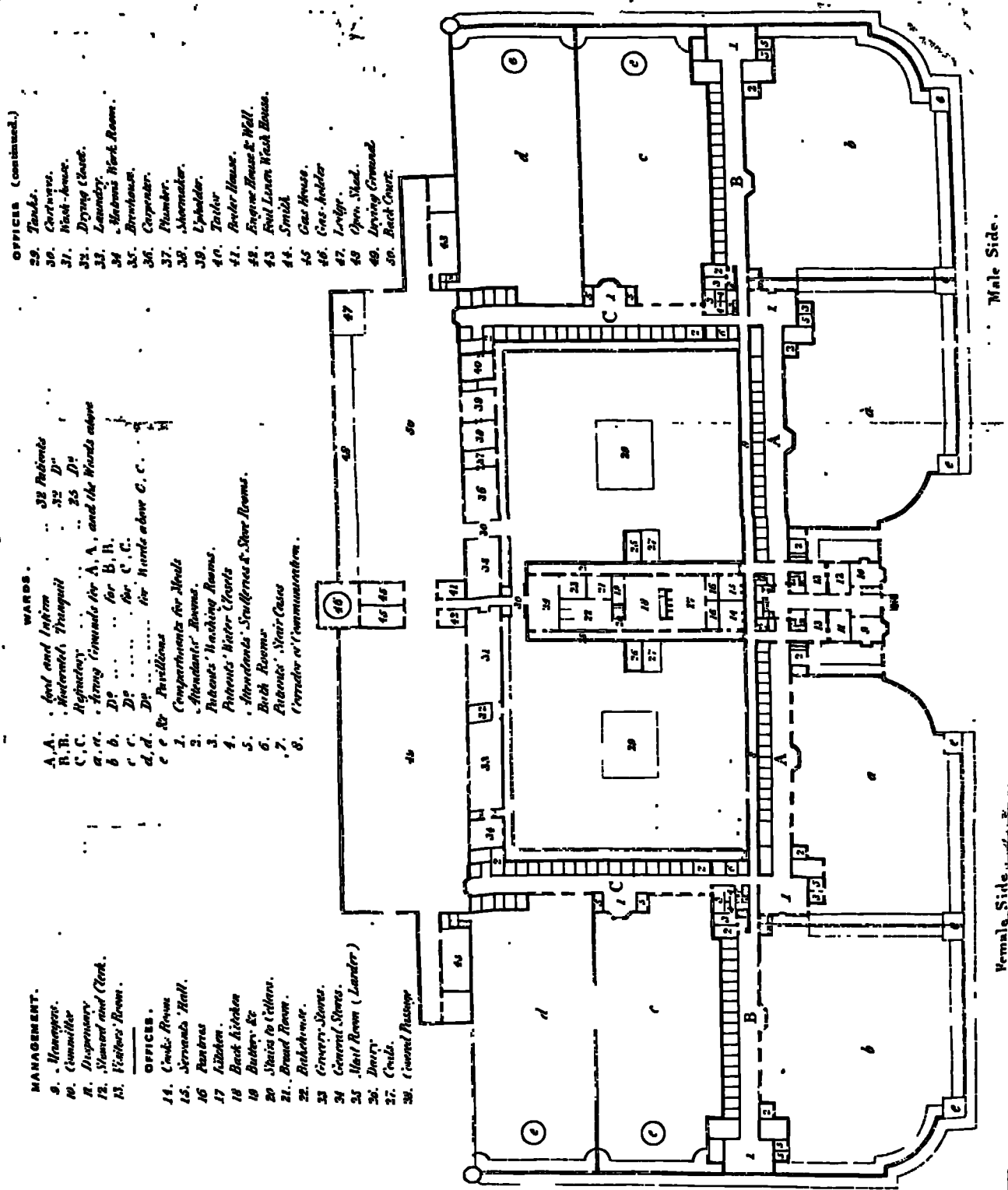
"In all asylums the proportion of single bedrooms appears to me to be too small; and I always recommend architects to have such rooms for at least two thirds of number of patients to be received into my proposed asylum. A few dormitories, containing not more than four or five beds in each, are useful in an asylum. The timid and melancholy are best placed in such rooms for the night, and those disposed to suicide are safer with others than alone. But in favour of large dormitories, I do not know one good reason that can be advanced". (1)

To emphasise his point Conolly reproduced a plan for the proposed new Derby asylum which clearly showed the degree of single-room accommodation which he favoured. (Fig. I) This shows the three main categories of patient, "aged and infirm" (A), "moderately tranquil" (B) and "refractory" (C) each with its own area divided into single rooms. The categories are duplicated for male and female.

This desire was not, however, to be. The Commissioners in Lunacy turned down the proposed plan. Single rooms made way for small dormitories, which in turn made way for large wards that became more overcrowded as patient numbers rose. For example, the old Lincoln asylum opened in 1820, housed over half its eighty patients in single rooms. The Nottingham asylum of the same period had 112 single rooms out of a total population of 350.⁽²⁾ By contrast, the new asylum at Sussex housed more of its patients in wards large enough to require three fireplaces. The quieter patients lived in smaller wards with only one fireplace. These had twelve beds, six along opposite walls. There were only a handful of single rooms.⁽³⁾ The asylum design submitted in 1886 by C.S.W. Cobbold of the Earlswood asylum⁽⁴⁾ seems to have preserved a similar accommodation arrangement. On the upper floor there were to be two dormitories, one each for "convalescent"

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1. CONOLLY, John: The Construction and Government of Lunatic Asylums and Hospitals for the Insane. 1847, p.24.
 2. BURDETT, Henry C.: op.cit.
 3. A Descriptive Notice of the Sussex Lunatic Asylum p.270.
 4. COBBOLD, C.S.W.: op.cit., p.468.

FIGURE I: Proposed plan for the Derby Asylum



- MANAGEMENT.**
- 9. Manager.
 - 10. Committee.
 - 11. Dispensary.
 - 12. Ward and Tank.
 - 13. Visitors' Room.
- OFFICES.**
- 14. Cooks' Room.
 - 15. Servants' Hall.
 - 16. Pantries.
 - 17. Larder.
 - 18. Back Kitchen.
 - 19. Butcher, &c.
 - 20. Store to Cellars.
 - 21. Bread Room.
 - 22. Baker's Shop.
 - 23. Greenhouse.
 - 24. General Store.
 - 25. Mail Room (Larder).
 - 26. Dairy.
 - 27. Cattle.
 - 28. General Passage.

- WARDS.**
- A. A. Bed and Lying.
 - B. B. Bedstead, Trinquet.
 - C. C. Refectory.
 - a. a. Army Grounds for A, A., and the Wards above.
 - b. b. Do for B, B.
 - c. c. Do for C, C.
 - d. d. Do for Wards above C, C.
 - e. e. Do Pavillions.
 - 1. Compartments for Males.
 - 2. Attendants' Rooms.
 - 3. Patients' Washing Rooms.
 - 4. Patients' Water-Closets.
 - 5. Attendants' Staircases & Store Rooms.
 - 6. Bath Rooms.
 - 7. Patients' Year Cases.
 - 8. Corridor or Communication.

- OFFICES (continued.)**
- 29. Tanks.
 - 30. Cartways.
 - 31. Wash-house.
 - 32. Drying Court.
 - 33. Laundry.
 - 34. Washers' Work Room.
 - 35. Brewster's.
 - 36. Cooper's.
 - 37. Weaver.
 - 38. Shoemaker.
 - 39. Upholder.
 - 40. Tailor.
 - 41. Barber House.
 - 42. Engine House & Well.
 - 43. Red Linen Wash House.
 - 44. Smith.
 - 45. Gas House.
 - 46. Gas Holder.
 - 47. Larder.
 - 48. Open Shed.
 - 49. Driving Ground.
 - 50. Back Court.

Female Side

Male Side

SOURCE: Reproduced from CONOLLY, John, The Construction and Government of Lunatic Asylums and Hospitals for the Insane, 1847. p.214

and "recent" cases, one ward consisting of 17 patients and the other of 20, with 4 and 6 single rooms respectively. On the same floor were wards for "chronic" and "working" patients. Two were for 57 patients and two for 18 patients. Below these, on the ground floor, were the "acute" and "epileptic" wards, with 30 and 33 beds in each, including 6 and 9 single rooms respectively. On this floor was also the general infirmary which consisted of two dormitories, one of 20 patients, one of 19, with 3 and 2 single rooms respectively.

Indeed, later mental physicians found reason to favour the abolition of single rooms on "medical" grounds, except for special use in "isolation". In earlier times, wrote Arlidge, when lunatics were regarded as "ferocious individuals",

"there was good reason for building corridors and rows of single rooms or cells; but since a humane system of treating the insane (has been) established the perpetuation of the 'ward-system' has been an anomaly and a dangerous mistake". (1)

Later building was in any case of the large ward type and single rooms were used only for first admissions and for isolation.

In rejecting single rooms Arlidge was not necessarily abandoning a more 'humane' or 'individualist' form of accommodation. That the lunatic asylum was a large institution was, of course, self-evident, particularly to its new arrivals. Far from offsetting the impact of this the use of single rooms may well have enforced the effect of structured isolation from 'outside' society as the patient lay alone with his own thoughts and fears. To share such thoughts with fellow patients in a small ward was probably the best way to introduce new patients to asylum routine. When we recall the disorientating effect of first arriving at the asylum, and the great

1. ARLIDGE, John T.: The State of Lunacy and the Legal Provision for the Insane. 1859, p.200.

anxiety felt by many new patients, we can understand why our anonymous ex-patient wrote that

"had I been put in a single room, and locked in, it would have been unendurable to me". (1)

As it was, he found companionship amongst others similarly afflicted.

Indeed, being put in a single room came increasingly to be a form of control that was bitterly detested by inmates because of the deplorable conditions which were associated with long hours in a small, and often lightless, cell. (2) However, the increasingly barn-like wards of the later century must have been rather less effective in allowing companionships to form, quite apart from presenting even more extreme noise problems.

The day-rooms even in the mid-century were inevitably of a somewhat institutionalised character, despite attempts to provide minimum comforts. In the Kent asylum, opened in 1854, the bottom of the windows was seven feet from the floor. (3) The windows themselves were of two sizes, 2' 8" x 3' 3" and 2' 2" x 2' 8", and made up of panes 7" x 10". These also had the characteristic semi-circular window added at the top, which opened inward from hinges along the bottom edge. This design, considered to remove the appearance of confinement and improve the lighting, was introduced in 1851. (4) At night, gas lighting was provided.

The walls of the asylum were generally plain, with only simple and inexpensive decoration. At Sussex they were of brick, lime-washed with a yellow tint on the lower half, to protect patients' clothing (that is, the asylum's clothing!) from the effects of the lime in the cement. Not much

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1. ANON: op.cit., p.15.
 2. see, for example, LOMAX, Montagu: Experiences of an Asylum Doctor, 1921. and SCOTT, James: Sane in Asylum Walls, 1931.
 3. HUXLEY, J.E.: A History and Description of the Kent Asylum. Journal of Mental Science, I, 3, 1854, pp.41-2.
 4. ANON: Description of a New Window for the Use of Asylums. Journal of Psychological Medicine, IX, 1851.

can be ascertained about the interior furnishings. These appear to have improved later in the century, with wood-varnish on doors and boards and pictures hanging from stained picture-rails on papered walls,⁽¹⁾ while in at least one asylum (and no doubt many more) there hung a prominent portrait of Queen Victoria.⁽²⁾ Consideration was given to the psychological consequences of these furnishings:

"A fashion has of late sprung up of staining and varnishing doors and skirting-boards, but, if the wall over it is coloured darker than the skirting, a feeling of insecurity results, which is quite fatal to repose. The walls seem about to topple over. On the contrary, if the walls are kept lighter than the varnished wood there is too much glare and dazzle".⁽³⁾

Thus Burdett, the eminent historian of hospitals, complained in 1891 of contemporary fashions in asylum decoration. In photographs of the West Riding lunatic asylum taken at about the same time the walls seem to be quite covered with heavily framed prints and paintings and other paraphernalia common to drawing-rooms of the period, such as gilt mirrors and ornate flower-vases.⁽⁴⁾ Potted plants line the mantelpiece, the walls are papered with a flower pattern and an upright piano sits in the corner. This is described as a "ward-sitting-room", but there is no way of knowing how much of this elegance was prepared for the photograph. Significantly, perhaps, no patients are in view.

For the most part the furniture consisted of simple tables and chairs. Again, there seems to have been some improvement in this area towards the later part of the century, for Burdett writes

"more objects of interest, and more comfortable, home-like articles are to be met with now than would have been thought necessary, or possible, twenty years ago".⁽⁵⁾

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1. BURDETT, Henry C.: op.cit., pp.41-50.
 2. ANON: op.cit., p.12.
 3. ibid., p.51.
 4. ASHWORTH, A.L.: Stanley Royd' Hospital, Wakefield. One Hundred and Fifty Years. A History. 1975, p.34.
 5. BURDETT, Henry C.: op.cit., p.41.

Not all this new furniture was suitable. Many of the chairs were light and flimsy and easily broken by restless or less careful patients. Also, notes Burdett, they become uncomfortable after half an hour. They tended also to make easy weapons should patients become aggressive. Similarly, new tables of a light, elegant make were appearing in the later 1880s constructed from mahogany, oak or pitch-pine. These were replacing the large, heavy tables used previously. Also gone by the end of the century was the specially-adapted asylum furniture, once much in vogue. Burdett comments that

"All special asylum furniture has gone forever. Fifteen years since or more we remember having seen a restraint chair, - not in an asylum, however". (1)

The focus, such as it was, of social life was not always a day-room, but was frequently the corridors themselves, which sometimes included window-bays where benches were set out against the walls. It was here, as often as not, that small gatherings of inmates collected, forming the basis of social communication. For those who did not want to accept such company, however, gatherings of this kind must have been hard to avoid. Many patients made do with wandering up and down the corridors, like displaced souls. In a place like this there must have been very little space which a person might establish as their own, a sanctum beyond the public bustle. Indeed, such a world, where nothing could be easily personalised and where everything formed part of an unfamiliar territory inhabited by a collection of strange beings, must have been profoundly disorientating to even the sanest souls, particularly soon after arrival. Arlidge records what an introduction to such a world must have been like. (2)

"The newcomer into the asylum is ushered into a long passage or corridor, with a series of small doors on one side, and a row of peculiarly-constructed windows on the other; he finds himself mingled with a number of

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1. ibid., p.47.
 2. ARLIDGE, John T.: op.cit., p.201.

eccentric beings, pacing singly up and down a corridor or perhaps collected in unsocial groups in a room opening out of it, or in a nondescript sort of space formed by a bulging-out of its wall at one spot, duly lighted, and furnished with tables benches and chairs, but withal not a room within the meaning of the term, and in the patient's apprehension. Presently he will be introduced through one of the many little doors around him into his single sleeping-room, or will find himself lodged in a dormitory with several others, and by degrees will learn that another little door admits him to a lavatory, another to a bath, another to a scullery or stove-closet, another to a water-closet another to a sanctum sanctorum - the attendant's room, within which he must not enter".

We are reminded of the experiences of our own ex-patients and particularly of that urge to "walk, walk, walk" to overcome the sense of displacement. The passage well illustrates the ironic paradox of the institutional treatment of behavioural problems: that a patient is being taken out of society in order to be resocialised back into it. Before we pass on to consider the psychological consequences of this, however, we need to look at the more immediately physical effects of the asylum upon its inmates.

(ii) Health and Hygiene

For the asylum was, after all, a medical establishment. In order to provide for its inmates' well-being it had to be equipped with an efficient supply of clean water, an adequate drainage and sewerage system and also means of heating and ventilation.

Fresh water had originally been drawn from spring and rain water, or from a local river." However, natural springs could dry up in hot weather and stored rainwater was often insufficient. Moreover, at the time in which our study begins much attention was being paid to the health-hazards associated with drinking water, and rivers were commonly suspected of being contaminated by surface and sewage outflows. One solution adopted was the installation of filter-beds to purify the water. West Riding had

its own beds by 1867 and Worcester acquired its filter-beds in 1876.

These provided 25,000 gallons of usable water per day and were so successful that the Commissioners in Lunacy advised the same method at Bristol.⁽¹⁾

However, Crichton Browne at the West Riding asylum was not impressed. In 1868 he reported that

"Tests less subtle than chemical examination, such as the observation of the unaided senses, occasionally intimate that (deleterious substances) are present to a most injurious extent". (2)

The most common solution to this problem was the sinking of a well. This had to be deep enough to avoid contamination of the supply, and would often need to be deepened as natural seepage progressed, as was the well at Brentwood in 1884.⁽³⁾ Very often new wells had to be sunk. Not until the arrival of piped water from the town supply, a very late nineteenth century development, was a constant source of pure water obtained.

This provision of clean water was all the more important because of the incidence of disease, which was frequently traced to contaminated water. Regular outbreaks of typhoid fever amongst the nurses in the early 1860s were attributed to a contaminated well examined by health officials in 1867.⁽⁴⁾ Similarly at Suffolk as late as 1890, "some deaths" resulted from dysentery and diarrhoea, "the diseases being attributed to impurities in the water supply".⁽⁵⁾ More than likely, however, it was defective drainage and sewerage which led to the spread of these diseases through the asylum than the purity of the original water supply because of leakage. Thus fouled water could find its way into the clean supply and spread contamination. This, at least, was the view taken by the Commissioners in Lunacy

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1. Thirty-Eighth Report of the Commissioners in Lunacy, 1884, p.69.
 2. ASHWORTH, A.L.; op.cit., p.45.
 3. Thirty-Eighth Report of the Commissioners in Lunacy, 1884, p.68.
 4. ASHWORTH, A.L.; op.cit., p.48.
 5. Forty-Fifth Report of the Commissioners in Lunacy, 1890/1, pp.48-9.

after an outbreak of fever at Salop and Montgomery asylums in 1888.⁽¹⁾

This led to a reconstruction of the drains after the water supply was found to be "contaminated by sewage percolation, and the water consequently unfit for dietetic purposes".⁽²⁾ A new well and pumping machinery was finally

sanctioned in 1890 at a cost of £2,990. Similar costs were incurred that year for drainage improvement at the Hampshire asylum⁽³⁾ and at Beverley in the East Riding new drainage was being considered after typhoid fever had been traced to polluted drinking water, "the pollution being derived from the sewage of the Asylum and of a neighbouring village".⁽⁴⁾ Nevertheless, disease continued to break out as a result of contamination by sewage.

The year 1895 was marked by an unusually high incidence of colitis, dysentery and typhoid fever, the most serious being at the Parkside asylum between July and September, when 24 patients and two members of staff were affected, resulting in six deaths.⁽⁵⁾ The cause turned out to be the pump which drew the town water-supply into the asylum water-towers. This pump was also used for the laundry water which had been contaminated by leakage from the drains. The drainage was subsequently re-laid.

To contemporary observers, nevertheless, the health record of the asylums often appeared good. Crichton Browne reported in 1872⁽⁶⁾ that the West Riding asylum had not been so free of disease for more than twenty years, not one single case of disease having occurred in the previous three months. The previous year, Browne had paid tribute to the success of "those sanitary arrangements which your Committee have from time to time sanctioned" in improving the overall level of health, saying that "the health of the community has been exceptionally good".⁽⁷⁾

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1. Forty-Second Report of the Commissioners in Lunacy, 1888, p.70.
 2. Forty-Fifth Report of the Commissioners in Lunacy, 1890/1, p.43.
 3. Forty-Second Report of the Commissioners in Lunacy, 1888, p.69.
 4. Forty-Fifth Report of the Commissioners in Lunacy, 1890/1, pp.48-9.
 5. Fiftieth Report of the Commissioners in Lunacy, 1896, p.20.
 6. Quarterly Report of the West Riding Asylum, 23rd July 1872, Wakefield PRO, C85 127.
 7. ibid.

Good health was not necessarily linked to clean water supply, as Browne's comment in 1875 makes clear.

"The health of the inmates has been exceedingly good, notwithstanding the great age and physical infirmity of a majority of those who have been admitted, and in spite of the execrable quality of the drinking water supplied to us". (1)

A more obvious cause of bad health (obvious, at least, to the asylum doctors) was overcrowding. Bevan Lewis, superintendent of the West Riding asylum from 1884 to 1910, commented that the incidence of phthisis was growing in parallel with overcrowded conditions.⁽²⁾ Indeed, so common was this disease that "phthisic insanity" became part of mental physicians' vocabulary. Richard Hunter⁽³⁾ has shown that TB (of which "phthisis" is one form) was more prevalent inside asylums than outside, so much so that in 1883 Clouston came to regard both conditions as resulting from the same "constitutional weakness".

Not only crowded conditions but also poor ventilation was seen as a cause of disease. The outbreak of acute pneumonia which occurred in the female wing of the West Riding asylum in 1889 was connected with the "filthy rubbish" pushed through the air-flue gratings by the "dirty and degraded class of patients".⁽⁴⁾ The gratings were later bricked up. Thus increasingly during the later nineteenth century poor sanitary arrangements and a lack of fresh air were seen as important obstacles to the good health of asylum inmates which needed to be tackled.

All this was, of course, perfectly in line with what was happening in the field of public health generally at this time. Lunatic asylums were not the only places which experienced such profound problems. General

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1. ibid., 26th October 1871.
 2. ibid., 30th April 1885.
 3. HUNTER, Richard A.: Tuberculosis and Insanity. St. Bartholomew's Hospital Journal, 61, 1957.
 4. Quarterly Report, 20th June 1889.

hospitals had them, too. The Birmingham General Hospital suffered from a severe inadequacy of drainage, as its annual report for 1862 makes clear.

It pointed out

"the bad sanitary state of the Hospital, as manifested by the unhealthy appearance of wounds, etc., and the slow recovery of patients suffering from them". (1)

These problems remained until 1874, when a new drainage system was constructed. F.B. Smith⁽²⁾ notes that at the Highgate Infirmary the WCs were blocked even before the building was officially occupied in 1870, because the drainage pipes were too narrow. Also,

"the drains under the scullery and kitchen of the Middlesex Hospital were of the old brick square type; they contained nine feet of stagnant sewage in them when the authorities finally moved to cleanse them in 1872. The drains under the Liverpool lying-in Hospital, which had finally to be abandoned in 1882 because of endemic erysipelas and puerperal fever, were found to run uphill when they were lifted in 1884". (3)

Moreover, at the Manchester Royal Infirmary in the 1850s the ventilation shafts conducted smells from the mortuary through all the female surgical wards, while the WCs had air-vents which led directly into the wards, giving them a "penetrating and sickly odour".⁽⁴⁾

Neither was it only medical establishments which were affected by outbreaks of disease caused by bad sanitation, though their susceptibility to them created an understandably greater outcry. Any institution could expect the same kind of misfortune. In 1874, a localised attack of enteric fever at Caius College, Cambridge, was traced to the drinking water which had been contaminated by sewage.⁽⁵⁾

Horrorifying as these accounts may sound today, they were no more than

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1. WOODWARD, John: To Do the Sick No Harm, a study of the British voluntary hospital system to 1875. 1974, pp.111-112.
 2. SMITH, F.B.: The People's Health, 1830-1910. 1979, p.267.
 3. ibid., p.267.
 4. ibid., p.219 and p.212.
 5. BRAND, Jeanne L.: Doctors and the State, 1871-1900. p.55.

what was to be expected at a time when sewage from the great industrial towns was passed untreated into the major rivers, which were also the main source of drinking water. Even as late as 1891 large-scale outbreaks of enteric fever could occur because of river pollution, as the special investigation into the Tees Valley outbreak reveals.⁽¹⁾ Sanitary science still had a long way to go. In the 1860s it was found that the corporation pump at Worthing was used to bring drinking water into the town and also to raise the sewage, which thus passed through the same valves and outlets,⁽²⁾ while even by 1898 Birmingham still possessed 30,000 pan privies and backyard middens, with all their attendant dangers of disease.⁽³⁾

Stories of this kind are legion and serve to show that the lunatic asylum, in an age of reluctant health legislation in which the true nature of infectious disease was only beginning to be understood,⁽⁴⁾ was by no means an exception. Indeed, in some respects it was in the forefront of the van of progress, lumbering as that unwelcome vehicle undoubtedly was. In the field of ventilation, for example, the need to circulate good air throughout the whole of the building led to some imaginative innovations which were not, even so, always successful. One ingenious idea relied upon the combined functions of ventilation and heating to achieve circulation. At the Kent Asylum, a network of air-tubes was installed with separate intake and extract flues. The movement of air was effected by fires lit at the base of the extract pipes, which was supposed to cause the air to rise and in the process draw in fresh air from below. The fires could be made to heat water-tanks which fed pipes laid along the fresh air intake ducts, thus producing warmth and ventilation together. In summer the hot water was not used, leaving only the "summer fires" for circulation.⁽⁵⁾

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1. ibid., p.55.
 2. SMITH, F.B.: op.cit., p.222.
 3. ibid., p.221.
 4. see e.g. POYNTER, F.N.L.: *Medicine and Science in the 1860s.* 1968.
 5. HUXLEY, J.E., op.cit., pp.39-41.

In each individual room the inlet duct was placed high up in the walls, and the outlet was placed near the floor. In the private asylum opened at Coton Hill, Stafford, in 1854, this was reversed, though the same system of combined heating and ventilation was used.⁽¹⁾ This method was also employed at West Riding, though it appears to have been a failure, owing to the unpredictable nature of the winds, which affected the movement of air at both the intake and extract flues.⁽²⁾ However, better methods of extraction were later developed along with an adequate gas-supply. With the coal fire replaced by gas-jets in the turret of each air-extract, up to 2,000 cubic feet of air could be moved each hour.⁽³⁾

Despite these attempts to introduce large-scale systems of fresh air supply and heating these functions were actually performed more effectively by the open window and the open fire. Another humble, but hygienically crucial, function was sanitation. Baths and sewage disposal rank high in a catalogue of essential features of the "modern" asylum. Once again, Victorian delight in mechanical innovation is evident from some of the descriptions given in contemporary sources. Burdett, one of the asylum's earliest architectural historians, seems positively gleeful in his description of a bath-tap in which the hot-water lever cannot be moved until the cold-water lever is turned on.⁽⁴⁾ This was to prevent scalding by careless attendants, an event which on more than one occasion resulted in the death of a patient.⁽⁵⁾ Another such innovation was the door-operated lavatory flush.⁽⁶⁾ By pushing the door open from outside the cistern was filled with water. When the door was then pushed open from the inside the

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1. ANON: The New Asylum for the Middle-Classes at Coton Hill. Journal of Mental Science, I, 6, 1854, p.90.
 2. According to Mr. A.L. Ashworth, sometime secretary of Stanley Royd's Hospital (West Riding Lunatic Asylum) and curator of the hospital museum.
 3. BURDETT, Henry C.: op.cit., p.51.
 4. ibid., p.55.
 5. see e.g. Twenty-Second Report of the Commissioners in Lunacy, 1867, pp.56-7.
 6. HUXLEY, J.E., op.cit., p.42.

flush mechanism was set in motion. A further characteristic of this device was that it combined the function of a lock, yet without the risk of a patient being unable to get out or an attendant to get in if need be. Since the door could only open alternately in and out it could not be opened by pushing from the outside if the cubicle was already occupied. An attendant could, however, gain entry by pulling the door. A further advantage of this mechanism was that it required no chain by which a patient might hang himself. This eventuality could also be avoided by the use of "pull-handle" flushes or by enclosing the chain in an iron pipe.⁽¹⁾

Neither did mechanical innovation stop at these small matters. The entire sewerage system could be combined with the asylum's agricultural activities in a way that turned the whole institution into a virtually self-contained unit. Baths and automatic-flush lavatories produced large quantities of liquid sewage. The average asylum produced some thirty gallons of sewage per person per day.⁽²⁾ Thus a 600-bed asylum would daily produce some 20,000 gallons, requiring 20 acres of land for safe disposal. Once disposed of in this way, the enriched earth was found to be very fertile, being most suitable for Italian rye-grass (to feed the cows to provide milk) or for growing cabbages. Milk and cabbage featured regularly in asylum diets, making the circulation almost a closed loop.

Yet for all these innovations it would be a mistake to regard the asylum as in even contemporary senses a "healthy" place. The emphasis given to measures of public health merely uncovered ever more examples of unhygienic conditions, in asylums as elsewhere. Moreover, like its counterpart, the general hospital, the lunatic asylum never confronted adequately the paradox of concentrating in one place so many diseased

1. BURDETT, Henry C.: op.cit., p.56.

2. ibid.

individuals whilst attempting to combat infection. A survey conducted by Dr. Mott, the official pathologist, in London between 1903-8, concluded that in the age group 15-45 deaths from TB were fifteen times higher than in the outside population, while in the over 45 age group the figure was double.⁽¹⁾ A simple glance at the chief causes of death in the asylum shows how much was attributable to tuberculosis, pneumonia and bronchitis, diseases which may well have been contracted as a direct consequence of asylum conditions.⁽²⁾ Indeed, something approaching a quarter of all deaths in the asylum (nearly 10% of total admissions) can be definitely linked with these three diseases. In terms of health and hygiene the asylums were forced to innovate merely to offset the effects of these concentrations of disease-inducing conditions.

(iii) Food and Drink

We have seen⁽³⁾ that for many of the text-book writers a good diet was seen as one of the asylum's chief remedies. But how good was the diet? There was no standard recommendation for the provision of meals but the Commissioners in Lunacy always inspected the food given and made their recommendations accordingly in their Reports. These in turn were used by asylum staffs as some sort of guide. Nevertheless, the Commissioners continued to find much to complain about.

"In some cases, our suggestions (for improved diets) have been encountered by statements that the existing dietary was better than the Patient had previously been accustomed to; or that his food, when at large, rarely consisted of meat; or that beer was not in general use in the country to which he belonged, etc.". (4)

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1. HUNTER, Richard and Ida MacALPINE: Psychiatry for the Poor, 1851 Colney Hatch Asylum, Friern Hospital 1973, a medical and social history. 1974, p.183.
 2. See Chapter 4, pp.167-168
 3. See Chapter 3.
 4. Thirteenth Report of the Commissioners in Lunacy, 1858, p.69.

Even in cases where asylums listed definite quantities of foodstuffs on their cooking rotas, the Commissioners found that the meals actually served bore little relation to them. Reporting on the Colney Hatch asylum in 1869 they found that

"on Monday the Dinner is stated to consist of 7 ounces of meat, 4 ounces of dumplings, and 12 ounces of vegetables. Whereas, in fact, it consists of pudding, without meat or gravy, having some small pieces of meat (2 ounces) placed on top and baked with it. The morsels of meat are scorched, and in many instances uneatable; at some of the tables one-third or half of the Patients left the greater part and the Patients employed in the Kitchen will not touch it". (1)

But such instances were clearly unusual enough to warrant special criticism. On the whole it seems that the quantities which were officially acknowledged were something like the amount of food actually given.

Mental physicians were understandably optimistic about the nutritional value of the diets they provided. An article in the 'Journal of Mental Science' stated that at the newly-opened Sussex asylum in 1860 a basic diet of 34-oz of meat per week was given to each patient, along with vegetables and beer, stout or water. The quantity recommended was 56-oz per week, but at 7d per pound this was considered too expensive.⁽²⁾ In most asylums there was a weekly menu. In one, dinner each day consisted of the following:

"SUNDAY: salt meat and unpeeled potatoes;
 MONDAY: roast beef in gravy, potatoes and cabbage;
 TUESDAY: pea soup and a half portion of potatoes;
 WEDNESDAY: boiled meat and potatoes;
 THURSDAY: meat pie (described as "gross and unpalatable");
 FRIDAY: soup maigre;
 SATURDAY: plum pudding only." (3)

In each case, dinner was served with half a pint of beer. The other meals of the day would be rather more sparse. Shortly before the First World War one asylum provided a breakfast consisting of tea with a little

1. quoted in HUNTER, Richard and Ida MacALPINE: op.cit., p.116.
 2. A Descriptive Notice on the Sussex Lunatic Asylum, p.260.
 3. ANON: op.cit., pp.22-4.

sugar and bread and margarine. For dinner there was meat or tinned beef and sometimes fish, sprouts or potatoes, beans or dried peas. At tea-time there was more bread and margarine.⁽¹⁾ At West Riding the staple vegetables were potatoes and rice, which appeared on alternate days⁽²⁾ and much later a fortnightly fish dish was introduced.⁽³⁾ Table XXIX shows the advertised diet at Mapperley Hospital, Nottingham, which nevertheless looks unrealistically optimistic. Were actual diets as generous as shown here?

If these figures seem to suggest an adequate, though not always abundant diet, there were nevertheless discrepancies which seriously undermined the therapeutic value which doctors attributed to asylum food. According to the House of Commons Select Committee in 1877,

"the dietary in the asylums, certainly around London, is much below the normal standard, according to the received quantities. I have calculated the dietaries of different asylums, or got them calculated, and I find that they are below the average determined by Dr. Lyon Playfair's inductive experiments for even moderate exercise; they are barely above the requirements for quiet. An excited person in an asylum would be wasting more tissue than would be replaced by such a diet". (4)

Andrew T. Scull describes this as

"the practice of keeping all inmates on a diet barely above starvation level". (5)

This assertion, however, seems unnecessarily extravagant. We need not take Dr. Playfair's or the Select Committee's nutritional calculations with quite the degree of apparent scientific accuracy which is implied here. A level of nutrition "barely above starvation" would in time produce familiar symptoms of emaciation for which no evidence exists in regard to asylum inmates. However, there was no doubt much scrimping on diets which were rarely any more than sufficient to begin with.

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1. LOMAX, Montagu: The Experiences of an Asylum Doctor. 1921.
 2. Quarterly Report of the West Riding Lunatic Asylum, 29th October 1885.
 3. Eleventh Annual Report of the Nottingham Borough Asylum, 1890.
Mapperley Hospital Library.
 4. Report of the House of Commons Select Committee, 1877, p.307.
 5. SCULL, Andrew T.: Museums of Madness, the Social Organisation of Insanity in Nineteenth Century England. 1979, p.203.

Table XXIX

PATIENTS' ORDINARY DIET TABLE
Mapperley Asylum

BREAKFAST

- * Males - 1 pint Coffee (a), 8 oz Bread, $\frac{1}{2}$ oz Butter.
Females - 1 pint Coffee, 6 oz Bread, $\frac{1}{2}$ oz Butter.

DINNER

SUNDAY	{	Males - 6 oz Cooked Meat, free from bone, 14 oz Vegetables, 4 oz Bread, $\frac{1}{2}$ pint Milk.
		Females - 5 oz Cooked Meat, free from bone, 12 oz Vegetables, 3 oz Bread, $\frac{1}{2}$ pint Milk.
MONDAY	{	Males - $5\frac{1}{2}$ oz Cooked Meat, free from bone, 14 oz Vegetables, 4 oz Bread, $\frac{1}{2}$ pint Milk.
		Females - $3\frac{1}{2}$ oz Cooked Meat, free from bone, 12 oz Vegetables, 3 oz Bread, $\frac{1}{2}$ pint Milk.
TUESDAY	{	Males - Meat Pie (containing 4 oz uncooked Meat and 12 oz Vegetables), $\frac{1}{2}$ pint Milk.
		Females - Meat Pie (containing 3 oz uncooked Meat and 12 oz Vegetables), $\frac{1}{2}$ pint Milk.
+ WEDNESDAY	{	Males - 13 oz Fish, 14oz Vegetables, 4 oz Bread, $\frac{1}{2}$ pint Milk.
		Females - 10 oz Fish, 10oz Vegetables, 3 oz Bread, $\frac{1}{2}$ pint Milk.
THURSDAY	{	Males - Irish Stew (containing 4 oz uncooked Meat) 14 oz Vegetables, $\frac{1}{2}$ pint Milk.
		Females - Irish Stew (containing 3 oz uncooked Meat), 10 oz Vegetables, $\frac{1}{2}$ pint Milk.
FRIDAY	{	Males - 6 oz Boiled Pork, cooked and free from bone, 14 oz Vegetables, 4 oz Bread, $\frac{1}{2}$ pint Milk.
		Females - 5 oz Boiled Pork, cooked and free from bone, 12 oz Vegetables, 3 oz Bread, $\frac{1}{2}$ pint Milk.
SATURDAY	{	Males - 1 pint Soup, 6 oz Suet Pudding, 5 oz Bread, $\frac{1}{2}$ pint Milk.
		Females - 1 pint Soup, 4 oz Suet Pudding, 3 oz Bread, $\frac{1}{2}$ pint Milk.

TEA

- Males - 1 pint Tea (b), 8 oz Bread, $\frac{1}{2}$ oz Butter.
Females - 1 pint Tea, 6 oz Bread, $\frac{1}{2}$ oz Butter.

SCALE for (a) COFFEE PER GALLON - $1\frac{1}{2}$ oz Coffee, 1 oz Chicory, 4 oz Sugar
1 pint Milk.

SCALE for (b) TEA PER GALLON - 1 oz Tea, 4 oz Sugar, 1 pint Milk.

PATIENTS' ORDINARY DIET TABLE
Mapperley Asylum

MALE ATTENDANTS AND SERVANTS

Are allowed daily - 8 oz Meat (cooked and free from bone) 1 lb Vegetables,
1½ lb Bread, and ¼ pint Milk. Weekly - 2 oz Tea, 3 oz Coffee,
14 oz Raw Sugar, ½ lb Butter, ½ lb Cheese, 1 lb Bacon.

FEMALE ATTENDANTS AND SERVANTS

Are allowed daily - 6 oz Meat (cooked and free from bone), 12 oz Vegetables,
1 lb Bread, and ¼ pint Milk. Weekly - same as the men.

The Male and Female NIGHT ATTENDANTS have, in addition, weekly, 1½ oz Tea,
and 8 oz Sugar.

+ On every alternate Wednesday, Soup and Rice Pudding are given in
lieu of Fish. Working Patients have for Lunch: Males - 3 oz Bread,
1 oz Cheese, ¾ pint Milk. Females - 2 oz Bread, 1 oz Cheese,
½ pint Milk.

* The feeble Epileptic and Paralysed Patients have - Porridge, 1 pint,
Milk, ½ pint.

SOURCE: Annual Reports of the Mapperley Lunatic Asylum, 1891.
Mapperley Hospital Library.

At any rate, quantities of food and drink seem to have been kept at a conservative minimum, despite falling prices for foodstuffs towards the end of the century. The average weekly cost of pauper patients in 1857 varied between asylums from 7/- (35p) to 10/- (50p) per head. Of this sum rather more than 5/- (25p) appears to have been spent on food. The old Nottingham asylum, with a weekly cost figure of 8/2½d (41p) per patient, spent 5/2¼ (26p) of this on "provisions" and another ½d (0.2p) on beer, while York, with the lowest cost figure of 7/1 (35.4p) per patient, spent 3/3½d (16.5p) on food and drink.⁽¹⁾ In 1883, the aggregate costs of all county asylums came to 9/2¾d (46.1p) per patient per week, of which 4/3½d (21.5p) was spent on food and another ¾d (0.3p) on beer.⁽²⁾ By 1890 the respective figures were 8/7¾d (43p) and 3/6¾d (17.7p) (including "malt liquor").⁽³⁾ Obviously, savings made from falling food prices were spent elsewhere, probably on additional items of furniture and decoration, or 'extras' such as tobacco, while the diet provided remained more or less constant. The only real changes seem to have been the introduction of tea towards the end of the century (which was general throughout institutional care and reflected the growing exports from the Indian tea-plantations⁽⁴⁾) and the substitution for butter of the cheaper new product, margarine.⁽⁵⁾ All this compares not too unfavourably with diets in general hospitals which, though apparently a little more generous on the whole, were nevertheless unchanged during the whole of the century. As Abel-Smith comments,

"The diet of patients was much the same as it had been seventy years earlier except (by 1883) for the introduction of tea The daily diet for males in St. Bartholomew's consisted of half a pound of meat, half a pound of potatoes, one ounce of butter, fourteen ounces of bread, two pints of tea and two pints of beer". (6)

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1. Twelfth Report of the Commissioners in Lunacy, 1857/8. Appendix C, pp.34-5.
 2. Thirty-Eighth Report of the Commissioners in Lunacy, 1884, pp.86-7.
 3. Forty-Fifth Report of the Commissioners in Lunacy, 1890/1, pp.48-9.
 4. see e.g. BRUCE, Maurice: *The Coming of the Welfare State,* 1961.
 5. HUNTER, Richard and Ida MacALPINE: *op.cit.,* p.117.
 6. ABEL-SMITH, Brian: *The Hospitals, 1800-1948.* 1964, p.42.

However, two factors tended to mitigate the effectiveness of the asylum diet: the institutional routine and the quality of preparation. As regards the former, meals were always provided at set times and with unchanging regularity. Once at the large dining tables the food had to be eaten with the utensils provided, which might be only an iron spoon. At one asylum patients were issued with a blunt knife and a fork with points but no prongs. The attendants carried a sharp knife and fork on a chain around their necks.⁽¹⁾ Patients had to ask for food to be cut up if required. No food was available outside of these set mealtimes. At night, not even a drink of water was possible at some asylums. Quite commonly, the last meal of the day would be at about five or six o'clock and breakfast would not be served until eight or nine the next day, which meant as much as fifteen hours without food or drink.⁽²⁾

The impact of the second factor, food preparation, is likewise uncertain. It seems clear, though, that with quantities kept at a modest level, the quality of the cooking had a significant effect upon standards of nutrition and general health. If the same "adequate" quantity was always prepared in the same, tediously predictable way, as was generally the case in large institutions, it lost much of its appeal and therefore value. Appetites were lost and digestion was poor. This may have served the logic of the deterrent workhouse (the model for so much institutional care) but hardly seems favourable in an institution geared (supposedly) to a therapeutic regime. However, such regularity did at least solve the problems of the patient who had come into the asylum after living for some time on the economic margins of society, with no regular source of nourishment (and there may well have been some of these, see Chap. 4). For the rest, however, such fixed routines were a part and parcel of institutionalised life, and may have been actually detrimental to cure.

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1. ANON: op.cit., p.22.
 2. SCOTT, James: Sane in Asylum Walls; a true narrative. 1931, pp.138-9.

b) A CLOSED WORLD

We left our two ex-patients, like their other contemporaries, waiting around in the long corridors of a strange, enclosed world. Now that we have spent a little time looking at the physical features of this world (with rather more detachment than its inmates) we can move on to consider its less definable aspects. But though quality of life is hard to define its impact on personal well-being is crucially important in a study of the likely therapeutical effects of the asylum upon its inmates. We need, then, to proceed with a degree of sympathetic imagination with which to vitalise some otherwise commonplace observations.

We have noted already two recorded first impressions of the shock of social translation from free individual to asylum inmate. One more may be recorded here, that of a playwright who calls himself simply "a sane patient" (though probably no more or less "sane" than many pauper lunatics). For this sensitive man the experience led to introspection and depression.

"About my identity I felt puzzled, and was a good deal occupied in arguing out with myself who I might be, from various insufficient data A short time before, I had been the possessor of home, family, name and friends; and at the time when I needed all those most, I suddenly found myself an unregarded cypher, a worn-out garment cast aside, an unowned 'Jo' at his crossing, and robbed of man's right of freedom without the mockery of a trial". (1)

Even those small but intensely personal things such as one's choice of clothing or the arrangement of one's living-space were controlled by the asylum. On entry, each person's clothes were removed and kept by the Poor Law guardians responsible for their keep⁽²⁾ and asylum-issue clothing provided instead.*⁽³⁾ In the dormitories where the patients slept there was seldom

* Much of this was made on the premises by patients in the tailors' shops. Other clothing was supplied by 'specialists', e.g. Charles Roope & Son, 144 Sloane Square, London. (See HUNTER, R. and I. MACALPINE: Psychiatry for the Poor, 1974, pp.133-5).

1. A SANE PATIENT: My Experiences in a Lunatic Asylum. 1879, pp.80-1.
2. The 1890 Lunacy Act, paras. 286, 1, and 290.
3. LOMAX, Montagu: op.cit.

a locker or any place to keep one's own things.⁽¹⁾ These are precisely the kinds of event which Erving Goffman describes as "processes of mortification",⁽²⁾ tending to strip away the physical associations with a previous social identity and leave the new inmate exposed to the anxieties of social dislocation. Our anonymous ex-patient describes how he spent his early days

"pacing across and athwart day-rooms and the airing-court day after day, wondering, fearing, and contending with my mental misery. How to bear up I knew not. This state continued, with little variation, for two months".⁽³⁾

Thereafter a more regulated institutional identity began to take its place.

There were, however, occasional reliefs for most patients from such a fate when visitors called at the asylum, but this was so rare, and the circumstances so strange, that these glimpses of the "outside" may have hurt more than they healed. The rules on visitors laid down by the Commissioners in Lunacy were in any case very strict. Permission was discretionary and visits were limited to specific times. At no time were visitors allowed in the wards.⁽⁴⁾ Patients were allowed only one visitor at a time and a strict time limit was imposed, in one instance, of fifteen minutes.⁽⁵⁾

Visits were consequently relatively infrequent. The 'Patients Visiting Book' at Mapperley Hospital, Nottingham, shows that in the year 1900 there were 1,230 visits for a population of around 200 (the book recorded only visits to male patients. Its counterpart appears to have been lost).⁽⁶⁾ Curiously, the visiting book, which lists the degree of relationship of visitor to patient, shows that only one person that year was described as a

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1. GRANT-SMITH, Rachel: op.cit., p.93.
 2. GOFFMAN, Erving: op.cit., Chap. I.
 3. ANON: op.cit., p.21.
 4. MERCIER, Charles: op.cit.
 5. ANON: op.cit., p.81.
 6. Patient Visitors' Book, Mapperley Hospital, 1890. Mapperley Hospital Records.

"friend". It seems visiting was usually restricted to relatives (generally "mother", "father", "sister", "brother", "spouse" or the occasional "nephew"), a factor which might even have enforced the fact of social isolation upon many inmates.

The visits themselves would have been conducted in circumstances untypical of either asylum life or the normal "outside" relationship. Visitors to one asylum were always shown the well-tended garden and often met their inmate relatives there, despite the fact that the garden was never used at any other time.⁽¹⁾ At most asylums special "reception rooms" would be set aside (the same room, no doubt, which Grant-Smith first entered when she was committed to the asylum) where patient and visitor met on 'neutral' ground. There seems no reason to suppose that visiting was a significant part of the patient's new world, merely an occasional reminder of the past.

What new associations, then, did the asylum offer to the raw recruit with which to forge a new life inside its walls? There were, perhaps, three kinds of association which were available to the new patient. Firstly, the officially organised routines of work and relaxation which were initiated by the staff. Secondly, there were the associations which were formed as an indirect consequence of asylum administration, that is, of its discipline, its regularity and "medical" routines which, though not intended as a deliberate basis for social organisation, were nevertheless the medium through which patient interactions of various kinds were bound to occur. Lastly, there were those associations which the patients formed for themselves, by their own initiative, and which were not an intended part of the official asylum regime.

1. GRANT-SMITH, Rachel: op.cit., p.99.

(i) Work and Relaxation

The asylum was always far more than a place of mere incarceration. It was also a workplace, a playground, a training school and a home. It was an organised system of activity even though many patients had little more to do in it than sit idly in day-rooms or wander about the corridors and grounds. Yet even these inmates were fragments of the total institution, marked by its rules and its boundaries. We have already made reference to work as a therapeutic regime.⁽¹⁾ Regular work was not, however, merely therapeutic, whatever doctors cared to say about it. For the asylum to function a whole host of tasks needed to be performed, not all of them very pleasant. Who better to do these tasks than the patients themselves? As Charles Mercier argued, "occupation" was something which could combine distraction from mental problems with something useful, like making rugs or stuffing cushions. Comparatively undemanding jobs such as polishing and cleaning could easily be performed by otherwise incommunicative patients, so that they were not entirely lost to the social world. Even "idiots" could scrub the floor.⁽²⁾ Everyone could be involved in one way or another in doing something "useful".

Not all mental physicians thought they were being as useful as they might. Andrew Wynter commented that

"at present by many patients the work is looked upon as a mere diversion, it lacks the stimulus that urges on a man in the world".⁽³⁾

But then Wynter was a Scot. A less dour attitude to labour, though more practical from the institutional point of view, seems to have been the rule. Some patients were set to pick coir for coconut matting and others worked in the cobblers' shop, repairing boots.⁽⁴⁾ For those who were capable of it,

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1. Chapter 3, pp.117-119.
 2. MERCIER, Charles: op.cit.
 3. WYNTER, Andrew: The Borderlands of Insanity and other applied papers. p.123.
 4. IOMAX, Montagu: op.cit., p.105.

there was always work to be done in the carpentry shops, weaving shops, shoe-repairers or the farm-buildings. Less capable, or perhaps less "acceptable" patients could be put to use in more manual labouring jobs such as scrubbing and digging. This last point seems relevant from a remark by Mercier that

"to set (higher class patients) to scrub floors is not merely an indignity but a waste. They may often be found very useful in the stores or the clerk's office". (1)

Such nice attention to outside social status does not, however, seem to have been universal, as Rachel Grant-Smith discovered when she was "astonished" at having to work in the laundry.⁽²⁾ But then, she had never been a working woman, unlike most of her female contemporaries. In all probability, a rough distinction was observed amongst the male patients between the skilled and the unskilled, but for the women there could be no such distinction. The woman's place was as carefully allotted inside the asylum as outside. According to Mercier,

"The laundry and the kitchen are to the women what the artizan's shops are to the men, and find occupation for a large number". (3)

As Elaine Showalter has suggested, "sex roles determined the division of labor even more rigidly than outside the walls. Male patients worked at a variety of jobs in workshops, in the gardens, and on the asylum farms. Women's employment offered much less choice, took place indoors, and in many cases was meaningless make-work. Cleaning, laundry and needlework were the primary tasks In Conolly's scheme for a model asylum, the traits he thought appropriate for women patients were projected onto his optimistic vision of their happy hours making puddings in 'the busy and cheerful and scrupulously clean kitchen'. These occupations were still a considerable step above those reported by Granville at Bethnal House, where women had

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1. MERCIER, Charles; op.cit., p.99.
 2. GRANT-SMITH, Rachel; op.cit., p.96.
 3. MERCIER, Charles; op.cit., p.97.

spent their days sorting colored beads into separate piles which were dumped back together again at night".⁽¹⁾

This naturally leads us on to consider how far patients were merely being used to supply cheap labour. The question is made complex by the fact that the asylum was to some extent a self-supporting society. There was surely no real objection to patients' performing useful work if those same inmates could, as a group, reap the benefits. But how far was this the true picture? The asylum authorities did, of course, employ ordinary paid labour. We know that these included builders, carpenters, engineers, painters, glaziers, tailors, shoemakers, bakers, brewers and laundry and kitchen staff. These were mostly provided with accommodation on asylum premises. In addition, various tradesmen who lived outside the asylum were also employed.⁽²⁾ The numbers of such staff were probably minimal. The note in the 'Journal of Mental Science' in 1860, describing the new Sussex asylum, refers to all those artizans in the singular.⁽³⁾ They were all (except the "tradesmen") expected to share in the asylum routine, however, and were no doubt required to take on patient labour as part of their duties.

There is no doubt that this could save money, for patients were not paid. They were instead "rewarded" with extras, such as tobacco or snuff or extra tea, or with privileges such as being allowed to stay up late.⁽⁴⁾ When unpaid labour was combined with the use of asylum land (and asylum sewage, as we saw earlier) the cost of feeding inmates could be considerably reduced. This left more of the basic asylum finances available for spending on other costs, including the cost of the doctors' own meals. With

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1. SHOWALTER, Elaine: Victorian Women and Insanity, in SCULL, Andrew, (ed): Madhouses, Mad-Doctors and Madmen (sic): The Social History of Psychiatry in the Victorian Era. 1981. pp.320-1.
 2. A Descriptive Notice of the Sussex Lunatic Asylum, pp.255-6.
 3. ibid., pp.255-6.
 4. LOMAX, Montagu: op.cit., p.110.

a fixed salary, any saving through the use of patient labour must have increased the provision of food and other goods which the staff received as their 'perks'. This allowed an incentive for staff to set their patients to such work, with questionable results.

Lomax records⁽¹⁾ that at his asylum demented patients were used to clean out the earth-closets and cart the contents to the farm. This was cheaper than installing piped water to all parts of the asylum and sewerage pipes to the farm premises. The conditions under which these wretches worked was abysmal. They ate breakfast in an open shed and Lomax estimated that 25% of them caught pneumonia within six months. Many patients refused to work under these conditions, even for "extras", for "lunatics are not all fools", but many others did work, probably out of sheer boredom. Of course, this particular case may well have been exceptional (the copy of Lomax's book from which I worked was heavily annotated by a contemporary asylum doctor who hotly denied seeing any such thing where he worked) but the possibilities were always there. Once again, it would seem to have depended upon the individual medical superintendent whether an asylum tended to exploit its inmates for labour or use their abilities more constructively.

In all probability, the attitude of staff towards their patients were not those of employer towards wage-earner, not only because inmates did not have that dependency for their livelihoods but also because doctors saw themselves as medical men and the work routines as largely therapeutic. A more general attitude toward patients as workers seems to have been that of patriarchal benevolence - though the degree of benevolence must be the subject of some speculation. Doctors saw their role as that of the father-figure or perhaps the squire of a country estate, providing benefits, guidance and carefully allotted "extras" by way of encouragement, and no doubt

1. ibid., p.108.

many patients responded accordingly. A photograph of the Stanley Royal Hospital* museum shows the kitchens at the turn of the century worked by paid staff and assisted by trusted patients who were regarded as "pets".⁽¹⁾ The obverse of this paternalist system was the disciplinary effect of the denial of "privilege", punitive work (such as coir-picking, a task similar to that given to the inmates of workhouses and prisons) and certain "medical" routines such as administering croton oil as a severe purgative or even seclusion in a single room. If the "privileges" were given to those quiet and trusted patients who gave no trouble then clearly the disciplinary routines were reserved for the noisy, the awkward and the generally unmanageable. Paternalism in labour-usage became one with "medical" treatment. (Indeed, the phrases "quiet and useful class" and "dirty and degraded class" abound in the medical literature).

After work came play. Even here, paternalism dominated. The asylum organised a range of activities for relaxation and pleasurable enjoyment, all controlled carefully by the staff and led by the superintendent himself, taking on the role of the head of the household. In the summer months, cricket proved to be a popular entertainment, with staff and patients forming their own teams.⁽²⁾ Further evidence of a stress upon competitive games comes from the accounts of athletics meetings and football matches.⁽³⁾ However, this emphasis on competition was mitigated by the regular dances and concerts that were held,⁽⁴⁾ with again the superintendent in the role of Master of Ceremonies.⁽⁵⁾ Many printed programmes for such concerts can be

* Then the West Riding Lunatic Asylum.

1. From a photograph in the Stanley Royd Museum, Wakefield, with comment by Mr. A.L. Ashworth.
2. HUNTER, Richard and Ida MACALPINE: op.cit., p.76.
3. Quarterly Reports of the Nottingham Borough Asylum, 30th July 1885; Mapperley Hospital Library.
4. ibid., 24th March 1892.
5. MERCIER, Charles: op.cit., p.201.

found in various museums⁽¹⁾ and they clearly show that some kind of co-operative integration was attempted, with patients, doctors and attendants joining in the cast. Sometimes a 'magic lantern' show would be integrated into the entertainments.⁽²⁾ As for the dances, these were generally a weekly attraction and occasionally might be held in the grounds.⁽³⁾ If not dancing, then tea parties might often be held on the asylum lawns, and an imaginative and dedicated medical superintendent would vary the mixture of entertainments sufficiently to overcome the tedium of a regular routine.⁽⁴⁾ It was sometimes even possible for patients to be given money and to visit local pubs.⁽⁵⁾ Even when left to themselves indoors, a careful selection of reading was made available which sought to extend the paternalist influence into patients' spare time. A large quantity of bibles were provided, at specially reduced rates from the Christian Knowledge Society, and care was taken to encourage participation in religious services, even to providing cotton umbrellas to shelter inmates on their way to the asylum chapel. As well as bibles, other books were provided as reading matter "for the use of patients in the dining hall who do not smoke but who prefer to devote a part of their dinner hour (n.b! So tight were asylum routines!) to reading".⁽⁶⁾

What kind of stimulation towards "normal" behaviour did this system of organisation give to individual patients? The evidence is not optimistic. Apathy, rather than rebellion or positive integration with the asylum's paternalist routines, is everywhere indicated. Not all of this social

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1. e.g. Nottingham Borough Hospital Library; Stanley Royd Hospital Museum, Wakefield; Wellcome Institute for the History of Medicine, London.
 2. Quarterly Reports of the Nottingham Borough Asylum, 24th March, 1892.
 3. ibid., 30th July 1885.
 4. ibid.
 5. DAVIES, F. Pritchard: Chemical Restraint and Alcohol. Journal of Mental Science, NS 80, Jan 1881, p.258.
 6. Quarterly Reports of the Nottingham Borough Asylum, 29th July 1858; ibid., 31st October 1861.

withdrawal was the result of "mental disease". W.A.F. Browne, in his lecture 'The Moral Treatment of the Insane', remarks that,

"in the vast asylums now extant all transactions, moral as well as economic, must be done wholesale". (1)

This was the consequence of the size of asylums, many of which held over a thousand patients. Inside such a vast edifice, the individual patient was easily lost sight of. As Mercier remarked;

"great individuality of treatment is not to be attained so long as the structure of the asylums provides only for the treatment of the insane in bulk". (2)

Indeed, despite the appearance of originating with the superintendent's bounty, the entertainment routines we have been describing were obviously, like work routines, a part of the total asylum's regulation, almost a part of an unchanging self-perpetuating system. This could easily lead to regimentation. Andrew Wynter described one such entertainment, a dance, in which this effect was clearly apparent.

"At nine precisely, although in the middle of a dance, a shrill note is blown, and the entire assembly, like so many Cinderellas, breaks up at once and the company hurry off to their dormitories". (3)

This was in 1857. With the steady growth of the asylum throughout the rest of the century (and beyond) it seems doubtful if these scenes were much modified.

However, the point is not so much the size of the asylum alone, as the effectiveness of the medical organisation within the asylum in coping with so many patients. This point is seldom made. A poorer patient/staff ratio might still have been effective if the available staff were organised more productively. The nineteenth century asylum remained wedded firmly to its authoritarian structure with all power vested in the superintendent and

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1. BROWNE, W.A.F.: The Moral Treatment of the Insane. 1864, p.18.
 2. MERCIER, Charles: op.cit., p.3.
 3. WYNTER, Andrew: Lunatic Asylums. Quarterly Review. Vol.101, Apr. 1857, pp.375-6.

seems to have reacted to increasing numbers of patients with greater degrees of regimentation. Yet if the medical staff had improvised different methods of deployment (perhaps involving greater delegation of responsibility and control) it is possible that the obvious failure of socialisation at the lower levels of asylum society (that is, amongst the patients) might have been mitigated. That such an option did not occur to mental physicians merely reflects the times in which they were living. Nevertheless, the evidence does not suggest that the strategy which doctors did adopt was at all productive.

It is true, of course, that asylum inmates were unlikely to make well-integrated elements within institutional society. A very great many of them were there, no doubt, as a result of their failure to integrate into the outside world in acceptable ways. Yet in view of the weight that was attached to the importance of "individualising treatment"⁽¹⁾ the failure to improve social integration must be seen as a major criticism of the asylum method. Certainly, doctors were aware of this failure, regarding what we might now call an "institutional syndrome" of bored detachment as the product of mammoth asylums. But this was an evasion. Mental physicians mounted a sustained campaign for smaller asylums, but never questioned the validity of the asylum itself or the medical organisation within it.

It seems a reasonable conclusion to draw that the paternalist style of control, with power stemming from one man and mediated through his (usually very small) staff was not adequate to effect even what passed for treatment in the nineteenth century, and became still less so as patient/staff ratios grew worse. The result was that medical men grew ever more remote from their patients and relied increasingly on the normal institutional bureaucracy to keep things ticking over. Critics, such as Wynter, noted that the monotonous atmosphere inside the asylum was

1. See Chapter 3, p.107.

"very well suited to a workhouse, but totally unfitted to an asylum for mental cure. Individuality is entirely overlooked; indeed, the whole system of life is the opposite of the ordinary mode of living of the working classes. When the visitor strolls along the galleries filled with listless patients, the utter absence of any object to afford amusement or occupation strikes him most painfully". (1)

It was a picture all too common in the Victorian mental asylum.

(ii) Rules and Regulations

Left to themselves patients were mostly lethargic and aimless. One can hardly blame them. Many were in no fit mental state for active life. Others had simply lost all interest after so many identical months of asylum living. Finnane has shown that inmates often lost all sense of time and when asked by doctors what date it was or when they had been admitted could not remember (which was often taken as a sign of continuing insanity). "What did time mean", he asks, "in the asylum which was arranged to eliminate it?"⁽²⁾ Organised work and games might exercise their bodies but they do not seem to have engaged their minds. In the hours of waiting for meal-times or some other asylum fixture they remained passive, almost like objects rather than people.

Yet this appearance may have been deceptive. The whole organisation of the asylum tended to passivity because all social initiatives rested with the administration, especially with the authority of the medical superintendent. Even so, it is still possible that the minds of patients were exercised in ways which medical authority did not see or recognise as purposeful behaviour. Such exercise would have to contend with the regimentation of asylum social life before all else. Therefore it is necessary to consider how far these asylum routines actually fostered a

1. WYNTER, Andrew: Non-Restraint in the Treatment of the Insane, Edinburgh Review, 131, 1870, p.223.
2. FINNANE, Mark: Insanity and the Insane in Post-Famine Ireland. Ireland. 1981, p.187.

passive compliance as a kind of positive behavioural response before we dismiss the possibility of patient-initiated behaviour inside the asylum.

For those who lived under its constant routines life was likely to become an endless succession of mute submissions. For example, those daily routines which constituted the asylum's "medical" function could generally rely upon each inmate allowing himself to be treated as an object beneath the doctor's scrutiny. Thus it was in some places an everyday occurrence for temperatures to be taken (under the arm-pit, very commonly) once or even twice a day.⁽¹⁾ Only the "maniacal" resisted. It was through such a routine that Clouston constructed tables of body temperatures in the "insane" which were published in an article for the 'Journal of Mental Science'.* All the familiar routines of bathing and feeding similarly helped to enforce the notion of the inmates as objects to be "serviced" (though, with the numbers of helpless and demented which we know existed, this must have been unavoidable in many cases).

Medical routines were, however, only a very small part of the normal asylum lifestyle. Far more pervasive were the rules and regulations governing the institution's whole internal procedure. In a sense, these regulations laid down a certain pre-condition for all social life, a base-line from which the usual human relationships had to operate. All human life was regulated by the asylum clock. At the Cumberland and Westmoreland asylum

* This was an unfamiliar business to most new patients. Clouston notes that many women insisted that "I was finding out the amount of ill-temper in each of them, and many a sly innuendo was put forth as to the quantity that would be found in certain of the touchy and irascible. Great anxiety was usually manifested to know at the conclusion if there was much ill-temper found. On the other hand many terrible effects were attributed to the harmless bit of glass. It sucked the blood out of some and the spirit out of others; it made some cold in that side for days, and others hot as long; while in one happy case it killed some rats that had been feasting on the woman's entrails for years!" It may be stretching a point to see in the concern with "ill-temper" an internalisation of the doctors' dominative attitude to treatment.

1. CLOUSTON, T.S.: op.cit., pp.35-6.

patients were expected to rise at 6.15 a.m. and go to bed at 8.00 p.m.⁽¹⁾
 At the West Riding Asylum the time of rising was 6.00 a.m.⁽²⁾ All administrative routines followed this fixed pattern, with set times for meals, exercise and Sunday religious services. At yet another establishment the patients rose at 6 a.m. in summer (7 a.m. in winter) to the shouts of attendants and began the day prison-like by "slopping out". Patients had to be back in bed by 8 p.m.⁽³⁾

Regulations governing the quality of social life bit even deeper. Probably no regulation was more fundamental in this respect than the rigid segregation of the sexes. No explicit reason was ever advanced for this apart from the middle-class virtue of "decency" and one is left with the impression that mental physicians regarded all "lunatics" as sexually unreliable. No doubt physicians also had in mind a reluctance to allow their "degenerate" condition to propagate itself.* Nevertheless, so rigid a system of demarcation smacks more of bureaucratic mentality and a desire for order and discipline than any practical measure to discourage promiscuity. Sexual segregation was anyway the rule in analogous institutions such as prisons, schools and workhouses.

Segregation in a place devoted to creating "normal" lifestyles out of "insane" individuals was not, however, likely to prove very productive. This fact was appreciated by many doctors, including Andrew Wynter, who wrote that

"the men, only a stone's throw off (from the women's wards) herd hopelessly together, starved of some of the best feelings of ordinary life, such as arise from social intercourse with the other sex". (4)

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1. CLOUSTON, T.S: Observations on the Temperature of the Body in the Insane, Journal of Mental Science, XIV, 65, April 1868, p.35.
 2. Quarterly Report of the West Riding Asylum, 3rd October 1861.
 3. ANON: op.cit., p.19.
 4. WYNTER, Andrew: The Borderlands of Insanity and other applied papers. 1875, p.112.

* See Chapter 2, pp.76-81, on the hereditary transmission of the lunatic condition.

The anonymous author of "Life in a Lunatic Asylum" records that for well over a year he was not allowed to see his wife, who was in the same asylum. Once, they chanced to see one another in the grounds, when in separate parties. When she saw him she rushed into his arms, but the superintendent was furious because he did not repel her embrace, threatening that if it happened again he would be confined to the building. On one other occasion they saw one another at a distance in the dining hall. She was forcibly turned away.⁽¹⁾ The only official time when the sexes were allowed to meet was on the dance-floor or as part of some other, carefully supervised, official activity. Such arrangements scarcely encouraged a normal social development.

Life in the male wards was "dismal precision" and "dreary apathy" according to Crichton Browne, while in the female wards there existed "an air of wholesome cleanliness and hopeful solicitude".⁽²⁾ The nurses in these wards would sometimes strike up a lively song such as "I hear tell of a better land", while they were going about their cleaning and bed-making,⁽³⁾ and seemed to be more helpful than their male counterparts. However, the principle of segregation remained as strong as ever throughout the century. In a design for a new asylum submitted in 1886 Cobbold noted approvingly

"the building is so arranged that if patients of both sexes were under treatment at the same time they would be kept thoroughly apart".⁽⁴⁾

Regimentation extended also into the daily working parties which went out onto the farm or the workshops. Our anonymous ex-patient describes how the

"coarse barking of the attendants, the violent unlocking of doors, coupled with the cropped heads and dresses of

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1. ANON: op.cit., pp.31-2.
 2. BROWNE, Crichton: Female Nursing in Asylums. Journal of Mental Science, XIV, 66, 1868, p.205.
 3. ANON: op.cit., p.96.
 4. COBBOLD, C.S.W.: op.cit., p.480.

the patients, are highly suggestive of prison discipline and convict life". (1)

The working party would leave at nine, when a bell would be rung. At eleven they would return for bread and cheese before setting back for work. At a quarter to one they returned for dinner. In the afternoon they worked from two until five. (2) Even times for relaxation were subject to the same treatment. Rachel Grant-Smith notes in her autobiographical account that the cry from the attendants which announced the exercise period was, "Turn 'em out!" (3)

It might be argued today that a fixed structure of routine such as this provided the necessary reinforcement to social interaction which many patients normally unable to make adequate socialisation in the more fluid outside world, would find helpful. Certainly one knew one's place in such a regime and in some senses it could serve as a crutch for an impaired ability to develop as an individual in the "normal" world, yet it does seem to have been a regime more influenced by military or penal systems of organisation than by any notion of providing individual support. This may have been more acceptable to working people of the period than may now be the case, however, since for a great many the armed forces were accepted as a last resort from the poverty and insecurity of the time. As far as refuge was concerned, the asylum may have been acceptable to some precisely because the social order of the day had less to offer them than in modern times.

(iii) The Context of Power

In all probability the asylum contained many people who were unmanageable, incomprehensible or disruptive. We cannot know how much of the

1. ANON: op.cit., p.34.
2. ibid., p.35.
3. GRANT-SMITH, Rachel: op.cit., p.99.

behaviour displayed by inmates and recorded in the evidence presented here was due to conditions which pre-existed the individual's life as an inmate and how much was due to an individual's response to asylum conditions. We can speculate that once inside the asylum, all behaviour tended to be regarded by the medical staff as part of the "disease" of insanity for which they had been admitted. The problem with this, however, is that we can see no practical distinction between the patient as an embodiment of insane symptoms and the patient as a whole human being. Consequently, inside the asylum, with all legitimate *initiatives for activity* held, designedly, by medical authority, any significantly self-willed activity by patients would in all likelihood be seen as a disruption of legitimate medical organisation and a challenge to the asylum's hegemony. Too much initiative by patients may have courted the staff's various powers of restraint.

For a key fact of asylum life was that the patient-staff relationship rested upon the dominance of one group (the medical staff and assistants) over the other (the inmates). This dominance was, in the last resort, maintained by the asylum itself, which was not only the "treatment"⁽¹⁾ but was also the tangible extension of the doctor's assertion of control in the field of lunacy. Within the walls of the asylum a relationship of power existed. It was like a drawn sword pointed down at the inmates, with the hilt firmly in the grasp of the medical superintendent. As we saw in Chapter 3 the therapeutic methods of the physician consisted largely of imposing an indiscriminately authoritarian regime upon the inmates in the hope of impressing "sanity" upon them by a system of regulation and discipline. It is obvious that inside the asylum such a vision renders the description "medical" redundant.

If any support were required for this assertion let us listen to Daniel Hack Tuke, the flat-footed visionary of the late nineteenth century

1. See Chapter 3.

asylum system.

"In what a strange land of shadows the superintendent lives! It becomes a matter of course that those with whom he mixes in daily life are of imperial royal blood - nay, more, possess divine attributes - and that some who are maintained for half a guinea a week possess millions and quadrillions of gold. He lives, in truth, in a world inhabited by the creatures of the imagination of those by whom he is constantly surrounded - a domain in which his views of life and things in general are in a miserable minority - a phantom world of ideal forms and unearthly voices and mysterious sounds, incessantly disputing his authority, and commanding his patients in terms claiming supernatural force to do those things which he orders them to leave undone, and to leave undone those things which he orders them to do in short, there is in this remarkable country, peopled by so many thousands of inhabitants, an imperium in imperio which renders the contest continuous between the rival authorities struggling for supremacy". (1)

Beneath the euphemism and schoolboy Latin it is clear that the aspect of insanity which comes most readily to Tuke's mind is the challenge to authority represented by the asylum inmates. The key issue for him is that of "struggling for supremacy".* All the devices of the asylum which he eulogised were turned to win that supremacy.

It was in the context of this power-relationship that patients made their social contacts. There was always something a little furtive about it and an element of rebelliousness was never far away. Patients were always

"prone to form cliques and coteries, each of which likes to appropriate a table or corner in the ward to its own more immediate use". (2)

Here patients made their individual friends. The author of "Life in a Lunatic Asylum" describes who he calls "my Intelligent Friend" who seemed to

* It is worth noting in this passage two points regarding the tone in which Tuke felt it was acceptable to talk about "lunatics". First, the levity, amounting to insult, of his description of the "strange land of shadows"; second, the collective description of the "insane" in bulk, with no sense of their individuality. Both points can be related to Tuke's assumption of the mental physician's "supremacy."

1. TUKE, D.H.: Chapters in the History of the Insane in the British Isles. 1882, p.464.
2. COBBOLD, C.S.W.; op.cit., p.474.

know all the asylum gossip and all the "skives" and "fiddles" - how to get tobacco, extra food or other advantage. A part of his "insanity" was apparently a perpetual headache, which he "put on" whenever work was being allocated so as to avoid undue exertion. Then there was his "white-washing and colouring friend" who, whilst painting the walls would engage him in a great deal of intelligent conversation.⁽¹⁾ Other of his friends were more obviously incapacitated mentally, yet made good companions if one took the trouble to get to know them. The writer thus describes

"Carrots, (who was) amusing and harmless if left alone, but being ill-treated was always in hot water - flung about, thrown down, cursed and called bad names; whereas when allowed he would sit on the floor of his padded room and amuse himself all day long, by simply tossing his bed about and drawing his arm backward and forward, fancying he was at work (painting pictures)" (2)

"Carrots" would always accept payment for his "work" in make-believe money. Another of his asylum friends was the alleged "idiot" who in fact proved to be merely deaf and dumb and consequently the subject of general abuse. Once having won his confidence his intelligence was clearly apparent.⁽³⁾ This writer, at least, found an adequate basis for his claim,

"I invariably found that, wretched as I was myself, a kind word, a kind look, or a kind deed, acted like magic upon the poor unfortunates who here abound". (4)

Kindness of that sort was seldom forthcoming from the asylum attendants who supervised every moment of the patients' lives. In general, it was these attendants rather than the doctors who were for the patients the immediate instruments of the asylum's dominance. They it was who lived with the inmates the whole time, keeping watch and exerting control at every turn.

"There was not a moment of the day or night which could be called private or helpful. Whether one were in the ward,

1. ANON: op.cit., p.37.
2. ibid., p.71.
3. ibid., p.84.
4. ibid., p.46.

the grounds, the dormitory, the lavatory, the dorridors, or anywhere else, one was always open to observation". (1)

Not that patients missed the opportunity to get their own back from time to time. When a new attendant was expected to say grace before dinner it became apparent that he could not remember the usual words.

"He can't say it!" cried a patient and the whole table laughed. (2)

The patients were also sharp enough to joke sarcastically about the staff's predilection for ascribing patient's aberrations to delusions,

"Delusions! Ha! We have often laughed together about delusions. 'What's your delusion, old chap?'
 'Oh, I always fancy a drink, mate!'
 'There's nothing in these sausages'.
 'Oh, they must be delusions!'" (3)

Lighter moments such as these testify to the resilience of the human spirit in even the most adverse circumstances. Even so, accounts of attendants given by ex-patients were seldom favourable. There was a further complication in that the attendants, whatever their shortcomings, were also the first people to be confronted in the passage through "recovery" to eventual release from the asylum. Meetings between patients and medical staff (apart from routine inspection by the medical superintendent of all the inmates, a process that was necessarily time-consuming and therefore, for each individual patient, brief) were arranged by the Head Attendant at the bidding of either his subordinate or the patient himself. (4) The inmates were therefore torn to some extent between distancing themselves from the attendants' constant presence for the sake of their humanity (one almost says "sanity") and placating them in the pursuit of their release. This is important since it hints at a contradiction in the patient-attendant relationship which must have coloured their interactions. However, the

1. SCOTT, James: op.cit., p.45.
2. ANON: op.cit., pp.81-2.
3. SCOTT, James: op.cit., pp.56-7.
4. MERCIER, Charles: op.cit., pp.243-4.

range of powers possessed by attendants made their dominance in the relationship a more immediate factor.

As well as acting as watchdog over inmates, they took a more positive role in enforcing the asylum's regime. To a large extent, they held patients at their mercy. The shower-bath or the seclusion room were always available to the attendant to control awkward behaviour, as were a range of unpleasant drugs, to which attendants commonly had unrestricted access.⁽¹⁾ Should occasion arise there was also the brutal process of force-feeding to be used at the attendant's suggestion, though often administered by a medical officer. Grant-Smith found this out when she refused her meal, claiming it had been drugged (which it may well have been). The nurse called for a doctor who, despite the fact that Grant-Smith had now relented, forced food down her throat by means of a wedge and funnel, the nurse remarking meanwhile, "You've lost your chance".⁽²⁾

Of course, it was never acceptable according to medical rhetoric to resort to "punishment", since this was deemed inappropriate for patients who suffered from a disease involving the loss of will.⁽³⁾ However, attendants generally did not share medical perspectives. For them, medical routines of "control" (which was acceptable for the insane) would be used with the justification (if challenged by the doctor) that the patient was in need of special treatment. (In any case, as we saw in Chap. 3, treatment even by doctors was often punishment under another name). In consequence, as Lomax pointed out,⁽⁴⁾ there were many ways "by which an attendant can get even with a patient without running any risk of dismissal". Sometimes these ways included straight physical assault, which could nevertheless be justified on the grounds of a patient's "homicidal" impulse. This did not

1. LOMAX, Montagu: op.cit., p.95.
2. GRANT-SMITH, Rachel: op.cit., pp.74-5.
3. See Chapter 3.
4. LOMAX, Montagu: op.cit., p.191.

always succeed and many attendants were dismissed for assault if it resulted in serious injury or death. Thus G.H. Day of the Durham Asylum was dismissed and subsequently charged with criminal assault.⁽¹⁾ Such occasions were by no means rare. Amongst the female attendants these assaults attained a refined degree of sadism. Maria Cringle was dismissed and prosecuted for smearing the soiled underclothes of a "dirty" (i.e. incontinent) patient across the patient's mouth and face.⁽²⁾ The male attendants could also abuse their power over patients with cruel results. The men, it seems, drew their responses from the mindlessness of military-style discipline, with all rules to be obeyed and no questions asked. The incident described by an anonymous patient, describing a fellow patient's death, typifies this response.

"When feeding him, just before his death, with salt broth, how he would clench his teeth, and bite the spoon! his beautiful eyes piercing me through. He who never spoke now shouted, 'Water! water! water!' I timid and fearful, not knowing what was right or what was wrong, went to the attendant to tell him that he wanted water. He, in his spiteful churlish manner, answered, 'Shan't have it'.⁽³⁾

Drinking water was not officially available on request but only at permitted times.

Although these remain isolated incidents they occur too frequently in the literature for comfort. What is more significant, perhaps, was the relationship between attendants and patients which allowed such abuses to occur so often. There is no doubt that patients were entirely exposed to whatever treatment the attendants meted out to them. With the attendant being regarded by medical authority as the patient's only sane companion⁽⁴⁾ there was usually little point in soliciting the aid of the attendant's superiors. If it happened that a nurse should respond to an assault by a

1. Thirty-Eighth Report of the Commissioners in Lunacy, 1884, p.108.
2. Forty-Second Report of the Commissioners in Lunacy, 1888, p.93.
3. ANON: op.cit., p.64.
4. See Chapter 3, p.124.

maniacal patient by beating the patient's head against a bed-rail and virtually throttling her, it was enough to explain the bruises to the doctor next morning by saying that she did it herself.⁽¹⁾ As a later writer, himself an ex-patient, put it:

"in the event of a man being injured by the wicked handling of the attendants, the trouble is usually explained away as having been done through the poor fellow's own violent actions. This easy explanation is usually accepted".⁽²⁾

It is a small wonder in these circumstances that the natural responses of patients could sometimes be distorted, either unintentionally or perhaps by design, into destructive impulses which seemed to threaten the asylum's raison d'etre.

An example of this might be the rash of glass-breaking which would sometimes occur. Lomax found this to be fairly common in his asylum, particularly after new buildings with large windows had been erected.⁽³⁾ He put this behaviour down to "claustrophobia", and recommended "a game of football, or work in the garden".⁽⁴⁾ To the attendants, however, it was simply refractory behaviour, to be "treated" by putting the patients into isolation (in this case in totally darkened cells). The attendants' reaction was understandable, since they were themselves held responsible, under pain of disciplinary procedure, for whatever happened to their patients. Moreover, as they had no say in the building arrangements, controlling the patients was their only recourse. Most probably, attendants simply regarded glass-breaking as a mental "symptom" rather than an expression of frustration.

This is not to suggest that such expressions were unaffected by whatever mental incapacitations each patient may have had, merely that incarcera-

1. GRANT SMITH, Rachel: op.cit., pp.86-9.
2. SCOTT, James: op.cit., p.114.
3. LOMAX, Montagu: op.cit., pp.82-8.
4. ibid., p.84.

tion in an asylum added to the problems and provided a specific social context in which behaviour had - sometimes destructively - to take place.

That "lunatics" were also people with feelings of their own is borne out by the efforts commonly made by patients to escape. It was for this reason that so much care was taken over security procedures such as locks and barred windows. In addition to this, all attendants were urged to count all their patients at every evening meal and also at bedtime to make sure that all were accounted for.⁽¹⁾ This urge to escape may have been for some patients an avoidance of the restraint put upon them by ever-watchful staff, and whatever their motives for avoidance - some patients missed at meal or other times were subsequently found to have killed themselves - Lomax's term "claustrophobia" was probably a fair description of their feelings.

Some patients were violent and could attack others around them without warning or provocation. Inmates soon came to recognise these and attendants were more than wary of them. In 1860 an attendant at West Riding was killed by just such an attack.⁽²⁾ More commonly, however, it was other patients who were at risk. William Latham, a patient, was killed by a blow from a wooden kneeling board wielded by another patient who, until that moment, had been quietly scrubbing the floor.⁽³⁾ Such patients were comparatively rare. Most patients' aberrations were of a more harmless kind.

In fact, the most common expression of destructive violence posed no threat to others' safety. Suicide was a form of violence turned inward,

1. Handbook for the Instruction of Attendants on the Insane. American Edn., Boston, 1886, p.110.
2. Register of Attendants at the West Riding Asylum. Stanley Royd Hospital Museum.
3. Quarterly Report of the West Riding Asylum, 20th June 1889.

and was far less rare than "homicidal" tendencies. "Suicidal" patients were so common that attendants had regular lists, known as "SS" lists (for "special suicidal").⁽¹⁾ These patients were never to be let out of the attendant's sight. Of course, many were automatically put on this list if it had been a suicide attempt which had led to their certification (see Chap. 4). Even so, suicides were a regular asylum occurrence, one year producing deaths by self-strangulation, drowning, falling from windows or down stairs, drinking linament, swallowing pins, needles or earth, and one "by placing his head in a bucket of water".⁽²⁾ Such attempts were often determined, as with a man at West Riding, described as "melancholic", who constantly asked to work in the shoemaker's shop. Once there he seized a knife and stabbed himself to death.⁽³⁾ Others have quietly slipped away and hanged themselves from window-panes or from trees.⁽⁴⁾

It is tempting to see in such actions an introversion of the violently aggressive behaviour described above. W.C. Sullivan in his seminal work on alcoholism in 1906⁽⁵⁾ noted that suicides amongst the population at large increased in direct ratio to the decrease in crimes of violence. If that holds good here, the suicide too may have been in some sense an "escape" from circumstances, whether of the asylum's oppression or of some other source we cannot tell. In any case, it hardly seems likely that a system of surveillance would help to alleviate the suicidal patient's problems. In reaction to his behaviour, as to other forms of aggression, the attitudes of staff were as much self-protective as (in these cases) protective of the patient. Suicides were reported to the Commissioners in Lunacy and as long as all security arrangements had been followed no-one was held to blame, the deaths being regarded as having been caused by insanity.

1. LOMAX, Montagu: op.cit., pp.70-2.
2. Fiftieth Report of the Commissioners in Lunacy, 1896, pp.26-7.
3. Quarterly Report of the West Riding Asylum, 27th April, 1882.
4. ibid., 3rd October 1861.
5. SULLIVAN, W.C.: Alcoholism, a chapter in social pathology. 1906.

c) CONCLUSION

Before leaving this area of study we need to remind ourselves once again of the atypical nature of the autobiographical sources which we have been obliged to use. Because these writers were articulate and apparently used to a higher standard of life than their unfortunate companions in the asylum they may have been unusually repelled by much of what they saw there. This might, in any case, be assumed from the fact that they saw fit to publish such accounts in the first place. As a result of using these sources we may have painted a darker picture of asylum life than more typical inmates would have given. Very many of these inmates would have found drudgery and injustice to be their lot in life anyway. Rachel Grant-Smith in particular seems to have been something of a pain to the staff, standing on her dignity (she was a doctor's wife, after all) and paying little attention in her account to other inmates. The asylum may, then, have been more acceptable to those who had learned to accept the type of society from which its population was drawn.

There appears in practice to have been a three-fold set of relationships which coloured life inside the asylum. The most obvious relationship was for each patient to be as a passive object within an organised paternalist regime. Cut off from outside influences and associations and encouraged to participate in pre-arranged events, the more astute patients learned how to 'play the game' of asylum inmate as it was apparently defined by these activities. Cutting across that response were informal relationships between patients which were nevertheless restrained by the asylum's administrative structure. Threaded through both these levels of interaction was an awareness of the overriding authority of the asylum system itself, mediated largely by the attendants.

In such circumstances inmates might be said to have been encouraged in the passive acceptance of already-defined social roles, which were recognised

as the desired goals of the whole asylum system. Whether those roles were appropriate to a workshop, a training school or, in the case of women, to a domestic setting, the general ethos of the asylum remained the same. Inmates were to be trained in useful employment about the business of their superiors, and if this did not always lead to "recovery" then they could still be usefully employed by their present, and ultimate, master, the medical superintendent.

This is not to say that the overt purpose of the asylum's supremacy was not in some sense benign. Medical men did believe they were discharging a beneficial function, but precisely who the beneficiary was - individual patient or outside society - remained inexplicit. In practice, the asylum system ensured that the treatment of the insane was to be a process of protecting or defending others, whether public, doctors or other patients, by casting each individual patient in the role of unreliable aggressor and dealing with him accordingly. A modern psychiatry, aware of its commitment to the relief of individual suffering, might well see in such a process a major obstacle to the attainment of cures. Yet at the time the contradiction involved in suppressing individual expression in the name of individual cure was never recognised as such - the protracted struggle of patients to seek accommodation with the prevailing asylum system remaining uncharted.

P A R T C

PSYCHOLOGICAL MEDICINE IN ITS
SOCIAL CONTEXT

CHAPTER 6: THE LUNATIC PROFESSION AND ITS STAFF

So far in our study of psychological medicine in pauper lunatic asylums we have approached the subject firstly by examining the theoretical body of "mental science" together with the treatment of insanity indicated by the writings of mental physicians, and secondly by a more empirical study of asylum records in order to discern the outcome of physicians' practices. This was also the concern of the succeeding chapter on the life and horizons of asylum inmates. Implicit in the analysis of medical theory, both of pathology and of treatment, was a view of the social relationship actually existing between doctor and patient, a relationship which clearly held sway inside the asylums whose performances we subsequently examined.

To this relationship we need to add a further social dimension. The claim to be able to provide remedies for insanity (increasingly qualified as a potential rather than existing possibility as the century progressed), although the fundamental element in the mental physicians' social discourse, was not in practice the only factor. Psychological medicine also served different purposes, some more effectively than others. These purposes must be considered in any evaluation of the medical enterprise, since they relate to the overall social discourse in which the therapeutic ideal was located and so help to explain the profession's survival in the face of mounting evidence of therapeutic failure. In addition to the doctors' relationship with their patients there were two other social relationships in which doctors were involved: the intra-professional, or the relationship with others in the profession at various levels of status, and the relationship between the profession as a whole and the rest of the administrative structure of later Victorian society. These significantly affect the nature of what was described as psychological medicine. The first is considered in this chapter and the second in the next.

As far as the profession itself was concerned, one fact was obvious. The doctors who advocated and worked in asylums had more at stake than the sanity of their patients. The medical enterprise touched on interests that were closer to their hearts, for upon its success stood the credibility of their profession and with it the benefits, financial and even social, which membership of that profession could bring. For the remainder of the asylum staff, nurses and attendants, the practice of psychological medicine was likewise a means of obtaining a living, though there was for them not the same value attached to status or security (for they had precious little of either).

Elsewhere⁽¹⁾ it was suggested that the medical organisation worked rather more effectively at the level of securing its own existence than in the business of curing its patients. Certainly the profession survived, even if it did not altogether flourish. Whatever they may have offered to their inmates the great county asylums of the nineteenth century proved an adequate foundation for the smallish group of medical men who ran them.

a) The Asylum as a Base for Medical Research

At first sight, these huge institutions seem an unpromising basis for professional success. They were not popular places, even with their medical staff, since they attracted a considerable social stigma. As Granville noted in his book "The Care and Cure of the Insane", published in 1877:

"It is above all things indispensable that medical superintendents of asylums should be educated gentlemen, and if that is to be the case, their wives cannot be matrons. Indeed, it is inconceivable that a man of position and culture would allow his family to have any connection with an asylum". (2)

1. See Chapter 2.
2. SCULL, Andrew T: Museums of Madness: the Social Organisation of Insanity in Nineteenth Century England. 1979, p.182.

Neither were they places of obvious medical success. The debates which raged throughout the century in periodicals such as "Cornhill", "Contemporary Review" and "The Nineteenth Century" (to name but a few) concerned themselves with the apparent failure of asylums to prevent a rising tide of madness that was commonly held to be sweeping the country⁽¹⁾ and with the inadequacy of large institutions in the face of such alternatives as "boarding out"⁽²⁾ or the example of the insane colony at Gheel.⁽³⁾ So ineffective was the asylum in practice that doctors simply regarded most insanity as "incurable".⁽⁴⁾ In the 31st Report of the Commissioners in Lunacy, 1876, only 7.22% of the lunatic population was classified as "curable".⁽⁵⁾ With circumstances such as these, mental physicians were under pressure to find ways of making their venture seem less hopeless than it was.

Luckily for them, the asylum afforded other activities more rewarding than an attempt to treat insanity directly. Such activities could be followed all the more easily because the very forbidding nature of asylums

1. See, for example, ALLBUTT, T. Clifford: Nervous Diseases and Modern Life, Contemporary Review, 67, February 1895; MITCHELL, Arthur: The Increase of Lunacy, North British Review, 50, March 1869. WYNNEER, Andrew: Lunatic Asylums, Quarterly Review, 101, April 1857; MORTIMER GRANVILLE, J.: Is Insanity Increasing? Nineteenth Century, 5, March 1879.
2. See TUKE, D.H.: Legislation for the Insane, Contemporary Review, 30, October 1877; BUCKNILL, J.C.: Abolition of Proprietary Madhouses, Nineteenth Century, 17, February 1885.
3. See, for example, SELLERS, Edith: A Colony for Lunatics. Cornhill, 24 NS, June 1895.
4. Twenty-Second Report of the Commissioners in Lunacy, 1868, pp.60-5. Peter McCandless' otherwise useful account of the debate over alternatives to the asylum (see: "Build, build!" Bulletin for the History of Medicine, Vol.53, 1979, pp.553-574) takes this statement by the Commissioners at face value. This is very incautious, given the state of medical "knowledge", and is merely a repetition of the contemporary myths that served to obscure the otherwise very obvious lack of any worthwhile medical treatment for the "insane" by shifting the onus of cure from the doctor to the patient.
5. Thirty-First Report of the Commissioners in Lunacy, 1877, p.78.

deterred the public gaze. The long dark corridors and secret places where laymen feared to tread thus provided many a perch for the mental physician as medical administrator.

One obsession of such men was with the fashionable practice of statistics. Quantification and tabulation were activities which could always be pursued, no matter how dismal the outcome which the figures indicated. Accordingly, doctors spent much of their time collecting information on all conceivable aspects of their patients' lives and diseases. Figures on admissions, recoveries and deaths were regularly tabulated, reproduced in annual reports and sent to the Commissioners in Lunacy, who then reproduced them in their annual reports. Information of this kind was collated with such factors as age, "type of insanity", length of stay, and so on. The tables shown here, for the West Riding area - Wakefield, Wadsley (now Middlewood) and Menston - are typical of the sort of thing which mental physicians felt it was important to know.

[See Tables XXX and XXXI.]

Every conceivable piece of information was used in these tables. Table III shows recovery and death rates correlated with marital status at Mapperley Hospital, Nottingham. Again, in Table IV, we see this information correlated with age.

[See Tables XXXII and XXXIII.]

It was not just recovery and death rates doctors were interested in. "Probable causes" of insanity are linked with outcome, "forms of insanity" are enumerated, breakdowns of patients' religious persuasion are given and there are also lists of their previous employments. Not content with all this, the Nottingham authorities published huge compilation tables showing the performance of the asylum for each year since its opening.

[See Tables XXXIV, XXXV, XXXVI and XXXVII.]

Admissions and Discharges at Wakefield, Wadsley and Menston Asylums, 1880-1889

Year Ending	Admissions	Discharges			Percentage of Recoveries on Admissions	Deaths	Percentage of deaths on average number resident	Resident Population Total
		Recovered	Relieved and not Improved	Total				
WAKEFIELD ASYLUM								
31st December, 1880	452	194	114	308	42.92	136	9.66	1400
" 1881	469	192	104	296	40.93	171	12.13	1402
" 1882	428	167	127	294	39.01	134	9.50	1402
" 1883	412	150	115	265	36.40	139	9.85	1410
" 1884	420	158	101	259	37.61	167	11.83	1404
" 1885	433	178	84	262	41.10	177	12.61	1398
" 1886	447	195	76	271	43.62	176	12.64	1398
" 1887	479	186	79	265	38.83	210	15.00	1402
" 1888	455	151	86	237	33.18	165	11.75	1354
" 1889	426	157	71	228	36.85	144	10.62	1339
Totals	4421	1728	957	2685		1619		13909
Annual Average	442	172.8	95.7	268.5	39.08	161.9	11.57	1390.0
WADSLEY ASYLUM								
31st December, 1880	494	161	82	243	32.6	131	12.1	1125
" 1881	495	191	72	263	38.9	138	11.3	1217
" 1882	526	207	118	325	39.3	124	9.8	1294
" 1883	508	208	80	288	40.9	149	11.0	1365
" 1884	550	209	109	318	37.8	159	11.0	1438
" 1885	434	194	59	253	44.7	172	11.9	1447
" 1886	527	212	77	289	40.2	142	9.4	1543
" 1887	506	191	58	249	37.7	150	9.4	1650
" 1888	501	211	81	292	42.1	177	10.6	1616
" 1889	411	153	49	202	37.2	185	11.6	1547
Totals	4952	1937	785	2722		1527		14242
Annual Average	495	193	78.5	272.2	39.1	152	10.8	1424
MENSTON ASYLUM								
31st December, 1880								
" 1881								
" 1882								
" 1883								
" 1884								
" 1885								
" 1886								
" 1887								
" 1888								
" 1889	275	53	16	69	20.22	49	13.88	486
Totals	275	53	16	69	20.22	49	13.88	486
Totals of the three Asylums	9648	3718	1758	5476	38.5	3195	11.1	28637

SOURCE: Annual Report of the West Riding Asylum Committee, 1890. Wakefield PRO

Showing the length of Residence in those discharged Recovered, and in those who have died during the periods undermentioned

WAKEFIELD ASYLUM - 1881 to 1888
inclusive

WADSLEY ASYLUM - 1881 to 1888
inclusive

MENSTON ASYLUM - 1st January
to 31st December, 1889
inclusive

Length of Residence	Recovered			Died			Recovered			Died			Recovered			Died		
	M.	F.	Total	M.	F.	Total	M.	F.	Total	M.	F.	Total	M.	F.	Total	M.	F.	Total
Under 1 month	51	14	65	64	54	118	32	34	66	73	64	137	-	1	1	4	8	12
From 1 to 3 months	238	237	475	72	49	121	269	354	623	84	60	144	9	6	15	8	4	12
" 3	189	230	419	59	27	86	189	372	561	124	62	186	10	17	27	8	5	13
" 6	73	123	196	57	24	81	71	119	190	52	33	85	2	5	7	3	3	6
" 9 " 12	46	50	96	56	20	* 76	30	54	84	36	24	60	-	3	3	2	3	5
" 1 " 2 years	37	46	83	127	63	+190	24	40	64	81	70	151	..	..	..	1	-	1
" 2 " 3 "	11	7	18	65	48	113	11	9	20	47	66	113						
" 3 " 5 "	8	6	14	75	73	†148	7	3	10	44	44	88						
" 5 " 7 "	1	3	4	49	39	88	2	4	6	56	45	101						
" 7 " 10 "	2	2	4	54	42	96	1	-	1	52	39	91						
" 10 " 12 "	..	..	..	19	28	47	..	..	..	8	17	25						
" 12 " 15 "	-	1	1	41	32	73	..	..	..	15	13	28						
" 15 " 20 "	-	1	1	20	24	44	..	..	..	-	2	2						
" 20 " 25 "	-	1	1	14	14	28												
" 25 " 30 "	..	..	..	11	5	16												
" 30 " 35 "	..	..	..	3	3	6												
" 35 " 40 "	..	..	..	4	1	5												
Upwards of 40 "	..	..	..	1	2	3												
Total	656	721	1377	791	548	1339	636	989	1625	672	539	1211	21	32	53	26	23	49

* over $\frac{1}{2}$

+ over $\frac{1}{2}$

† over $\frac{2}{3}$

NOTE: The Wadsley Asylum had not yet been in existence a sufficient number of years to afford a true comparison with Wakefield Asylum, and hence there had at Wadsley been relatively few deaths of patients whose length of residence had been more than 10 years. The same cause had a certain bearing upon the Death Rates for the two Institutions.

SOURCE: Annual Report of the West Riding Asylum Committee. Wakefield PRO.

TABLE XXXIII

Showing the Condition as to Marriage in the Admissions, Recoveries, and Deaths, during the year 1890, and of Patients Resident 31st December, 1890

Condition as to Marriage	Admissions			Recoveries			Deaths			Patients Resident 31st Dec. 1890					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.			
Single	64	69	133	6	11	17	7	3	10	157	150	307
Married	42	42	84	12	19	31	17	5	22	84	93	177
Widowed	11	22	33	3	5	8	2	5	7	16	44	60
Total	117	133	250	21	35	56	26	13	39	257	287	544

SOURCE: Annual Reports of the Mapperley Incurable Asylum, 1891.
Mapperley Hospital Library.

TABLE XXXIII

Showing in Quinquennial Periods the Ages of those Admitted, Recovered, and Died, during the year 1890, and of those remaining on 31st December, 1890

Ages	Admissions		Recoveries		Deaths		Patients Resident 31st Dec. 1890	
	M.	F.	M.	F.	M.	F.	M.	F.
From 10 to 15 years	3	0	1	0	0	0	2	0
" 15 " 20	5	3	0	1	0	1	10	2
" 20 " 25	7	7	2	3	1	2	12	8
" 25 " 30	10	16	2	8	0	1	17	24
" 30 " 35	19	18	3	3	1	1	36	33
" 35 " 40	17	18	0	1	1	7	31	32
" 40 " 45	15	8	5	5	1	4	34	29
" 45 " 50	13	16	3	3	0	2	30	40
" 50 " 55	10	20	2	3	2	4	29	45
" 55 " 60	7	11	1	7	0	1	21	33
" 60 " 65	6	6	2	0	3	5	20	12
" 65 " 70	4	3	0	0	0	1	11	9
" 70 " 75	1	4	0	1	0	1	1	8
" 75 " 80	1	2	0	0	3	4	2	6
" 80 " 85	0	0	0	0	0	1	1	4
" 85 " 90	0	1	0	0	0	0	0	1
" 90 " 95	0	0	0	0	0	0	0	1
Total	117	133	21	35	26	13	257	287
Mean Age	38.3	43.3	40.7	38.8	44.5	54.2	42.5	46.7
				39.5		47.7		44.7

SOURCE: Annual Reports of the Mapperley Lunatic Asylum, 1891. Held at the Hospital.

TABLE XXXIV

Showing the Probable Cause of the Disorder in the Admissions, Discharges and Deaths during the Year

Causes	Admissions			Recoveries			Deaths		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
MORAL:									
Business Anxiety	2	0	2	3	0	3	3	0	3
Disappointed Affection	0	1	1	0	1	1	0	0	0
Domestic Trouble	4	2	6	0	1	1	2	0	2
Mental Anxiety & Overwork	4	5	9	2	3	5	2	0	2
Religious Excitement	1	1	2	0	1	1	0	0	0
Fright & Nervous Shock	0	1	1	1	1	2	0	0	0
PHYSICAL:									
Congenital Defect	1	0	1	0	0	0	0	0	0
Climacteric Change	0	3	3	0	1	1	0	0	0
Epilepsy	4	3	7	0	1	1	3	1	4
Fall	1	0	1	0	0	0	0	0	0
Fevers	0	1	1	0	2	2	0	0	0
Hereditary Predisposition (sole cause)	1	4	5	1	2	3	1	3	4
Intemperance in Drink	12	5	17	5	1	6	1	2	3
" Sexual	0	0	0	0	0	0	1	0	1
Injury	3	2	5	0	1	1	3	0	3
Masturbation	1	0	1	1	0	1	0	0	0
Menorrhagia & Illtreatment	0	1	1	0	0	0	0	0	0
Old Age	4	1	5	0	0	0	3	0	3
Paralysis	3	0	3	0	0	0	2	0	2
Phthisis Pulmonalis	0	0	0	0	0	0	1	0	1
Previous Attacks	1	6	7	1	3	4	0	0	0
Puerperal State	0	2	2	0	1	1	0	1	1
Sunstroke	2	0	2	1	0	1	1	0	1
Syphilis	0	0	0	0	0	0	1	0	1
Poverty	0	0	0	1	0	1	0	0	0
Not Ascertained	9	6	15	1	3	4	9	5	14
Totals	53	44	97	17	22	39	33	12	45

SOURCE: Annual Report of the Mapperley Lunatic Asylum, 1891.
Held at the Hospital.

TABLE XXXV

Showing the Form of Disease in the Admissions
during the Year, 1890

Form of Disease	M.	F.	T.
Mania - Ordinary	17	17	34
" Acute	1	2	3
" Puerperal	0	1	1
Melancholia	11	14	25
Dementia	10	8	18
" Senile	3	1	4
Idiocy	1	1	2
Imbecility	3	0	3
General Paralysis	7	0	7
Totals	53	44	97

SOURCE: Annual Reports of the Mapperley Lunatic
Asylum, 1891.
Held at the Hospital.

TABLE XXXVI

Showing the Religious Persuasion of those Admitted
during the year, 1890

Religious Persuasion	M.	F.	T.
Church of England	29	24	53
Congregationalists	1	1	2
Baptists	1	4	5
Dissenters	6	6	12
Methodists	2	2	4
Roman Catholics	1	1	2
Swedenborgian	1	0	1
Wesleyan Methodists	1	5	6
No Religion	5	0	5
Not ascertained	6	1	7
Totals	53	44	97

SOURCE: Annual Reports of the Mapperley Lunatic
Asylum, 1891.
Held at the Hospital.

TABLE XXXVII

Showing the Occupation or Social Position of the New Cases
Admitted during the year, 1890

Occupation	M.	F.	T.	Occupation	M.	F.	T.
Agricultural Implement Fitter	1	0	1	Labourers	5	0	5
Artist	1	0	1	Lace Workers	6	8	14
Blacksmith	1	0	1	Lithographic Printer	1	0	1
Bobbin & Carriage Hand	1	0	1	Machine Fitter	1	0	1
Book-keeper	1	0	1	Maltster	1	0	1
Brickmakers	2	0	2	Milkseller	1	0	1
Carters	2	0	2	Milliner	0	1	1
Charwomen	0	2	2	Musician	1	0	1
Compositor	0	1	1	Painters	2	0	2
Domestic Servants	0	4	4	Policeman	1	0	1
Draper's Assistant	1	0	1	Porter	1	0	1
Dyer	1	0	1	Shoemakers	2	0	2
Ex-Policeman	1	0	1	Shopkeeper	1	0	1
Framesmith	1	0	1	Solicitor's Clerk	1	0	1
Framework Knitters	2	0	2	Stationer's Assistant	0	1	1
Gentleman's Servant	1	0	1	Stone Mason	1	0	1
Hawker	0	1	1	Tailors	3	0	3
Hose Folder	1	0	1	Waitress	0	1	1
Hosiery Mendors	2	5	7	Whitewasher	1	0	1
Housewives	0	16	16	No Occupation	4	3	7
Joiner	1	0	1	Not Ascertained	0	1	1
				Totals	53	44	97

SOURCE: Annual Reports of the Mapperley Lunatic
Asylum, 1891.
Held at the Hospital

No conclusions seem to have been drawn from all this. Perhaps it was felt that something would emerge from this endless tabulation; the cards, if tossed in the air often enough, would come down in some meaningful sequence.⁽¹⁾ The time-consuming performance was repeated often enough to suggest that mental physicians thought something worthwhile was coming out of it. Writers in "The Journal of Mental Science", insisted on the importance of uniform recording and quantification. In 1869 a special committee was appointed to look into such matters and recommended a standardised procedure of book-keeping, regularised classification of cases, a standard form of case-book and a plan of treatment under the separate heads of 'nourishment', 'bodily disorder', and 'brain function'.⁽²⁾ Four years later, J.A. Campbell wrote

"There can be no reasonable doubt that if these tables are accurately kept in the different asylums, they must, from their exactitude and uniformity, become the material from which the history of insanity in this country will be drawn".⁽³⁾

All this fits well with the attention mental physicians were already paying to statistics. In furtherance of this attention, Campbell recommended two additions to the list of information required of patients; the number of previous "attacks" of insanity and details of hereditary disposition to insanity according to blood-lines. This latter task proved too daunting. It was hard enough obtaining information from the patient about himself, let alone finding out his family history! The first recommendation was sporadically taken up, though again access to such information was very difficult, but the very lack of consistency involved frustrated the purpose of the operation.

1. As D.J. Mellett says, "assembling of information was dangerously near to becoming an end in itself". See MELLETT, D.J.: Bureaucracy and Mental Illness. Medical History, XXV, 3, July 1981, p.235.
2. Report of the Committee appointed at a Meeting of the MPA, held at the Royal College of Physicians, Edinburgh, 1869. Journal of Mental Science, 74, July 1870, pp.223-232.
3. CAMPBELL, J.A.: Unity in Public Asylum Reports. Journal of Mental Science, 85, XIX, April 1873, pp.67-78.

In practice, this elaborate statistical exercise not only failed to show worthwhile results but actually retarded valuable enquiry. Statistics seemed to many to provide a way of producing rabbits out of hats. The very complexity of the relationships which figures could be brought into, all the tabulation and cross-corresponding, tended to conceal the inadequacy of the original data. This data-base was not significantly widened. The questions which doctors asked of their patients remained administrative ones - age, place of habitation, religion, marital status, Poor Law union responsible for charges - and rarely pertinent medical ones. To ask a patient what s/he supposed the cause of insanity to be was scarcely ever instructive. To break down recoveries and deaths according to crude "types" of insanity was not helpful at all. The hopes of the special committee for a standardised case-book of medical observations, which could then be added to the available information, came to nothing. No research was conducted beyond the asylum to check supposed causes and no course of action followed from the discovery (see Table XXXV) that most "insanity" fell under the heading of "mania". There is no doubt, however, that the regular appearance of such thoroughly tabulated information satisfied those it was intended to satisfy, namely those who funded the asylums - the Poor Law authorities and the cabals of rate-payers on local councils.

If the tables of statistics marked the limit of doctors' researches amongst the living, they found themselves more in their element with the dead. Here, the asylum was a positive boon. Within its walls lived, or existed, several hundred inmates, about a third of whom would die there. What better situation could there be for obtaining a steady stream of post-mortem material? There was no legal objection to such examination without a coroner's order,⁽¹⁾ provided no fees were charged, the only hindrance

1. See 6th and 7th, William IV, C89.

being that it could not proceed if any of the relatives objected.

Accordingly,

"Notice of the intention to make a post-mortem examination shall be given to the relatives or friends of the deceased in advance", (1)

which, given that deaths could not always be predicted, involved routine enquiry during the patient's lifetime. If no specific objection was lodged then the examination could go ahead. Patients who had no known friends or relatives were easy meat for the dissector's scalpel. As A.T. Scull remarks,

"Particularly popular, if figures given in the annual reports of the Commissioners in Lunacy are to be believed, was research on dead bodies, which even though it might be repetitive and lead nowhere, at least bore a passing semblance to more conventional medical practices!" (2)

Scull might have given more credit to the doctors' medical aims, particularly since having defined "insanity" as a "disease of the brain" it was only reasonable to pursue their one real lead, yet it must be recognised that they still had a long way to go in relating the appearances of the brains of the dead with the behaviour of the living. W.G. Balfour of the Hampstead Asylum published the results of over 700 post-mortems and concluded that in only 60 of these cases were there no signs of lesion in the brain, (3) a fact which he ascribed to the inadequacy of observational technology.

[See Tables XXXVIII and XXXIX.]

However, when he attempted to relate these findings to insane behaviour he was reduced to the usual crude surmises, based on the objectivisation of social value and judgement.

1. Directive from the Commissioners in Lunacy, 1878. PRO MH51 775.
2. SCULL, Andrew T.: op.cit., p.182.
3. BALFOUR, W.G.: Pathological Appearances observed in the Brains of the Insane. Journal of Mental Science, 89, XX, April 1874, pp.49-60.

Showing the lesions and their frequency in the brains of 333 persons who died insane, arranged under the different forms of insanity

	Mania	Melancholia	Epilepsy	Dementia	General Paralysis	Total
Number of cases	100	26	68	82	57	333
CALVARIUM -						
Abnormally thick	17	3	16	13	8	57
Thin	8	2	9	11	9	39
Injection of Diploe of	15	10	21	11	19	76
Softened	-	-	-	1	-	-
Hard and dense	3	-	-	-	-	3
MEMBRANES -						
Dura Mater very firmly adherent to						
Calvarium	9	-	4	7	6	26
Thickened	14	4	9	6	15	48
Ossification of	1	1	2	2	1	7
Tumours attached to	2	1	2	2	1	7
ARACHNOID -						
Effusion into Sac of Sanguine						
" " Serous	4	1	2	2	1	7
" " " "	10	-	4	9	5	28
" " " "	-	-	-	1	1	2
False membrane in sac of	6	-	4	4	8	22
Injection of	1	-	-	-	-	1
Sanguineous cysts in	-	-	-	-	1	1
Granulations on	-	-	-	1	1	2
Opacity of	53	11	33	51	41	189
PIA WATER -						
Marked injection of vessels of						
Edema of	37	10	34	30	27	138
Local bulla of fluid in meshes of	1	-	1	4	4	10
Sanguineous effusion "	16	3	4	18	11	52
Tumours attached to	8	1	7	7	5	28
Deposits in	-	1	1	-	-	2
Adhesions of to surface of grey matter	3	-	2	2	1	8
	6	2	5	4	9	26
BLOOD VESSELS -						
Injection of in brain						
Atheroma of	14	7	11	7	9	48
	9	5	4	16	6	40
GREY SUBSTANCE -						
Abnormalities in thickness of						
In colour of	12	2	6	6	8	34
Flattening of convolutions	14	6	17	15	8	-
Effusion of blood into	4	-	9	3	6	-
	1	-	-	-	2	-
WHITE SUBSTANCE -						
Induration of						
Edema of	7	-	7	9	6	-
White softening of	3	-	1	-	1	-
Effusion of blood into	3	1	3	2	2	-
Excessive shrinking of	-	-	2	1	5	-
Marked injection of vessels of	1	-	2	-	1	-
Cysts in	14	7	10	6	6	-
	1	-	1	1	-	-
OPTIC Thal. and Corp. Striat. -						
Effusion of blood into						
Pink gelatinous softening of	2	1	-	-	2	-
Tumours in	2	-	-	4	4	-
Cysts in	-	-	-	1	1	-
Cicatrix in	2	-	-	1	3	-
	1	-	-	1	1	-
CEREBELLUM -						
Softening of						
Cysts in	-	-	-	2	-	-
Cicatrix in	-	-	1	-	-	-
	1	-	-	-	-	-
VENTRICLES -						
1. Excessive serous fluid in						
Sanguineous	50	11	38	49	45	-
Opacity of lining membrane of	2	2	-	3	3	-
Crystalline granulations on lining	9	1	6	7	8	-
membrane of	18	1	11	9	19	-
Adhesions of lining membrane	22	5	14	14	11	-
Cicatrix in septum lucidum	1	-	1	-	-	-
Choroid plexus cysts in	17	6	2	18	4	-
Tumours in	-	-	1	-	1	-
Barthy deposit in	3	1	3	3	2	-
Apparently normal Brains	6	3	1	4	-	-

Showing the percentage of the lesions found in the different forms of insanity

	Mania	Melancholia	Epilepsy	Dementia	General Paralysis
Number of cases	100	26	68	82	57
CALVARIUM -					
Abnormally thick	17	11.45	23.5	15.8	14.03
" thin	8	7.6	13.2	13.4	15.7
Diploe, injection of	15	38.4	30.8	13.4	33.3
Softened	-	-	-	1.2	-
Hard and dense	3	-	-	-	-
DURA MATER -					
Very firmly adherent to Calvarium	9	-	5.8	8.5	10.5
Abnormally thick	14	15.3	13.2	7.3	26.3
" thin	-	-	-	-	-
Ossification of	1	3.8	2.9	2.4	1.7
Tumours attached to	2	3.8	2.9	2.4	1.7
ARACHNOID -					
Effusion sanguineous into Sac	4	3.8	2.9	4.8	1.7
" serous	10	-	5.8	10.9	8.7
	-	-	-	1.2	1.7
False membrane in Sac of	6	-	5.8	4.8	14.0
Ossification of	-	-	1.4	-	-
Injection of	1	-	-	-	-
Sanguineous cysts in	-	-	-	-	1.7
Granulations on	-	-	-	1.2	1.7
Opacity of	5.3	42.3	48.5	62.1	71.9
PIA MATER -					
Marked injection of vessels of	37.	38.4	50.	36.7	47.3
Edema of	1	-	1.4	4.8	7
Local bulla of fluid in	16	11.5	5.8	21.9	19.2
Sanguineous effusion in	8	3.8	1.4	-	-
Tumours attached to	-	3.8	1.4	-	-
Brown gelatinous deposit in	3	-	2.7	2.4	1.7
Adhesion of to surface of grey matter	6	7.6	7.	4.8	15.7
BLOOD VESSELS -					
Aneurismal dilatation of	-	-	1.4	-	-
Injection of in brain	14	26.9	16.1	8.5	15.7
Atheroma of	9	19	5.8	19.5	10.6
GREY SUBSTANCE -					
Abnormal in thickness	12	7.6	8.8	7.3	14.
" colour	14	23	25	18.2	14.
Flattening of convolutions of	4	-	13.2	3.6	10.5
Effusion of blood into, old	1	-	-	-	3.5
WHITE SUBSTANCE -					
Induration of	7	-	10.2	10.9	10.5
Edema of	3	-	1.4	-	1.7
Softening of	6	3.8	4.4	2.4	3.3
Effusion of blood into recent	-	-	2.7	1.2	8.7
Excessive shrinking of	1	-	2.9	-	1.7
Marked injection of vessels of	14.	26.9	14.7	7.4	10.5
Cysts in	1	-	3.4	1.2	-
OPTIC Thal. and Corp. Striat. -					
Effusion of blood into	2	3.8	1.4	-	3.5
Softening of	2	-	-	4.8	7
Tumours in	-	-	-	1.2	7
Cysts in	2	-	-	1.2	5.2
Cicatrix in	1	-	-	1.2	1.7
CEREBELLUM -					
Adhesions of membranes to grey matter	-	-	-	-	-
Softening of	-	-	-	2.4	-
Blood in substance of	-	-	-	-	-
Cysts in	-	-	1.4	-	-
Cicatrix in	1	-	1.4	-	-
VENTRICLES -					
Excessive fluid in serous	50.	42.3	55.8	59.7	78.9
" " sanguineous	2	7.6	-	3.6	5.2
Opacity of lining membrane	9	3.8	8.8	8.6	14
	18	3.8	16.1	10.9	33.3
Adhesions of	22	19.2	20.5	17.	19.2
SEPTUM LUCIDUM -					
Tubercle on	1	-	1.4	-	-
CHOROID PLEXUS -					
Cysts in	17	23.	2.7	21.9	7
Tumours in	-	-	1.4	-	1.7
Earthy deposit in	3	3.8	4.4	3.6	3.5
Apparently normal brain	6	11.4	1.4	4.8	-

"An unhealthy idea, however generated, will surely produce in the nerve cells through which it passes, an unhealthy condition, which, if not remedied, will sooner or later lead to a permanent change in these cells, and they in turn will corrupt others". (1)

Balfour's use of the word "unhealthy" should be compared with that of Jarvis on the "fixed laws" behind human behaviour. (2)

The hopelessness of this sort of approach was neatly summed up by a writer who described himself as "A Sane Patient", who was nevertheless an asylum inmate during much of the 1870s. In recalling his experiences he says that after his release he studied medical literature in order to understand what had been ranged against him in those years. Citing an (unnamed) textbook, he writes,

"It states that in simple insanity he finds certain alterations in the grey matter of the cerebrum, consisting of minute apoplexies, effusions of haematin and haematosin into the lymphatic sheaths, infarctions, atheroma, capillary dilations, and necrosis of vessels, and certain changes of cerebral cells'. Quite so. It may all be very true, but I can offer no suggestions as to medical treatment based upon these remarkable assumptions. When, shortly before my final removal, I was allowed to see a relation of mine at a town some distance off, the principle objected to the permission being too often given, because conversation carried off too much white matter from the brain. I distinctly assert that he said 'white', because by connotation with the statement with Voisin's valuable remarks, it will appear that the 'grey' remained in my case unaffected. That neither haematin nor haematosin has been effused into my sheaths, that my capillaries remain undilated, and that I am proudly conscious of having escaped both atheroma and infarctions, I must ask my reader to accept my word". (3)

Nevertheless, post-mortem examinations remained a popular preoccupation, despite the lack of relevance to curative therapy, and virtually every death in the asylum was the occasion for such an examination.

[See Table XL.]

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1. ibid., pp.59-60.
 2. See Chapter 2, pp.46-48.
 3. "SANE PATIENT", My Experiences in a Lunatic Asylum, 1879, pp.96-7.

TABLE XL

Showing the Causes of Death during the year, 1890

Cause of Death	M.	F.	T.
CEREBRAL:			
Abcess in the Brain	1	0	1
Atrophy of the Brain, with Gangrene of the Lung	1	0	1
" " " " " Granular Disease of Kidneys	1	0	1
" " " " " Disease of Heart	1	0	1
Apoplexy (Congestive)	2	0	2
" (Sanguineous)	0	1	1
Cerebral Hemorrhage	1	0	1
Epilepsy	2	1	3
" with Phthisis Pulmonalis	0	1	1
" " Scald of the Hand	1	0	1
General Paralysis	14	4	18
" " with Cancer of Uterus	0	1	1
" " " Disease of Heart	2	0	2
" " " Rupture of Intestine	1	0	1
Syphilitic Disease of the Brain	1	0	1
Yellow Softening of the Brain	1	0	1
THORACIC and ABDOMINAL:			
Fatty Degeneration of the Heart	0	1	1
Valvular Disease of the Heart	1	0	1
Phthisis Pulmonalis	2	2	4
Cancer of Intestine	1	0	1
Internal Strangulation of Intestine	0	1	1
Total	83	12	45

SOURCE: Annual Reports of the Mapperley Lunatic Asylum, 1891.
Held at the Hospital.

In the short-term one can only criticise this activity in the field of medical cure. Once again, it was a ritual which employed only a limited universe of referents. Having assumed that insanity was a "disease of the brain" mental physicians looked no farther afield for solutions. Even when dissection of brains revealed no lesion whatsoever, the only conclusion was that finer means of analysis were needed. No attempts were made to investigate patients' thought or behaviour, and only gross correlations with other physical disease were attempted.⁽¹⁾

Against such a view it could be held that physicians were building up a body of information which they hoped, as medical men, would finally prove valuable, just as Campbell appeared to believe that the collation of statistics would "become the material from which the history of insanity in this country will be drawn".⁽²⁾ The signs are, however, that these activities were mere routine, published and then forgotten. How genuinely they were regarded as aids to a determination to cure patients of their insanity must remain in question.

Indeed, the argument that such research was laying the basis for future advance contains a fatal flaw, which medical historians would do well to observe. Having obtained exclusive control of insanity there could obviously be no other basis for future psychiatrists to work on. Campbell's remark about the historical role of statistics was a truism. His careful tabulations have indeed been a significant part of the historian's material, but only because little else exists. Yet, as earlier chapters have shown, they have not proved overly productive. Similarly, we can question the value of so much limited brain-dissection to

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1. e.g. NORMAN, Conolly: On Insanity Alternating with Spasmodic Asthma. Journal of Mental Science, 133, XXXI, April 1885. See also HUNTER, Richard A: Tuberculosis and Insanity, St. Bartholomew's Hospital Journal, 61, 1957.
 2. See above, p.281.

later psychiatry. It may incidentally have laid a basis for an anatomy of the brain, yet the importance of this to mental health is still a fraught subject.

b) The "Journal of Mental Science"

Be this as it may, there is no doubt that the asylum allowed mental physicians a great deal of scope in the pursuit of their interests and many learned publications resulted from their labours. Probably the most widely known example of these was the six-volume collection of anatomical researches carried out under Crichton Browne at the West Riding asylum in the 1870s.⁽¹⁾ This included sections on cranioid injuries, the effects of nitrous oxide, the uses of the ophthalmoscope, arachnoid cysts, and also the connections between general paralysis, phthisis and insanity. These researches have themselves become the subject of more recent research, showing how asylum populations were effectively the guinea-pigs of the doctors, as they followed their professional concerns.

A more common outlet for publication of researches such as these was the "Journal of Mental Science". From the first, this journal had been founded upon the new county asylums built under the 1845 Lunacy Act. Indeed, it began life as "The Asylum Journal", in 1853, but added "Mental Science" to its title in 1855, finally dropping the word "Asylum", with its unpleasantly parochial connotations, in 1858. Henceforth, it became the focus of much professional interest. Having its roots still very firmly bedded in the lunatic asylums, in fact if not in name, it was able to provide a secure arena in which aspiring doctors could float ideas, publish

1. See Journal of Mental Science, 81, XVIII, April 1872. The end-paper carries an advertisement for the whole series, priced at 7/6d. (37.5p)

researches and letters, and so attempt to build careers. Many papers appeared in its pages over the years and a great number of tabulated statistics went with them.

As early as 1861, tables of the results of 295 post-mortems were published,⁽¹⁾ and also figures on "wet and dirty cases" at the Sussex asylum presented by C. Lockhart Robertson, the superintendent.⁽²⁾ In 1873, R. Boyd published tables of his findings in an article on brain tumours.⁽³⁾ In 1890 a massive study of some 1,565 post-mortem examinations performed over eleven years at the West Riding Asylum was published. This included tables analysing "sub-dural haemorrhage, cerebral wasting, ventricular dilation and atheroma of the blood vessels" and correlating them with five "types" of insanity: Melancholia, general paralysis of the insane, dementia, mania and epilepsy.⁽⁴⁾

Attention was not paid only to the qualities of the brain. Doctors looked at other factors, too. There was, for example, the study of body temperatures in the insane, which T.S. Clouston carried out in 1868.⁽⁵⁾ (See Table XLI). In 1872 an experiment at the West Riding Asylum into the uses of electricity was reported.⁽⁶⁾ Electrodes were placed in

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1. BOYD, Robert: Vital Statistics and Observations on the Causes of Death amongst the Male Patients at Somerset. Journal of Mental Science, 39, VII, 1861, pp.398-407.
 2. ROBERTSON, C. Lockhart: Some Results of Night Nursing - being a record of wet and dirty cases in the Sussex Lunatic Asylum. Journal of Mental Science, 39, VII, 1861, pp.391-8.
 3. BOYD, Robert: Tumours in the Brain in the Sane and Insane. Journal of Mental Science, 85, XIX, April 1873, pp.54-67.
 4. BULLEN, F. St. John: An Abstract of 1,565 Post-Mortem Examinations of the Brain Performed at the Wakefield Asylum During a Period of Eleven Years. Journal of Mental Science, 52, XXXVII, January 1890, pp.17-39.
 5. CLOUSTON, T.S.: Observations on the Temperature of the Body in the Insane. Journal of Mental Science, 65, XIV, April 1868, pp.34-50.
 6. ALTHAUS, Julius: A Treatise on Medical Electricity, Theoretical and Practical, and its Use in the Treatment of Paralysis, Neuralgia and Other Diseases. Journal of Mental Science, 89, XX, April 1874, pp.99-111.

various positions on the patient's body to see what the effects might be of the passage of a small current. Similar experiments were carried out in many other asylums and the results published in the "Journal", but little, if anything, came of this research in the nineteenth century.⁽¹⁾

Towards the end of the 1880s there was even an interest shown in the "Journal" in the uses of hypnosis, then being attempted at the Salpêtrière in Paris.⁽²⁾ R. Percy Smith of the Bethlem Royal Hospital carried out experiments of his own into this unusual new technique, but the published results were not altogether hopeful.⁽³⁾ Other published experiments included the uses of digitalis⁽⁴⁾ and the results of comparative studies on epileptics.⁽⁵⁾

1. See Chapter 3, pp.86-90.
2. It is perhaps worth noting here that *these experiments*, aimed at using the heightened suggestibility of people in hypnotic trance to persuade them that their delusions were figments of the imagination and should be ignored, mark a radical new approach to therapy which, in subsequent development, conflicts with the positivist basis of treatment outlined in this thesis. This new approach was, indeed, the beginning of the patient's inclusion in the therapeutic process as a conscious individual and so exposed the tension between medical responses to the patient as a suffering individual and as a social deviant which we have referred to elsewhere. However, it was not in the pauper lunatic asylums but beyond, in the private clinics of Charcot, Janet, Bernheim and Freud, that this new therapeutic approach was utilised. The tension was thus largely avoided by the class composition of patients receiving such therapy, which developed largely in isolation from the pauper asylums - with questionable results. (6)
3. SMITH, R. Percy: On the Treatment of Insanity by Hypnotism. Journal of Mental Science, 153, XXXVI, April 1890.
4. MICKLE, W. Julius: The Use of Digitalis in Maniacal Excitement. Journal of Mental Science, 85, XIX, April 1873, pp.87-93.
5. BROWNE, Crichton J: Notes on Epilepsy and its Pathological Consequences. Journal of Mental Science, 85, XIX, April 1873, pp.19-46.
6. See, e.g. HEARNSHAW, L.S: A Short History of British Psychology, 1840-1940. 1964;
ACKERNECHT, E.H: A Short History of Psychiatry. 1959.
SZASZ, Thomas S: The Myth of Mental Illness: Foundations of a Theory of Personal Conduct, 1972, Chapter 1.

TABLE XLI

Body Temperatures in the Insane

Form of Insanity	No. of cases examined		Morning Temperature			Evening Temperature			Mean Temperature			Difference between Morning & Evening		% of the cases in which Evening Temperatures were higher than Morning Temperatures		
	M.	F.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.		T.	
Acute and Chronic Mania	7	21	28	deg.	deg.	deg.	deg.	deg.	deg.	deg.	deg.	deg.	deg.	deg.	41%	
Mania	46	45	91	97.2	97.2	97.21	97.1	97	97.07	97.16	97.1	97.13	.1	.2	.14	38%
Melancholia	9	8	17	97.33	97.46	97.39	97.22	96.8	97.03	97.27	97.13	97.21	.11	.66	.36	31%
Dementia (mild)	30	14	44	97.23	97.5	97.32	96.79	96.79	96.79	97	97.15	97.05	.44	.71	.53	35%
Dementia (complete)	24	21	45	97	96.88	96.96	97.04	96.97	97	97.03	96.92	96.98	.04	.09	.04	39%
Epilepsy	29	9	38	97.48	97.62	97.52	97.38	97.12	97.32	97.43	97.38	97.42	.1	.5	.2	39%
General Paralysis	14	-	14	97.37	-	-	98.	-	-	98.	-	-	.7	-	-	100%
Phthisical	5	4	9	97.69	99.16	98.35	97.95	99.39	98.59	97.82	99.28	98.47	.26	.27	.42	56%
Convalescent	11	8	19	97.23	97.57	97.37	96.84	97.3	97.02	97.03	97.43	97.2	.39	.27	.35	31%
Totals & Averages	175	130	305	97.3	97.32	97.31	97.21	97.17	97.19	97.25	97.25	97.25	.09	.15	.12	41%
Sane persons in good health	19	21	40	97.47	97.52	97.5	96.47	96.9	96.7	96.97	97.21	97.09	1	.62	.8	27%

SOURCE: *Journal of Mental Science*, XIV, No.65, April 1868, p.37.

In short, mental physicians were fortunate in having at their disposal a journal which served exclusively their interests and which could act as a reputable forum for new ideas. That it was based on one specific institution - the lunatic asylum - in one sense tended to make its contents, and contributors, exclusive to that circle of medicine. Yet in another sense, that very exclusivity enhanced the scramble for advancement within the profession and added a productive ulterior motive to the furtherance of research.

c) The "Journal" and the Development of Intraprofessional Relations

In the early years of its publication, the "Journal of Mental Science" offered more than an arena for the self-advancement of the already more elevated members of the profession. It had also provided a route into the profession at all levels - from superintendent down to cook - and was a forum for the development of all facets of asylum function. However, over the first ten years the "Journal" fell into the exclusive hands of the profession's upper echelons and no longer served an all-round purpose. This meant that at levels below that of research and superintendence the scramble to establish careers within the asylum network had to be carried on elsewhere. A split was growing between the higher and lower sections of the lunatic "business". This capture of control of the top end of the profession can be clearly seen in the "Journal's" early history, which is worth considering here.

It was originally started not as an initiative of the mental physicians' own professional organisation, The Association of Medical Officers of Hospitals for the Insane,⁽¹⁾ but as a private venture by J.C. Bucknill in 1853, the AMOHI being still a small affair, with only a handful of members being able to attend meetings.⁽²⁾ There was at the

1. See below, p.301.

2. WALK, A: The Centenary of the Journal of Mental Science. Journal of Mental Science, 99, 1953, p.633.

time an already existing journal supplying the same market, Forbes Winslow's "Journal of Psychological Medicine", and many AMOHI members were subscribers to this journal. But by launching his new publication with the willing consent of AMOHI members, Bucknill was able to take advantage of the expanding interest in the subject created in the wake of the 1845 Lunacy Act. After placating Forbes Winslow in 1857 by electing him President of the AMOHI, the Association won his support for the new journal and the "Journal of Psychological Medicine" was closed down.

The new journal was at first a modest publication. It consisted of sixteen royal octavo pages, and cost sixpence. For the first fourteen issues it was a bi-quarterly, then in 1855 it grew to 128 pages, issued quarterly. This growth presumably reflected the great interest (and financial support) shown in the Journal by mental physicians. Two years later the Journal grew to 156 pages and the following year became known as the "Journal of Mental Science". In 1861, with funds increasing, the printing was transferred from a provincial printer to a superior firm of printers in London.

The earlier numbers show a down-to-earth quality with an almost homely feel. The editorship seems close to the readership. The back pages carried job advertisements; an "experienced cook" was wanted at Devon for £20 per annum; ⁽¹⁾ a "clinical assistant" was needed in Oxfordshire. ⁽²⁾ A salary of £70 per annum was offered, plus board. Even the top jobs were advertised in the pages of the "Asylum Journal". After the suicide of Dr. Grahamsley at Worcester, a new medical superintendent was sought for, with an advertisement offering £350 per annum, furnished lodgings, coals, candles, washing and vegetables from the garden. ⁽³⁾ There

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1. Asylum Journal, 6, 1854, p.96.
 2. ibid., 4, 1854, p.64.
 3. ibid., 7, 1854, p.112.

were letters from doctors offering practical "tips". One from James E. Huxley at Maidstone advised the use of dilute sulphuric acid to clean the urine from wooden floors of "wet and dirty wards".⁽¹⁾

However, these homely articles soon disappeared as the Journal grew up and became a weighty and influential quarterly. Quite quickly it divorced itself from direct asylum involvement, not only by its dropping of the word "Asylum" from its title but also by its selection of contents. A look at the main contents of the first "Journal of Mental Science" (as it became known) in October 1858 shows where its emphasis was being directed. To begin with, the Journal carried a leading article entitled, "Hamlet: A Psychological Study". There followed a discussion of Tuke's paper on the diagnosis of general paralysis of the insane. Dr. Davey then had a paper on the relationships between crime and insanity, and Dr. Huxley had an article on the relations between the Lunacy Commission and the Medical Superintendents of the various asylums. There was the second part of an article on warm and cold baths in the treatment of insanity (a heavily theoretical paper) and a report of the annual meeting of the AMOHI. The last section contained accounts of two Inquisitions of Lunacy, a criticism of a newspaper attack on private asylums, book reviews - "The Ganglionic Nervous System" by James George Davey, among them - and a letter from a doctor regretting that local residents at seaside resorts often objected to asylum inmates being allowed to live there, since it lowered the rateable value of the properties. Lastly, there were notices of appointments (obviously the applications had gone on elsewhere), including, interestingly, notice that a "Dr. H. Maudsley to be Assistant Medical Officer at the Essex County Lunatic Asylum, Brentwood".⁽²⁾

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1. ibid., 9, 1854, p.143.
 2. Journal of Mental Science, 27, V, October 1858.

The career of Dr. Henry Maudsley was in some ways not unconnected with the development of the "Journal of Mental Science" and its growing remoteness from those nearer the bottom end of the profession. From his new, if modest, position as an Assistant Medical Officer he was able to interest Dr. J.C. Bucknill, the editor, in his private ideas on matters physical and mental.* His first published paper came one year later, when Maudsley had already become Medical Superintendent at the Manchester Royal Lunatic Hospital. It was "The Correlation of Mental and Physical Force; or, Man a Part of Nature", and its chief interest is in revealing his philosophical interest in the paradox of appearances and reality. His approach is clearly in tune with the evolutionary climate of the time, though he takes care not to overstep the mark of acceptability, declaring

"all forces are then but modes of manifestation of one force - the Will of God - manifest in highest form, and will least obscuration in the temple of man's body". (1)

The heavy theoretical emphasis which Maudsley brought to the Journal was also in tune with the editor's ideas. Gone were the handy hints on washing floors. Issue No.32 carried, "Consciousness as a Truth-Organ considered", by the Rev. W.G. Davies, Chaplain of the Abergavenny Asylum.(2) Speculations on the "Causes of Mental Disease" by American writers, a report on the Jamaican Asylum, an account of the religious revival in Belfast, reviews of medical works and reports by Lunacy Commissions formed the staple diet of the average Journal reader by 1860.(3) No.33 also contained a further article by Maudsley on the psychology of Edgar Allen Poe.(4)

* The liaison became more firmly established in 1866 when Maudsley married the daughter of John Conolly, by then a well-established figure in lunacy and the leading name behind the earlier "non-restraint" campaigns.

1. MAUDSLEY, H.: see Journal of Mental Science, 31, VI, 1859, p.78.
2. DAVIES, Rev. W.G.: see Journal of Mental Science, 32, VI, 1860, pp.101-119.
3. ibid.
4. MAUDSLEY, H.: Edgar Allen Poe. Journal of Mental Science, 33, VI, 1860, pp.328-369.

In 1863, with issue No.44, the Journal's editorship was transferred to C. Lockhart Robertson, a frequent past contributor.⁽¹⁾ This number carried a third article by Maudsley - "Considerations with Regard to Hereditary Influence", which again reflects his interest in evolutionary philosophy.⁽²⁾ Although none of his writing had concerned the plight of patients, or the organisation of asylums, these published works by Maudsley were not without significance. With the following issue, No.45, Maudsley became joint editor, with Robertson.⁽³⁾ Henceforth, a more "scientific" bias is discernible, beside the more doctrinal articles. Administrative and peripheral matters were dropped and heavily theoretical material, including reviews of foreign language works, dominate the pages. The future direction of the Journal had been established.

d) The Growing Structure of the Lunatic Profession

With the passing of the "Journal of Mental Science" into the hands of those with influence and position within the upper echelons of the profession,* it ceased to be a significant forum in which the bulk of the profession could contest for advancement. Nevertheless, the asylums themselves remained the base for the making of professional careers. By and large, new posts were no longer advertised in the 'Journal', however, applicants having to rely, in the first instance, on the penny daily papers for opportunities to enter the profession and subsequently on intra-professional contacts and influence.⁽⁴⁾

* At this time, for example, Maudsley left asylum work to become one of two physicians at the West London Hospital. (5)

1. See title page to the Journal of Mental Science, 44, VIII, 1863.
2. MAUDSLEY, H.: see Journal of Mental Science, above, pp.482-513.
3. See title page to the Journal of Mental Science, IX, 1863.
4. See, for example, the Appointments section of the Journal of Mental Science, IX, 45, 1863, p.149, which gives apologies for an inaccurate appointment which "was cut out of one of the penny daily papers, which now team with such medical notices".
5. WALK, A.: Medico-Psychologists, Maudsley and The Maudsley. British Journal of Psychiatry, 128, 1976, p.22.

Most of the appointments recorded in the asylum reports show movement within the asylum framework, though there was some passage to and from the wider medical profession. Experience was already becoming vital in the 1870s, as this extract from the Quarterly Reports of the West Riding Asylum shows.

"[On the appointment of] Dr. George Burnham: - One of the Assistant Medical Officers, becoming selected out of a large number of candidates as Medical Superintendent of the Bristol Asylum; and being required to enter upon his duties at once, Dr. Burnham who was for six months a clerical clerk here in 1868 and who since that time has been Assistant Medical Officer in the Devon County Asylum has with the approval of the Chairman, been appointed to fill his place subject to the approval of the Committee today". (1)

When Dr. Ernest Bevan became Senior Assistant Medical Officer, Female Department, his post as Second Assistant, Male Department fell vacant. This was filled by Dr. Arthur Ronnie, Pathologist and Assistant Medical Officer. (2) Promotions often involved a change of asylum and could in some cases be swift. Dr. Richard Miller was promoted to Senior Clinical Assistant from within the West Riding Asylum in April 1885. By October he had become Assistant Medical Officer at the Sussex asylum. (3)

There was, in addition to experience and personal contact, a clear premium put upon a university degree, preferably Edinburgh or London. A new Clinical Assistant at West Riding Asylum was an Edinburgh graduate. (4) So was Dr. Paterson, who left his post of Clinical Assistant to become Assistant to the State Criminal Lunatic Asylum at Broadmoor. (5) The West Riding's new Clinical Assistant in the Male Department in 1886 was a Bachelor of Medicine and a Master of Chemistry at Edinburgh, (6) while the

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1. Quarterly Report of the West Riding Lunatic Asylum, 27th July 1871. Wakefield PRO C85 123.
 2. ibid., 29th January 1885.
 3. ibid., 30th July 1885.
 4. ibid., 26th January 1882.
 5. ibid., 20th January 1885.
 6. ibid., 29th October 1885.

man who replaced Dr. Paterson was a graduate from London.⁽¹⁾

Quite a few members of the asylum staff did leave that particular branch of the profession and move on elsewhere, however. Dr. William Dudley, the Second Assistant Medical Officer at West Riding left in 1889 to go into general practice. This movement out of asylum work seems to have been fairly common, particularly at lower levels.

e) Medical Education in Lunacy

On the whole the asylum network was supporting its own career structure with previous asylum experience as its basis. In some ways this gave superintendents and the local Committee of Visitors a freer hand than if special qualifications were required for new staff, though over a more limited field. Although by the 1870s and early '80s the asylums were no longer open to the individual entrepreneur, entering on strength of character and determination - such as the earlier influential men like Ellis, Conolly and even Maudsley* in his way - still no recognised qualification in that field of medicine existed. There had been various courses of lectures instituted by individuals, such as Alexander Morison (1823), John Conolly (1842) and Thomas Laycock (1860s); and also courses conducted inside asylums themselves. It was not until 1885, however, that the General Medical Council introduced the Certificate in Psychological Medicine, at the instigation of the mental physicians' organisation, the Medico-Psychological Association. This required three months residence and a course of lectures. However, no-one applied for the first examination.⁽²⁾

* Aubrey Lewis ("The State of Psychiatry, essays and addresses", 1967,)) has some interesting things to say about Maudsley's lack of training. One must be careful to remember, however, that his paper was delivered to members of the Royal College of Psychiatry inside the Maudsley Hospital.

1. ibid., 29th January 1885.
2. LEWIS, Aubrey: The State of Psychiatry, essays and addresses. 1967.

This lack of an obvious route into the asylum meant that each asylum authority could draw upon its own resources and initiative. Their own internal courses on "psychological medicine" on which they came to rely, and which in time, came to influence the educational structure of the whole medical profession, became the basis for the Certificate in Psychological Medicine. Dr. Bevan Lewis, superintendent of the West Riding Asylum, was appointed Lecturer on Mental Diseases to the Leeds School of Medicine in 1885, following his own successful lectures within the asylum. He reported that

"the experience of this Summer's Session has impressed me with the fact that the teaching capabilities of the Asylum might be widely extended. At present the Asylum Museum [still in existence] shows numerous desiderata in the way of models, Diagrams, anatomical and microscopic preparations and these we shall be able in time to supply at a trifling outlay and by our own individual resources". (1)

The asylum was able to supply also the resources of their own pathology laboratory where not only anatomy but also vivisection was available as a teaching aid.⁽²⁾ Bevan Lewis felt confident enough in 1890 to offer a postgraduate course of lectures to medical practitioners throughout the West Riding, which was well attended,⁽³⁾ and before long he found that the courses he was giving at Leeds attracted a growing interest, with "an exceptionally large class of 40 students" in 1894.⁽⁴⁾ It was during these years of growing interest that the British Medical Association itself adopted "Mental Diseases" as a separate section in its Annual Meeting for the first time. Dr. Hack Tuke gave the very first address to this new Psychological Section in 1889.⁽⁵⁾

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1. Quarterly Report of the West Riding Lunatic Asylum, 30th July 1885.
 2. ibid, 19th March, 1891.
 3. ibid, 23rd June, 1892.
 4. ibid, 21st June, 1894.
 5. ibid, 26th September 1889.

f) The Medico-Psychological Association and Control of the Profession

The bonds between senior staff throughout the country received extra support from the existence of their own organisation, the Medico-Psychological Association.* At the foundation meeting in Gloucester, it was declared that the Association's object was to be the

"Improvement in the management of such Institutions and the Treatment of the Insane, and the acquirement of a more extensive and more correct knowledge of Insanity". (1)

The Association was happy to take on board the new 'Journal of Mental Science' and from the early 1860s its annual meetings were reported in detail under the heading "Notes and News". Thereafter the concerted interests of mental physicians were expressed through the MPA.

Senior mental physicians had thus been able to go some way in establishing their own professional identity through means of an exclusive journal, their own professional society and by moves towards a separate area of education. Their control of the profession was not, however, as great as they might have liked. There was yet no regulation of who might enter the profession, whilst specialist education was too ad hoc to lay down clear codes of ethical conduct to those who did. Indeed, the upper echelons of the profession were already operating at some remove from the regular asylum ward. Inevitably, practical work at these lower levels was influenced to some extent by the calibre and outlook of new staff entering over the years.

* Originally an initiative by the very energetic Samuel Hitch in 1841, who created the then Association of Medical Officers of Hospitals for the Insane as part of his asserted campaign against the practice of physical restraint in the treatment of the insane. The Association changed its name in 1865. (2)

1. WALK, A. and D. Lindsay WALKER: Gloucester and the Beginnings of the R.M.P.A. Journal of Mental Science, 107, 1961, p.621.
2. ibid., pp.603-632.

At first sight such new blood as there was does not seem to have brought a great deal of challenge to the system in the period of our study. Probably this reflects the tight grip held by the few who came to the top in the field in the 1860s. Maudsley and Lockhart Robertson controlled the "Journal" very effectively, reducing the involvement of new men in the profession by concentrating upon an approach to the subject matter which was not obviously pertinent to the actual asylum situation, as our study of the "Journal" contents have shown. Fresh involvement would need to have taken place at the level of research and theory, areas which attracted attention from men experienced in fields such as neurology and clinical psychology as well as from those aspects of asylum work least involved with the care and treatment of patients. As far as the more routine side of asylum work was concerned, this received very little attention and consequently had little influence on the overall direction of the profession as the top men in the MPA conceived it.

However, this does not mean that there was no change at the level of care and therapy, only that such change as there might have been would have gone largely unrecorded. Indeed, with the growing remoteness of the "Journal" from everyday asylum practice and the involvement of top mental physicians, such as Maudsley, in academic and clinical research work there must have grown up a body of day-to-day routine which informed those "lower" levels of asylum work. Whatever had been established from previous practice would have been passed down by existing staff to all new recruits - either explicitly or by example on the wards - without the aid of "official" published sources. This body of orally-transmitted "know-how" would not then have made much impression upon the sources which an historian is bound to examine, while yet changing significantly with the aims and outlook of each succeeding wave of new staff. To all appearances, the period from the 1850s to the beginning of the twentieth century was an uneventful one in the

history of the embryonic "psychiatric" profession, yet we should be aware that there may have been changes at submerged levels, which did not become apparent until much later.

Because there is this possibility we need to look more closely at the employment structure in the asylum and the ways in which normal asylum working advantaged the various groups working there. Since each asylum was most strongly identified with its medical superintendent we shall begin by considering his position at the top of the ladder. Below him, and next on our list, were the professional staff of medical officers and dispensers, and at the bottom of the ladder came the most menial, yet arguably most vital, section of the asylum's workforce, the nurses and attendants. Each found benefits from involvement in the asylum system, but they were by no means equally distributed.

g) The Medical Superintendent

The greatest benefits undoubtedly accrued to the superintendent, particularly if he was a man with a taste for power and personal authority. This was the legacy of the heavy emphasis placed (at one time, at least) upon "moral treatment" and the influence of the sane mind upon the insane.⁽¹⁾

From this, as J.T. Arlidge remarked,

"it follows that one man must be placed at the head of the establishment and that his mind must pervade the whole establishment". (2)

As we saw earlier,⁽³⁾ the concept of "moral treatment" underwent important changes with the growth of asylum populations and above all with the application of the idea to the "labouring classes", though still directed by middle-class professional men across a class barrier. The

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1. See Chapter 3.
 2. ARLIDGE, John T: On the State of Lunacy and the Legal Provision for the Insane, with observations on the construction and organisation of asylums. 1859, p.122.
 3. See Chapter 3.

therapeutic interpretation of the term subsequently decayed into virtually any treatment which was neither chemical nor mechanical. Arlidge himself includes exercise, useful employment, amusement and cleanliness under the heading of "moral treatment".⁽¹⁾ What did not decay, however, was the belief in personal authority as the arbiter of a rigid social system. Such a system, where lunatics were under the constant influence of an order they could not subvert with their madness, came to be seen as the sine qua non of any asylum. There should be "only one captain of a ship," said Charles Mercier, reworking an already old metaphor. He

"must be before all things a man of strong character, a man of dominist will, who can impose his will on others and compel obedience by the sheer force of his own strong nature" (2)

Mercier was convinced, of course, that this would avoid "strife and ill-feeling" as well as achieving complete control over patients,⁽³⁾ yet with a certain contrariness he goes on to outline the kinds of ill-feeling which such authoritarian attitudes can engender. We have seen⁽⁴⁾ that in consequence of such personal authority patients' dances sometimes had to wait upon the superintendent finishing his dinner, or the cricket match be delayed because he wanted to use the pitch to graze "his" cows (actually the property of the local rate-payers) or a broken window in the wards must be left until "the superintendent's" greenhouse is attended to. Mercier claims that

"it will be said that this picture is a caricature, but the instances above given are not fancy pictures, and those who are acquainted with many asylums will know of one or two in which such events have been possible". (5)

The superintendent's power to choose a medical officer was his alone (though

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1. ibid, pp.106-7.
 2. MERCIER, Charles: Lunatic Asylums - their Organisation and Management. 1894, pp.196-8.
 3. ibid, pp.195-6.
 4. See Chapter 5.
 5. MERCIER, Charles: op.cit, p.201.

officially the appointments were made by the local Committee of Visitors) and it was not unknown, Mercier goes on, for personal considerations to interfere, with the superintendent avoiding any undue challenge to his medical powers by selecting "a companionable chap a good-humoured, pleasant, patient gentlemanly fellow, with no conspicuous ability, and no very firm strength of character".⁽¹⁾ Medical Officers themselves complained that the younger amongst them were discriminated against for their more recent, and therefore superior, knowledge, which may show up the superintendent in a poor light, and G.H. Savage in his 1886 Presidential Address to the Medico-Psychological Association bore this out.⁽²⁾

These drawbacks were, however, put down to the poorer quality of some superintendents' natures and faith in authority per se was maintained. Indeed, the high calibre of the asylum superintendent was extolled, especially by their colleagues. Daniel Hack Tuke, the flat-footed visionary and apologist for the asylum system, wrote in his book, "Chapters on the History of the Insane in the British Isles",

"It is one of the happy circumstances connected with the great movement which has taken place in this and other countries, that men have arisen in large numbers who have proved themselves equal to the task. We witness the creation of an almost new character - the asylum superintendent" ⁽³⁾

Along with tributes like these the asylum superintendent could enjoy more tangible benefits. Bevan Lewis, on his appointment in 1884 to "medical director" of the West Riding Asylum, could draw a salary of £600 per annum. This was increased to £800 in 1892 and to £1200 in 1910. His successor, Shaw Bolton, was appointed at an annual salary of £1,050.⁽⁴⁾ Such a sum

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1. ibid, p.245.
 2. See DODDS, STRAHAN and GREENLEES: Assistant Medical Officers in Asylums: Their Status in the Speciality. Journal of Mental Science, 52, XXXVII, 1890, pp.48-9.
 3. TUKE, D.H.: Chapters in the History of the Insane in the British Isles. 1882, p.462.
 4. Staff Wages Book. Stanley Royd Hospital Museum, Wakefield.

may be modest, yet it was four or five times the sum which lesser ranks could command.⁽¹⁾ Indeed, this in itself added greatly to the new superintendent's self-esteem and so could dangerously aggravate his latent absolutist tendencies, as Charles Mercier pointed out.⁽²⁾ Moreover, along with the post went a large house, built in gentlemanly style with several bedrooms.* The salary compares favourably with average incomes for medical practitioners outside. In 1910 the average gross income of provincial medical men was £832,⁽³⁾ this without the hidden extras provided by the institution. These included full board and the pick of the stores for the superintendent's table.

In return for these rewards he provided a fairly imprecise set of services. His medical duties were left undefined by any clause in the Lunacy Acts or any official guideline, so that it was easy to delegate these to the medical officers and concentrate on administrative matters.⁽⁴⁾ These nevertheless included the regular inspection of staff, often by surprise visits to the wards, and a peremptory system of discipline, particularly where attendants and nurses were concerned.⁽⁵⁾ As far as his duties towards his patients were concerned, Hack Tuke paints an attractive picture of dedication and altruism.

"A formal walk through the wards, and the ordering of a few drugs, compriseth but a small part of his means for restoring the troubled mind. To prepare for this work, and to make the means effectual, he carefully studieth the mental movements of his patients. He never begrudges the moments [n.b. only "moments"] spent in quiet, familiar intercourse with them, for thereby he gaineth many glimpses of their inner life that may help him in their treatment".⁽⁶⁾

* These houses can still be seen in most mental hospitals, though now usually made over as a suite of offices.

1. ibid.
2. MERCIER, Charles: op.cit., p.246.
3. PETERSEN, M. Jeanne: The Medical Profession in Mid-Victorian London. 1978, p.217.
4. LOMAX, Montagu: Experiences of an Asylum Doctor, 1921, Chapter 1.
5. MERCIER, Charles: op.cit., pp.175-9.
6. TUKE, D.H.: op.cit., p.463.

Charles Mercier is more prosaic. The recommended timetable which he lays down runs as follows.

"The superintendent should be in his office not later than nine o'clock.

9.00 - 10.30 : Signing reports and notices. Correspondence.

10.30 - 1.00 : Tour of the wards, accompanied by the medical officer.

1.00 - 2.00 : Inspection of inmates' lunch, then takes his own.

2.00 - 5.00 : Interviews with patients brought to him by the head attendant. Tour of any remaining wards. Inspection of staff.

After dinner : Social functions. Surprise visit to the wards." (1)

To such internal work we should no doubt add the business of maintaining relations with others of his profession. This would involve social visits to local (and not so local) medical men, a scrutiny of literature and perhaps the preparation of a paper of his own for the "Journal of Mental Science". In addition, there were, of course, meetings of the MPA to be attended. In this way, the superintendent was able to provide for himself a reasonable status within a limited profession from which to aspire, perhaps, to private medicine as a visiting physician or to work with the Lunacy Commissioners. This no doubt helped to offset a modest but comfortable professional income.

h) The Medical Officers

The subordinate officers in the asylum were a growing breed. From the more common procedure of appointing one medical man to act as assistant to the superintendent, the appointment of several men in various positions had become so commonplace by 1888 that the Medico-Psychological Association set up a four-man committee to represent this "large and growing body".⁽²⁾

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1. MERCIER, Charles: op.cit., pp.243-4.
 2. DODDS, STRAHAN and GREENLEES: op.cit., p.43.

The committee promptly sent a questionnaire to all asylums asking for numbers, terms of service and levels of salary. It was not pleased with what it found. At the quarterly meeting in November 1889 Drs. Dodds, Strahan and Greenlees (Dr. Wigglesworth having died just previously) presented their case.⁽¹⁾

There were, they said, essentially two levels of staff: the senior officers who were of long standing and experienced in their speciality, having spent on average six years in its service, and the junior officers, who were of less dedication, yet were receiving rather more than they were worth. These junior officers, argued the committee,

"are in great part birds of passage, who take an asylum appointment merely to gain very useful experience, or in order to spend the time necessary to acquire that grave and senior look deemed essential to the private practitioner. They use their asylum appointment as others do resident hospital and infirmary appointments. They have from the first no intention of remaining within the speciality, and after a brief experience betake themselves to other and more attractive fields. These juniors receive from £80 to £120 or more per annum, with the usual allowances, and so are fairly paid. So far as we have heard, there is neither complaint nor ground for complaint here".⁽²⁾

The committee, obviously feeling itself to be more representative of the senior staff than the juniors, went on to lament the poor reward offered to the former.

"They are men who are doing work which would not be equally well done by any qualified man whatever, taken at random from the junior ranks of our profession, and they should consequently be rewarded in view of that special knowledge".⁽³⁾

Whatever the value of their attitude to those "birds of passage" the senior staff did appear to have a valid grievance. They wanted parity with

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1. The paper was read before a quarterly meeting of the M.P.A.
See ibid.
 2. ibid, p.44.
 3. ibid, p.45.

officers of similar standing in other public medical services. Army and Navy surgeons, they pointed out, could get £280 a year and a gratuity of £1000 after ten years' service, yet the average salary for asylum officers was only £161. (1)

They had other complaints, too. They felt ill-used and unappreciated as skilled medical men. The size of asylums, by that time growing virtually out of control, meant that the superintendent could not possibly give attention to so many patients so that much of the essential work had to be done by subordinate staff who, at the same time, were expected to take on increasing loads of clerical work. There was more than just exploitation here. The medical officers felt their skills were undervalued, whilst resenting the kudos that accrued to the asylum's figurehead.

"The recognition of such seniors as responsible physicians would undoubtedly do away with the pious fraud at present perpetuated on the public, viz, that the Superintendent is in all cases the physician who marks the symptoms in the sick in body and mind and treats those symptoms as they appear". (2)

But such were the relations between the superintendent and his subordinates that medical officers felt the need to tread warily.

"This is delicate ground, on which we will not venture further". (3)

Rather they retreated a little, adding an ironic touch of sweetness to their words.

"Some persons have criticised us for not contrasting the fat salaries of Superintendents with the lean ones of the assistants [i.e. subordinate officers] Our position is not that our superior officers are too highly paid - the reverse is often the case - but that assistants as a class are underpaid". (4)

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1. ibid, pp.46-7.
 2. ibid, p.48.
 3. ibid, p.49.
 4. ibid, p.50.

Clearly, all was not well in the lower ranks of asylum medicine.

Their other criticisms of the asylum system were more plainly stated, since they constituted less of a challenge to the superintendent's personal authority. There should be a class of junior clerks to remove the "millstone of clerical work" from their necks. Asylums should be smaller, assistant staff should be regarded as physicians and lastly, yet perhaps not insignificantly, they should be allowed to marry.⁽¹⁾

The life of a senior medical officer in an asylum was not enviable. Usually he would be expected to live on the premises, in a room provided and with the usual board and washing facilities.⁽²⁾ His income was small. Ernest Birt, the House Surgeon at West Riding in 1880, received £130 per annum. This increased to £180 in 1884, £210 in 1890, £260 in 1901 and £300 in 1905.⁽³⁾ The Deputy Chief Assistant was appointed in 1885 on a salary of only £64, which increased to £100 in 1890. There was slender hope of advancement from positions such as these. Charles Mercier noted that the medical officer

"sees the best years of his life slipping away from him without any advancement of his interests or improvement in his prospects".⁽⁴⁾

The usual route out of this impasse was to drop out of asylum work altogether and go into private medicine.⁽⁵⁾ It was hardly surprising that so many young men were "birds of passage" under these conditions and one can understand the hostility toward them shown by those with dedication, or without alternative means, who remained for years the widowers of lunacy.

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1. ibid, p.52.
 2. Staff wages book. Op.cit.
 3. ibid.
 4. MERCIER, Charles: op.cit., p.246.
 5. ibid, p.246.

1) Nurses and Attendants

If medical officers felt themselves poorly paid at £161 per year they could at least look down upon the bottom rung of asylum staff from a reasonable height. In 1890 a nurse was appointed to the West Riding Asylum at £17 per year, with board and lodging.⁽¹⁾ In the 1870s the rate had been £15 and in the early sixties a meagre £12 or £13. Male attendants could get double that figure, despite the fact that they were not allowed to marry.⁽²⁾ Nevertheless, there were on the whole more women than men in this type of work⁽³⁾ and so the lower rate is arguably the most relevant. Along with this rate there was, of course, full board and lodging, a clothing allowance and washing facilities, such as any domestic employment would supply.⁽⁴⁾

The work was arduous. J.T. Arlidge says that

"their duties necessarily partake largely of a household character; they are engaged in cleaning and polishing, in bed-making and dressing, in fetching and carrying, and in serving meals".⁽⁵⁾

They were also required to assist in the "treatment" of patients by providing exercise, employment, amusement, supervision and general cleanliness. But in addition to these duties, attendants had more particular "medical" work to perform, as the "Handbook for the Instruction of Attendants on the Insane" makes clear.⁽⁶⁾ In describing how to attend to patients in sick-rooms it advises scrupulous cleanliness (which, particularly in incontinent patients was no easy matter), keeping the air fresh and the temperature warm, maintaining records of the patient's progress and

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1. Staff wages book. Op.cit.
 2. Register of Attendants. Stanley Royd Hospital Museum, Wakefield.
 3. ibid. This result is also confirmed by the Census Enumerator's Records, Public Reference Library, Wakefield.
 4. Staff wages book. Op.cit.
 5. ARLIDGE, J.T.: op.cit., p.105.
 6. Handbook for the Instruction of Attendants on the Insane. American Ed., Boston, 1886, pp.61-73.

the taking of body temperatures. The attendant must also know how to apply cold dressings and poultices, fomentations, enemas, suppositories, baths of various kinds, (1) as well as the technique of packing patients in a wet sheet. (2) These medical duties were seen as a vital part of the work of both attendants and nurses.

"The nurse who can enter most closely into the mind of her patient, who can probe her feelings with instinctive readiness, and adapt her circumstances to the varying moods presented, is, indeed, a valuable auxiliary to the medical [officer,]" (3)

wrote Bevan Lewis, agreeing entirely with the conclusions of the Commissioners in Lunacy forty years earlier:

"Although the Patient depends on the Superintendent of the Asylum for proper medical treatment the condition of a Patient is materially promoted or retarded by the activity or supineness of the Attendant, who exercises great powers of control over him during the greater portion of the day, and during the whole day is his only sane companion". (4)

On occasions they were expected to help the cause of medical science in less usual ways, as when T.S. Clouston used his staff to run a control experiment when measuring body temperatures in the insane:

"Instead of taking the usual standard of sane temperature at 98.4°, I examined all the officers, attendants and servants employed in the asylum at the same time in the morning as I had examined the patients, and again at night after they had been in bed for one to two hours, as in the case of the patients". (5)

In immediate charge of attendants and nurses was the Head Attendant, who acted as a link between the ordinary staff and the medical officer. His job was largely to oversee the general administration and supervise up to 300 or more patients. It was he who first inspected new inmates and

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1. See Chapter 3.
 2. Handbook for the Instruction of Attendants on the Insane. American Ed., Boston, 1886, pp.101-2.
 3. LEWIS, W. Bevan: A Text-Book of Mental Diseases: with special reference to The Pathological Aspects of Insanity. 2nd Ed., 1899, p.462.
 4. Thirteenth Report of the Commissioners in Lunacy, 1859, pp.61-2.
 5. CLOUSTON, T.S: op.cit., p.36.

presented a medical report to the medical officer. It was the Head Attendant, too, who acted as go-between for patients who wanted to speak to the medical superintendent.⁽¹⁾ At the West Riding Asylum in 1881 he was a man of 63 and received a significantly higher wage than his subordinates.⁽²⁾ Charles Mercier outlines his duties as follows:

- 7.30 Breakfast
- 8.00 Back on the wards
- 10.30 Tour of inspection
- 1.30 Dinner. Supervision of wards and airing courts.
- 5.00 Patients' tea.
- 10.00 Masterlock all communication doors. (3)

Nurses and attendants could expect to be at work for most of the day and sometimes at night, although special night-nurses were increasingly employed during the century.⁽⁴⁾ Even so, according to Mick Carpenter the average number of hours per week was still around 70 in 1912.⁽⁵⁾ Sometimes coverage at night would be achieved by changing the shift patterns, day shifts starting at midday following night-duty and finishing at 3 p.m. before night-duty, as at Colney Hatch,⁽⁶⁾ or even run together with only four hours rest after a twenty-hour stretch, as occurred at Lancaster in 1896.⁽⁷⁾ More often, "night" shifts would include "light work" during the day with staff working from 10 a.m. until 2 a.m. the next morning, with only four hours' break in the afternoon.⁽⁸⁾ Even when asleep the nurses

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1. A Descriptive Notice of the Sussex Lunatic Asylum, Hayward's Heath. Journal of Mental Science, VI, 33, 1860, p.255.
 2. Staff wages book. Op.cit., also Census Enumerator's Records, op.cit.
 3. MERCIER, Charles: op.cit., pp.280-3.
 4. Eleventh Report of the Commissioners in Lunacy, 1857, p.46; Thirteenth Report, 1859, pp.64-5; Quarterly Report of the West Riding Lunatic Asylum, 29th January 1885, op.cit.
 5. CARPENTER, Mick: Asylum Nursing before 1914: a chapter in the history of labour, in, DAVIES, G. (Ed.), Rewriting Nursing History, New Jersey, 1980.
 6. Thirteenth Report of the Commissioners in Lunacy, 1859, pp.65-7.
 7. Fiftieth Report of the Commissioners in Lunacy, 1896, pp.27-8.
 8. Thirteenth Report of the Commissioners in Lunacy, 1859, p.68.

could not always escape duty since they were commonly expected to use a room adjoining a ward⁽¹⁾ and (when not woken up in the interests of medical science) were frequently kept awake by the noise made by disturbed patients.⁽²⁾ Staff could normally look forward to one afternoon off each week, one or two Sundays in the month and seven days during the year,⁽³⁾ although at some asylums a little more time off, seemed to be allowed.⁽⁴⁾ The rest of the time they lived, of course, within the walls of the institution.

Some historians have regarded the work with optimism. John Walton, for example, sees the pay as being "certainly much better than domestic service".⁽⁵⁾ However, optimism is less valid when we consider working conditions. Lunatic asylums were not, by their nature, desirable residences and had certain disadvantages as compared with domestic service. Firstly, they lacked the familiar domestic arrangements of a private home. In the asylum the sexes were kept rigidly apart and much of the asylum's institutional nature rubbed off onto its staff.⁽⁶⁾ Moreover, unlike domestic service, it was not possible for staff to identify with their employers when mixing with others of their own class.⁽⁷⁾

The wages offered at Lancaster, where Walton drew his information, seem also to have been unusually generous. Figures of between £15..12s and £19..8s for women and between £27..12s and £37..12s for men are recorded in 1852.⁽⁸⁾ Yet at Wakefield in the 1870s a rate of £15 or £16 for women

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1. ibid., p.64.
 2. MERCIER, Charles: op.cit., p.286.
 3. ibid., p.286.
 4. Quarterly Report of the West Riding Lunatic Asylum, 20th June, 1889, op.cit.
 5. WALTON, John: The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816-1870, in, SCULL, A.T.: Madhouses, Mad-doctors and Madmen. The Social History of Psychiatry in the Victorian Era, 1981, p.180.
 6. MERCIER, Charles: op.cit., p.285.
 7. John Walton has quite rightly pointed out that these remarks apply more to a "big house" environment than to smaller households.
 8. WALTON, John: op.cit., p.181.

and £30 for men seems general.⁽¹⁾ At Nottingham in 1881 the scales began at £16 and £30 respectively, which rates were described as "liberal".⁽²⁾ On top of this it was possible to obtain allowances of ten shillings a year for good conduct and extra money after long service. There was, in addition, a pension payable under the 1862 Lunacy Act, though it required the formal consent of a magistrate,⁽³⁾ (the 1890 Act amended this to require the agreement of the County Council).⁽⁴⁾ However, this was awarded only after fifteen years' steady service and was entirely discretionary.⁽⁵⁾ Extras such as a small plot of asylum farm-land could be granted in return for extra supervision.⁽⁶⁾ On the other hand, the provision of food does seem to have been reasonably generous. The basic official weekly allowance of 14-lbs of potatoes, 7-lbs of bread and 4.25-lbs of meat (5.25-lbs for men), together with extras such as butter, cheese, sugar, coffee and tea,⁽⁷⁾ was virtually identical to the ration-sheet published by the Nottingham asylum forty years later.⁽⁸⁾ The only problem here is that there is no way of knowing what staff (or patients, for that matter) actually received. It seems unlikely, however, that institutions could match the fare commonly available in a wealthy residence, if not in a more humble abode. Certainly Charles Mercier saw no cause for optimism regarding the dietary, the working conditions or the future prospects of his staff and regarded the whole system as over-regulated and underpaid.⁽⁹⁾

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1. Register of Attendants, op.cit.
 2. Annual Report of the Nottingham Borough Asylum, 1881. Mapperley Hospital Library.
 3. "The Superannuation Clause of the Lunacy Acts Amendment Act, 1862". Journal of Mental Science, XIV, 65, 1868, pp.75-84.
 4. ADAMS, F.R.: From Association to Union-professional organisation of asylum attendants, 1869-1919. Brit. Journal of Psychiatry, 20, 1969, pp.11-26.
 5. Quarterly Report of the West Riding Lunatic Asylum, April 1885. Wakefield PRO, C85 123.
 6. MERCIER, Charles: op.cit., pp.288-98.
 7. WALTON, John: op.cit., p.181.
 8. General Records of the Mapperley Hospital. Mapperley Hospital Library. This table is reprinted in Chapter 5, p. 231
 9. MERCIER, Charles: op.cit., pp.285-7.

Conditions for nurses and attendants nevertheless did improve slightly in the course of the century. Provision for a private mess-room was spreading in the 1880s. In 1887, Bevan Lewis, the superintendent of the West Riding Asylum, ordered a reading and recreation room to be built.

At present, after duty hours, if the weather be increment [sic] or if the nurses do not desire to leave the building, she has no resource other than returning to her bedroom, which in all cases is too small and confined even as a 'sleeping room". (1)

The new Nurses' Recreation and Reading Room was opened in 1888 and was much appreciated by the staff. (2) Also spreading were lessons in games and music, and competitions between asylum and local bands took place, usually at the local public house. (3) The benefits of this were presumably intended more for the patients, yet it is a sign of a developing trend within the nursing staff and perhaps an early indicator of a shifting of attitudes away from the quasi-military style noted in Chapter 5.

Evidence on the security of the work, however, all suggest that nurses and attendants faced serious risks which not only threatened dismissal but also the possibility of criminal charges and even a spell in prison. Of the male attendants working at the West Riding Asylum between 1860 and 1880 nearly 4% (21 in all) were sacked for "cruelty" to patients, though amongst females the figure was around 1.4% (a total of 8). This accounted for about one third of all dismissals amongst men and women. (4)

"Cruelty" was something which the Commissioners in Lunacy abhorred. Much of the pauper asylum's credibility was built on the abandonment of "restraint" and the adoption of a "humanitarian" regime. Any act of coercion which could be construed as punitive or involving undue physical

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1. Quarterly Report of the West Riding Lunatic Asylum, 27th October 1887, op.cit.
 2. ibid, 26th April 1888.
 3. MERCIER, Charles: op.cit., p.287.
 4. Register of Attendants. Op.cit.

force was vigorously condemned since it threatened this credibility. In practice, of course, a good deal of punishment and force was used under "medical" guise - see Chapters 3 and 5 - but this could not always escape the more obvious interpretation, particularly when severe injuries or death were the results. When medical men could not keep the lid on their activities, or incautious attendants were caught out by a superior in the act of "controlling" a refractory inmate, the official retribution which followed could be relentless.

In 1891 an attendant was dismissed for "forcibly pushing" a patient.⁽¹⁾ Often in cases such as this the Commissioners would prosecute for assault, as happened when John Owen was found guilty of "striking a patient" and fined 17/6d.⁽²⁾ Attendants were not, as a rule, wealthy people and so could not afford to pay fines such as these. An attendant at the Northwood asylum was fined £15 for assault, but because he had no money he was forced to spend two months in prison instead.⁽³⁾ Another attendant found guilty of taking a patient into the bathroom and striking him was fined £5. He also could not pay and so was sentenced instead to one month with hard labour.⁽⁴⁾

It was not only incidents such as these which rendered an attendant liable for dismissal or even prosecution. The unpredictable nature of some of the patients added to their insecurity and liability to discipline. In 1876 a patient who was not stated to be suicidal was given a pocket handkerchief by an attendant because he complained of a cold. This was against the regulations of the asylum and when the patient succeeded in hanging himself with the handkerchief the attendant was blamed for neglect

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1. Minutes of the Meeting of the Commissioners in Lunacy, 11th September 1891. PRO, MH50.
 2. ibid., 6th March 1876. 17/6d is equivalent to 87.5 new pence.
 3. ibid.
 4. ibid.

of duty.⁽¹⁾ Incidents of this kind not only illustrate the degree of petty regulation to which nurses and attendants were subjected but also the fact that the medical authorities would go to great lengths to lay the burden of responsibility for what happened to their patients at the door of their most vulnerable employees.

That doctors were often overstepping the mark in this respect is suggested by those cases where prosecutions for neglect which were brought by the Commissioners were thrown out by the jury. However, this did not save the attendants concerned from losing their job. A jury in 1890 heard how a 31-year-old cripple, "noisy, restless, incoherent and of faulty habits" was put in a bath with the taps running and the plug left out, so that the foul water could drain away. The patient cried out and was removed back to bed and assistance summoned. The medical officer found scalding which was "not severe" around the legs and buttocks. Nevertheless, the patient, "being feeble", died ten hours later from shock. "It was calculated that the heat of the water was about 120°F". The Commissioners felt it was their duty to commit one of the two nurses involved for manslaughter. The assize jury rejected the charge.⁽²⁾

Even in cases where it was felt there was insufficient evidence for a criminal charge, attendants might be dismissed if any fault were found. When a patient committed suicide at the North Riding Asylum in 1875 an enquiry was conducted on one attendant "on whom the blame of the patient's death appears to rest". Despite the recognition that not enough evidence existed for a prosecution for neglect it was held that the attendant in question "ought no longer be employed as an attendant on the Insane".⁽³⁾

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1. Thirty-First Report of the Commissioners in Lunacy, 1877, p.79.
 2. Forty-Fifth Report of the Commissioners in Lunacy, 1890/1, p.62.
 3. Minutes of the Meeting of the Commissioners in Lunacy, 7th June 1875, op.cit.

A similar fate awaited an attendant who left a "suicidal" patient in the lavatory for a few minutes, returning to find that he had hanged himself with a piece of twine. The Commissioners commented that although the attendant had been given no written instructions,

"we considered that the attendant could not be acquitted of blame for relaxing his vigilance, while his orders, though verbal, were still in force". (1)

The impression of a firm disciplinary control which these instances give is borne out also by the fact that in total 91 out of 567 men employed at the West Riding Asylum between 1860 and 1880 were sacked by the superintendent for reasons varying from "dishonesty" to "drunk". Some of them simply went absent without leave. In general the turnover of male staff seems to have been very rapid, 2-3 months being common, especially in the 1870s, though this may have been emphasised by the mining boom in Wakefield at that time. Even so, many of the women spent similarly brief spells of work in the asylums, though periods of one or two years are more common. (2)

Charles Mercier also found the turnover to be rapid, complaining that a third of them would leave each year. (3) The Commissioners in Lunacy reported that attendants were an all too mobile workforce, commenting that the perpetual change in staff led to the "recurrence of bad habits, and a retrogression in the general condition of the Patient". (4)

Although mental physicians were constant in this lament at the unreliability of their attendant staff and in the reiteration of the need for higher wages to offset this, very little seems to have been done to make the job more amenable to the type of person they professed to need. The conditions of work which are described here hardly seem appropriate to

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1. Thirty-Eighth Report of the Commissioners in Lunacy, 1884, p.73.
 2. Register of Attendants, op.cit.
 3. MERCIER, Charles: op.cit., p.285.
 4. Thirteenth Report of the Commissioners in Lunacy, 1859, p.62.

the temperament of the Commissioners' ideal attendant:

"It is the duty of a good Attendant to lead his Patient by advice and example into habits of occupying and amusing himself; to encourage him when timid; to soothe him when irritable; to supply his wants, however imperfectly expressed; to prevent all bad habits, and finally, to bring him back gradually to the recollection of a former rational state and stimulate his intellect when dormant, until it recovers its original tone and power. To effect all this there should be intelligent, judicious, industrious, and active attendants". (1)

To effect all this and make the beds, clean incontinent patients, scrub and polish the wards, fetch, carry, serve meals and take the blame for mishaps, yet still retain

"a quiet, calm, gentle demeanour, free from the least flurry, a constant cheerfulness and brightness unruffled by any of her patient's vaguaries, an absolutely even temper, great patience and forbearance". (2)

Instead of paragons such as these the Commissioners found that most of the staff they employed were

"coarse, harsh, passionate, indifferent, untrustworthy, intemperate; having no higher conception of their office than that of gaoler and having no better or kinder or humane bond with [the patients] than that of watchdog and warding and ruling them". (3)

They were seen as "lazibodies" and the "outcasts of other trades". (4) One medical superintendent was

"horrified by the brutal and illiterate instruments through whom he was expected to act". (5)

Mental physicians on all sides called for ways to improve this situation.

The Commissioners argued that

"the moral treatment of the insane must remain a mockery and a deception and a failure until the art has its artizans," (6)

and called for higher wages to attract "persons of this quality". (7) Yet

1. ibid, pp.62-3.
2. LEWIS, W. Bevan: op.cit., p.462.
3. Journal of Mental Science, XII, April 1866, p.44.
4. ibid, p.45.
5. ibid.
6. Thirteenth Report of the Commissioners in Lunacy, 1859, p.59.
7. ibid, pp.62-3.

despite declarations of this kind, physicians actually remained curiously supine on the matter both of wages and of employing "Attendants of good character, and in some instances of superior education".⁽¹⁾ Wage-rates, as we have seen, remained fairly constant and little was done to make asylum work agreeable to persons of quality. On the contrary, it was the doctors themselves who encouraged the attitudes of gaolers and watchdogs by their own obsession with order and security.*

One could simply say that mental physicians were asking too much. This, of course, is clear from endless eulogies on "the good attendant". Yet why were they asking so much of attendants in the first place, and why, with the problem of acquiring high quality staff obvious from an early stage, were not more vigorous means employed to achieve that end? To some extent they were hampered by financial restrictions, since the wages of all staff

* This can be seen, for example, in the great and constant interest shown in locks and keys, and the establishment of a hierarchy around these amounting to military discipline. As early as 1854 the Kent asylum devised a system in which the doors to each bedroom were fitted with handles on the outside only, so that once closed they could not be opened from the inside.⁽²⁾ Thirty years later many refinements had been developed. In an article published in the "Journal of Mental Science" in 1885⁽³⁾ an entire system of keys and locks was described. In this system the turning of the key drew back the bolt, which remained retracted until the key was withdrawn, when it would spring back. Thus the door could neither be opened nor closed without the key. A second key, held only by Head Attendants, could override this mechanism and lock the patients in more securely. At the same time a third key, held only by medical officers, would be used to secure the doors leading to the grounds or to other parts of the asylum. Furthermore, the construction of the locking mechanism was carefully made to defeat attempts at lock-picking by knife, spoon-handle or any other means. This concern with locks suggests a strong prison-like feel to the asylum, with as much intention on the part of the doctors to control the attendants as well as the inmates.

1. ibid, p.61.
2. HUXLEY, J.E.: History and Description of the Kent Asylum. Journal of Mental Science, I, 3, 1854, pp.39-45.
3. ANON: On Locks in the Cork Asylum. Journal of Mental Science, XXXI, 135, 1885, p.440.

had to come from the poor rates. Yet we do not find any evidence to suggest a conflict of interest on that score. In fact we find regular complaints of the poor quality of staff coexisting with statements, like that made at Nottingham, that the wages already offered were liberal enough at £16 and £30 p.a.⁽¹⁾ It is true also that some attempts were made to provide educational facilities for nursing staff with special training in psychological medicine, yet on the whole these attempts did not go very far. One or two superintendents set up courses for attendants in the early days of public asylums (e.g. Alexander Morison at Surrey in 1843 and W.A.F. Browne at Crichton Royal in 1854) but nothing of a general character was mooted until a letter in the "Journal of Mental Science" in 1870, to which there was no immediate response. Then, in 1876, T.S. Clouston began a series of lectures to his own Association on the importance of training good attendants, to which there was equally no great response. Not until the enterprise of Campbell Clark in 1883, proposing competitions and prizes for essays on matters of insanity written by attendants, was any enthusiasm shown. It then consisted in the compiling of "A Handbook for the Instruction of Attendants on the Insane", published by the Association in 1885. Finally, systematic training and examination for attendants began in 1890, under pressure from similar schemes in the large teaching hospitals.⁽²⁾

It seems more likely that attacks upon the calibre of nurses and attendants served to mask a more significant failure - that of the medical profession itself to find cures for insanity. The much-publicised ability of medicine to provide such cures in as many as 90% of all cases, which doctors had paraded in the 1830s and 40s, had been transferred to the amazing powers of the ideal attendant. Quite simply, the doctors were now saying that good nursing could achieve what they alone could not. The inflated

1. See above, p.315.

2. See WALK, A: The History of Mental Nursing. Journal of Mental Science, 107, 1961, pp.1-17.

ability of "the good attendant" was another mirage of the curative potential which asylums were alleged (usually by the doctors working in them) to possess. When the mirage was reduced to dust the attendants seemed most naturally to blame. Similarly, when doctors found they were unable to run their rigidly authoritarian system without mishap and violence it was the nurses and attendants who carried the can.

Where did the asylums find the staff on whom so much depended? On this question the necessary evidence is scanty. One enterprising superintendent sought them from the mechanics' institutes but found such self-taught people "as harsh and slovenly, and more dogmatic and opinionated than clodhoppers".⁽¹⁾ Turning to the army for recruits he found ex-soldiers possessed of "a tyrannical spirit" and "addicted to drink". Even resorting to teetotal organisations was no guarantee, he warned, darkly, "against the other evil tendencies to which uncultivated minds are heir to". An article in the "Journal of Mental Science" advised farm labourers for male attendants, and for nurses, "young housemaids under twenty".⁽²⁾ Charles Mercier warned against taking staff from other asylums as they were "up to all sorts of tricks".⁽³⁾ Ex-army men were too disciplinarian (especially ex-bandsmen) whilst young, inexperienced lads were "apt to try their fortunes at other employments". Nurses were in a more plentiful supply and were, of course, cheaper. After such a catalogue of unsuitable candidates it is difficult to know who in fact was taken on. John Walton in his article (see above) argues that careful selection was used by doctors since the ages of attendants (median age 30 for men and 25 for women) would be unlikely to emerge spontaneously from the labour market.⁽⁴⁾ The Wakefield census returns for 1861 show median ages of 27

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1. Journal of Mental Science, XII, April 1886, p.44.
 2. A Descriptive Notice, op.cit., p.257.
 3. MERCIER, Charles: op.cit., pp.288-98.
 4. WALTON, John: op.cit., p.182.

(male) and 26 (female) at the West Riding asylum. Twenty years later the figures were 30 (male) and 26 (female).⁽¹⁾ There does appear to be some consistency here, though, as yet we are unable to say what the selection criteria were.

"The attendants are the backbone of a lunatic asylum. The happiness and welfare of the patients while they are in the asylum depend far more on the character and conduct of the attendants than on those of all the rest of the asylum staff put together".⁽²⁾

What Charles Mercier says seems to be largely true, particularly bearing in mind the state of psychological medicine. We clearly need more research into this most important aspect of the growth of psychiatry.

As for the nurses and attendants themselves, there were clear signs that despite medical condemnation and paternalist training schemes they were beginning to develop an identity of their own by the end of the century. Mick Carpenter, for example, suggests that mental nurses were by that time beginning to reject the "angels" image which the doctors had placed upon them, in favour of a more realistic view of their work.⁽³⁾ By contrast, Finnane⁽⁴⁾ considers that a transition in outlook from "attendant" to the more professional "mental nurse" was being initiated by the medical profession through developments in educational provision and was intended to make subordinate staff more amenable to medical authority. There is some truth in this, although it was probably a shift in attitudes amongst attendants which prompted this response from above. New ideas from below came to the surface anyway, despite these responses. F.R. Adams,⁽⁵⁾ for

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1. Records of the Census Enumerator for Wakefield. Public Reference Library, Wakefield.
 2. MERCIER, Charles: op.cit., p.284.
 3. CARPENTER, Mick: Asylum Nursing Before 1914 - a chapter in the history of Labour, in, DAVIES, C. (Ed.), Rewriting Nursing History. New Jersey, 1980.
 4. FINNANE, Mark: Insanity and the Insane in Post-Famine Ireland. 1981, pp.181-2.
 5. ADAMS, F.R.: op.cit.

example, has traced the origins of the National Asylum Workers Union to the machinations of leading mental physicians and to the feminist-inspired British Nursing Association, which led first to the foundation of the Asylum Workers' Association in 1897. Yet from this the more trade union conscious NAWU sprang in 1910.

With what changed social perspectives did this new generation of asylum nurses and attendants set about their work? Regrettably, the subject falls outside the scope of this present study. Yet it may well be that the asylum system upon which psychological medicine rested, which so suited its superintendents if not the medical officers lower down in the hierarchy, was being transformed at last by new ideas and different social attitudes introduced from below, by the nursing staff, whose composition and demeanour the medical men at the top had never been fully able to control.

CHAPTER 7: A VAST INSTITUTION: THE LUNATIC ASYLUM AS A
CONSTRUCTION OF VICTORIAN SOCIETY

a) OUTLINES OF SOCIAL STRUCTURING

Relationships between mental physicians and others involved in the medical enterprise, either as subordinate staff or as patients, were not as satisfactory as they would have liked. Junior doctors were often mere birds of passage, flying off to other posts as the opportunities presented themselves. Nursing staff displayed a similar restlessness, together with an intractable temperament, which created difficulties for their superiors who were trying to run well-disciplined and ordered asylums. The greatest difficulty of all, however, was provided by the patients, whose refusal to behave in a rational, sane manner constantly threatened doctors with a recognition of the futility of their whole venture.

This limit to their ability to achieve what they had apparently set out to do has been traced, insofar as it can be related to "medical" practices, in the foregoing chapters of this thesis. We have seen⁽¹⁾ that the construction of "mental science" was largely the dressing up of social value-judgement in the garb of a neutralist terminology and did little to assist the handling or understanding of those problems posed by the "insane". It succeeded, nevertheless, in reinforcing the medical profession's credibility and control within that field.⁽²⁾ The overwhelming evidence of the profession's failure to achieve its early claims of 90% cure-rates was reflected in the gradual establishment of the con-

1. See Chapter 2.

2. As Roger Smith has aptly remarked, universalist knowledge such as medical men claimed was the "mirror image" of central power. See SMITH, Roger: Trial by Medicine: Insanity and Responsibility in Victorian Trials. Edinburgh, 1981, p.161.

cept of "incurable" insanity, dependent upon a construction of theory which took evolution as a basis and accepted "degeneration" as an irreversible failure of that process. (Henry Maudsley in particular did much to propagate this view). The concept of "incurable insanity", itself one aspect of a general appeal to natural science to legitimate mental physicians' authority, did much to protect the profession through long years of non-achievement, whatever its consequence to its patients.

In its treatment of patients, meanwhile,⁽¹⁾ the profession effectively abandoned any attempt to extrapolate curative regimes from the body of mental science it had established, preferring instead an institutionalised system of commonsense (based on culturally-oriented attitudes towards the "sick") and common discipline (based on equally cultural attitudes towards irredeemably awkward individuals). The institutional machine which they employed was adopted with ease from its socially constructed origins and taken finally to be the cure for insanity. The underlying principle of all treatment was ultimately the pressing down of a regulation and order upon the inmate population of the lunatic asylum. This impress of sanity was to be made by Authority itself, through the agency of the asylum's totalitarian regime. As the Commissioners in Lunacy's own figures show, it was not a successful approach.

The reality of this method of handling "insanity" was a massive irrelevance to patients' actual problems.⁽²⁾ Indeed, it sought to cover up whatever difficulties the "disease" had created by imposing a system of moulding aberrant individuals into usable members of "society" who could undertake work of a domestic, craft or labouring nature. Fundamental to this system was, again, the exercise of authority by members of

1. See Chapter 3.
2. See Chapter 5.

the medical profession. Established in the field of "scientific" knowledge, this authority found a practical application in the everyday tyranny of the asylum, where mental science had already been abandoned in the face of practical problems in the control of large numbers of people and the "medical" was indistinguishable from the administrative. The result was an enclosed system which was quite sterile in its functioning. It existed in structured isolation from the rest of society and offered no adequate bridge across the divide. Inmates were held in its grip by the exercise of power by doctors and by the law, and also by the fact of their own powerlessness.

Nevertheless, it was out of this highly contrived situation that mental physicians drew their conclusions about the nature of insanity and the consequences of treatment. Having found their way into the asylum through whatever causes (and as we saw in Chapter 4 these remain largely obscure) people became raw material for the medical "gaze"⁽¹⁾ the phenomenological basis of subsequent "psychiatry". Whatever social processes had isolated those particular individuals and had directed them to the asylum became invisible and were subsumed into constructed theories about "insane types", as organism-centred medical models were wound around the new inmates. The actual contexts of distress, which lay in pauperism, alcohol addiction, marital crises, illegitimate births, reactive depression and other troubles not specified even obliquely in the medical writings, were obscured by this exertion of medical privilege and a necessary understanding of the whole situation to which adequate remedies would need to be addressed was made difficult to obtain.

1. The term is borrowed from Foucault, who uses it to characterise the new ways of perceiving pathological symptoms which went with the growth of hospitals in the early nineteenth century. See FOUCAULT, Michel: The Birth of the Clinic: an Archaeology of Medical Perception. Trans. A.M. Sheridan. 1973.

It was on this raw material that mental physicians performed their practical research. The asylum provided a ready source of experimental and post-mortem opportunities impossible in the outside world. In Chapter 6 we saw how not only routine information concerning patients' ages, marital status, religion and the like were solicited and used as "medical" evidence, but also how patients' own bodies were used to provide information, even though the usefulness of such information to curative therapy was open to grave doubt. As soon as anatomical findings were related to insane behaviour amongst the living the scientific objectivity of the post-mortem was replaced by the spurious objectivisation of social values and assumptions which the very concept of "insane behaviour" had introduced.

In short, "psychological medicine" as such was virtually non-existent. What did exist were those social constraints which the medical venture ran up against in every aspect we have considered. Whether we look at the underlying assumptions about rational and irrational behaviour which middle-class society adopted, the subservient and industrious behaviour which it preferred of its subordinate classes, or at the legal and quasi-legal mechanisms which gave practical expression to those ideas, we find the same intrusion of extra-medical preoccupations. In purely "medical" terms there were no "cures", nor any way of describing irrationality other than in common forms of social identification - which often became practical classifications under a different name - nor any preventative achievement, as the ever-growing numbers of pauper lunatics showed.

Yet though doctors may have failed in a "medical" sense, that is, in effecting either "cure" or adequate care for individual sufferers, we need to be more cautious of passing such a judgement upon the larger social functions which they were performing in the guise of medicine. Other objectives were involved here. Whatever may have been the attitudes

towards the patient as a suffering individual, as a subject of society s/he created problems that required other than medical solutions. We need to ask ourselves certain questions: why were lunatics so conspicuously pauperised? What forces demanded their social exclusion? What did late Victorian England expect of its "insane" population?

The medical venture with regard to the "insane" was set within a network of social structures. This structuring, which first isolated the "insane" and placed them in asylums, also determined the nature of those asylums and what their outcome would be, at least, within broad limits. It is to this social context we must look if we are to understand how mental physicians were able to maintain their profession when in medical terms they had so little to show for it and, indeed, what "psychological medicine" and the asylum system were really doing in the later nineteenth century.

The social history of lunacy provision has been well covered in recent years by a host of writers whose numbers increase almost in ratio with the unfortunate subjects of their concern. Probably the best analysis of our period is given by Mellett,⁽¹⁾ though several others have made valuable contributions. It is not my intention here to attempt a thorough study of this aspect of lunacy, not only because the ground is now well established but more particularly because I have been concerned to look at the asylum in its "medical" aspect - the asylum from inside, as it were. This theme has now been traced to its outside social origins and I shall use the body of existing material on the social organisation of lunacy provision purely to embed my particular conclusions.

1. MELLETT, D.J.: The Prerogative of Asylundom: Social, Cultural and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth Century Britain. 1982.

In this, the last main chapter, I shall attempt to advance an interpretation of late Victorian social organisation which can handle and explain the actual performance of the lunatic asylum, thus explaining through external social processes the results we have already found by looking within its walls. This organisation can best be considered under three heads: the impact of lunacy legislation, the on-going mechanisms which facilitated the translation of individuals into "lunatics", and lastly, the broader mechanisms of social administration which informed the nature of "asylumdom".⁽¹⁾

b) THE LUNACY ACTS FROM 1845 TO 1890

1845 was, of course, the major year for lunacy legislation. In that year Ashley, later Lord Shaftesbury, steered through Parliament the bill which created the Commissioners in Lunacy, with powers to visit all public and private asylums⁽²⁾ and, four days later, a second bill which made compulsory the building of asylums for pauper lunatics in each county of England and Wales.⁽³⁾ These two acts defined the structure of provision for the insane for the next one hundred and fourteen years.⁽⁴⁾ An integral part of this legislation was the certification procedure by which patients were held in the asylum by law. For pauper inmates the signature of one doctor and one magistrate were required. For private admissions, two doctors' signatures were needed. This practice was deemed essential since lunatics were supposedly not by nature capable of appreciating the need for their own cure. There were a few minor amendments to

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1. I borrow the term from D.J. Mellett, op.cit.
 2. 8 & 9 Vict. c.100.
 3. 8 & 9 Vict. c.126.
 4. That is, until the Mental Health Act of 1959, which completely reorganised the legal situation of the insane. See JONES, Kathleen, Mental Health and Social Policy, 1845-1959. 1960; also, MELLETT, D.J.: Bureaucracy and Mental Illness: The Commissioners in Lunacy, 1845-90. Medical History, XXV, 3, July 1981, pp.221-250.

the legislation in the course of the nineteenth century, but their impact was minimal. In 1853 the visiting powers of the Commissioners were extended to include the insane wards of workhouses and in 1862 changes in Poor Law funding made pauper lunatics chargeable to Poor Law Unions rather than to individual parishes.⁽¹⁾ This act also contained a clause which modified the definition of who was able to sign certificates of insanity.⁽²⁾ In 1874 an amendment to the Poor Law regulations allowed a four shilling grant to be paid in respect of each workhouse lunatic who was transferred to the asylum, a payment intended as an inducement to workhouse masters to unload some of their insane inmates.⁽³⁾ In 1890 a massive consolidating act was passed which sought to tie up all the existing loose ends in the legislature and confirm existing practices as far as possible.⁽⁴⁾

The influence of the two acts of 1845 was thus to permeate subsequent asylum development. They contained certain implications for the treatment of the insane at the hands of society (as opposed to their treatment at the hands of the medical profession),⁽⁵⁾ which need to be considered at greater length. Broadly speaking, the 1845 Acts were the expression of two parallel concerns: that lunatics should be "cured" wherever possible, and that until and unless they were they should be kept in a secure place to protect society at large. The first concern was expressed in the setting up of the Commissioners in Lunacy and also in the compulsory provision of medical staff within asylums. The second concern was satisfied by the regulation that inmates were to be certified and held in the asylum by law.

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1. TUKE, D.H: Chapters in the History of the Insane in the British Isles, 1882, Chapt.4; also, HODGKINSON, R.K: Provision for Pauper Lunatics, 1834-71, Medical History, 10, 1966, p.138.
 2. 25 & 26 Vict. c.111.
 3. TUKE, D.H: op.cit., Chapter 4, outlines all this legislation in detail. MELLETT, D.J: op.cit, also cites these details.
 4. 53 & 54 Vict. c.5.
 5. For this, see Chapter 3.

The asylum created by the 1845 Acts was thus the result of a conflation of two purposes: relief for the suffering individual, and protection of society from a particular kind of individual deviance. When, however, the curative pretensions of the medical profession proved chimeral,⁽¹⁾ the legislation of 1845 in effect bent its whole weight behind the second of these purposes, that of segregation. To be sure, the Commissioners in Lunacy were still present to lend an assurance of humanitarian idealism to the asylum process and to steer the medical profession towards some hope of its original goal. Thus it was that the curative ideal lived on under the guise of kindness and noble intention, with asylums seen (by the medical profession) as being "merely brain-hospitals" whose inmates find in them "a comfortable home and kindly and skilful care".⁽²⁾ No doubt the Lunacy Commissioners were able to ensure that some kindness and humanity did survive inside the asylums, yet even so their achievement was by any criterion a modest one.⁽³⁾

Moreover, even whilst considering the desirability of facilitating individual cures the legislation of 1845 gave still greater weight to the social benefits of preventing a mass lunatic population from accumulating and so becoming a drain upon public expenditure. McCandless⁽⁴⁾ has suggested that it was this financial argument which finally won the bill, since it was seen as a true economy to enforce cures in the short term and so save the cost of long-term support for the intractably insane. Thus beneath the concern for "cures" there existed a second concern for social order - this time in the guise of financial cost.

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1. As we have seen at length in Chapter 3, also Chapters 2 and 5 and to a lesser extent 6.
 2. YELLOWLEES, David: Lunacy and Pauperism, 1884, p.6.
 3. See MELLETT, D.J.: op.cit.
 4. See McCANDLESS, Peter: Insanity and Society. Ph.D. thesis, Wisconsin University, 1974.

Of these two major fears for social order which lunacy thus appeared to present - that for public safety and that for the public purse - it was the question of the cost of lunacy to society which in the end was dominant. Thus, whilst maintaining the function of social segregation, the Act of 1890 was careful to lay down precise figures for the costing of asylum expenditure:

"Every visiting committee shall fix a weekly sum, not exceeding fourteen shillings, for the maintenance and other expenses of each pauper lunatic in the asylum, and of such amount that the total of such weekly sums shall be sufficient to defray such expenses and also the salaries of the officers and attendants of the asylum". (1)

It is important to realise that this cost limit was geared not to the provision of adequate care and treatment of inmates but to the overall expense incurred by society on behalf of each one. For that reason the wording of the Act makes no distinction between costs essential to patients and costs such as salaries and other incidental expenditure. Indeed, an increase in salary or an improvement in living conditions for the staff could be achieved at the patients' expense quite easily without overturning any of the Act's copious rules.

As far as therapy itself was concerned, the process of restoring "normality" to the inmates had to take place within these social confines as well as within the physical confines of the asylum itself. The fact that patients were paupers, and therefore subordinate rather than free individual members of society, was a pre-condition upon which medical practice functioned. This fitted well with the assumption of power in the medical encounter which it suited mental physicians to adopt.⁽²⁾ If their construction of "mental science" denied a voice to the "insane" then

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1. 53 & 54 Vict. c.5, 283i. The money was raised, of course, from the the county rates.
 2. See Chapter 2.

so too did the fact of their superior social status.

The principle of segregation, based as it was upon the policy-makers' fears of lunatics at large, undisciplined within normal society, was also reflected in doctors' therapeutic practices. In Chapter 3 we saw that fundamentally it was acceptability to outside society which determined the end-point of the "curative" process. Doctors faced a dilemma in so doing, between the needs of the patient as an individual sufferer and the demands of society upon a social deviant, but in practice followed the line of least resistance, putting the demands required by law and by the society which employed them before the particular demands of the patient. These may not have been altogether dissimilar, of course. Assuming curative technique had any effect at all (which is very doubtful) a patient might have welcomed such a restoration to "normal" society. Be that as it may, the dominance of societal interest ensured that he had no choice either way. The confluence of those two concerns for social order, particularly with regard to social expenditure, effectively limited any meaningful consideration of the peculiar needs of the "insane".

c) SOCIAL IDENTIFICATION AND SEGREGATION OF THE LUNATIC

The mechanisms by which persons were labelled "insane" and translated into asylum inmates is further illustrative of this concern for public order and safety beyond the purely formal enactments of lunacy legislation.

This is not to say that the material upon which these processes of selection and segregation were worked did not contain some objective consistency which potentially marked it out for such treatment in that particular society.⁽¹⁾ We have already seen that many of the people dealt with

1. See, for example, Chapter 4, pp. 199-203

by the lunacy administration certainly posed problems, chiefly of unmanageability and incomprehension. But bizarre or problematic individuals, like the rest of us, do not exist independently of social connection. This simple truth was appreciated as much by some late Victorian doctors as by modern sociologists.⁽¹⁾ W.T. Gairdner⁽²⁾ commented in a lecture on insanity in 1879,

"It is not an affair of definitions, nor even of doctrines as to what insanity essentially is, but a question of practical adjustment, so to speak, between society and the individual; between the average sane mass (or mob if you like) of commonplace persons or 'Philistines' on the one hand, who control, and at the same time constitute, the social machinery, and the eccentric, abnormally good or bad, or otherwise peculiarly endowed individualities on the other hand, dwelling within the protection of the law, and therefore responsible to public opinion".

Gairdner was far from accepting insanity as a mere product of social regulation and went on to talk of the insane person's inability to "control his own eccentric individuality"⁽³⁾ and to discuss the amount of "actual insanity"⁽⁴⁾ present at different points in history.⁽⁵⁾ Nevertheless,

1. Or perhaps more so, as the curious debates on "labelling" versus "deviance" theories in sociological writings on social control seem to suggest in their inability to overcome an individual-social distinction. See, e.g. GOVE, W.R.: Who is Hospitalised? A Critical Review of some Sociological Studies on Mental Illness. Jnl. Health and Social Behaviour, 11, 1970, pp.294-303; ibid., Societal Reaction as an Explanation of Mental Illness - an evaluation. American Sociological Review, 35, 1970, pp.873-884, on the importance of individual "deviance", and DAVIS, N.J.: Labelling Theory in Deviance Research - a critique and reconsideration. Sociological Quarterly, 13, 1972, pp.447-474, and GIBBS, J.P.: Rates of Mental Hospitalisation - a study in societal reaction to deviant behaviour. American Sociological Review, 27, 1962, pp.782-792, who affirm the importance of active social control in placing labels upon "deviant" individuals.
2. GAIRDNER, W.T.: Insanity: Modern Views as to its nature and treatment. A Portion of the Morisonian Lectures on Insanity, Delivered in 1879. Glasgow, 1885, p.18.
3. ibid., p.20.
4. ibid., p.22.
5. In other words, he follows the usual contemporary view which affirmed the existence of insanity as something "real" in a positivist sense, despite the difficulty of its definition and diagnosis. See Chapter 2, pp.29-37

he recognised that in practice the business of identifying and isolating the "insane" was always a process of social control and occurred at the point of disruption to society:

"Even our modern British society would be startled into intolerance if a Mohammedan dancing or howling dervish, or an Indian fakir, should insist on going through the more extravagant of his performances in the streets of London. The choice would then be between the asylum and the police-office, and who shall declare which would be the more just and true solution of such a complicated social problem?" (1)

Gairdner's illustration of this disruption is, of course, naive (and shows less understanding of Oriental practices than of British insanity) and he offers no detailed structure to his image of a controlling society acting upon uncontrolled eccentricity beyond the telling references to the "asylum" and the "police-office". The reality of this controlling process was actually more complex than doctors realised. The asylum, with its concomitant legislation, which we have already looked at, was merely the official repository of those who passed through the process of identification and segregation. Before its gates were sighted, before even the medical profession became involved, the isolation of the "insane" from the rest of society had begun.

From the complexity of social life it would be helpful to isolate four areas in which people were exposed to the forces of selection and segregation. These are pauperism and crime (respectively the constructs of the Poor Law and common law), the workplace and the kinship community. These areas embrace, of course, virtually the whole of social life, for the working-classes at least, but are relevant in that each presents a particular mechanism for the identification of deviant behaviour. We will consider these one by one.

1. - ibid., p.19.

(i) Pauperism

The route from workhouse to asylum was referred to in Chapter 4. It was a regular source of new inmates yet the selection process by which people were translated from workhouse inmate to lunatic depended less on any supposed insanity than on the responses of workhouse masters to certain kinds of behaviour, as Crichton Browne, superintendent of the West Riding asylum made clear:

"The majority of the patients received here are brought from Workhouses, in which they have passed through a period of probation, their removal to the asylum being determined, not by the amenability of their mental malady to treatment, but by the nature of the propensities which they manifest. If they are violent, dirty in their habits or degraded they are forwarded here. If they are quiet and inoffensive they are detained in the Workhouse". (1)

This apparent disregard for medical authority occasioned a long and unremitting campaign by the Commissioners in Lunacy against the retention of "quiet and inoffensive" lunatics in workhouses, which nevertheless was not a fruitful one, as we shall see in a moment. A further complication of this method of selection was that those whom the workhouses turned over to the asylum authorities were not necessarily those whom the authorities considered proper persons for such a place. Arlidge complained that

"some are sent to the asylum in a state of paralysis, some are aged and in a state of fatuity, and others when they become troublesome". (2)

They remained in the asylum nonetheless. How many inmates found their way into the asylum in this way is hard to determine. The situation is further complicated by the fact that, as Mellett has pointed out, the relieving officer and the local policeman were often one and the same

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1. Quarterly Report of the West Riding Asylum, 30th January 1873.
 2. ARLIDGE, John T: On the State of Lunacy and the Legal Provision for the Insane, with observations on the construction and organisation of asylums. 1859, p.92.

person,⁽¹⁾ which confuses the first route of entry with the second - entry via the criminal procedure.

(ii) Crime

The most commonly acknowledged cause of entry through the intervention of the law was drunkenness. Dr. Wiglesworth, for example, alleged that one sixth of all cases admitted at the Rainhill Asylum "had a history of alcoholic parentage".⁽²⁾ D.H. Tuke is also convinced of the importance of this cause.

"Intemperance unmistakably takes the lead. This is one of those facts which amid much that is open to difference of opinion, would seem to admit of no reasonable doubt".⁽³⁾

Mellettt has shown how drunken behaviour might have come to the attention of the asylum authorities. He suggests that Poor Law relieving officers who were also police officers were sending such cases to lunatic asylums as a punitive act, making use of "an available tactic under the Lunacy Laws".⁽⁴⁾ As much as 7% of the admissions at Prestwich, for example, came from the police, mostly for drunkenness. The Commissioners in Lunacy confirmed in 1876 that one in eleven of their admissions was due to drink.⁽⁵⁾

Of course, not all admissions via the police were for this crime alone. Joseph Rogers, a workhouse medical officer, described how acts of petty crime often took a person before a magistrate, only to find that he in turn called for a doctor to certify lunacy, rather than pass sentence.⁽⁶⁾ Petty theft was one symptom of the onset of syphilis which, under the guise

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1. MELLETT, D.J.: The Prerogative of Asylundom, op.cit, p.83.
 2. quoted in KELYNACK, T.N. (ed): The Drink Problem of Today, in its Medico-Surgical Aspects. 1907, p.131.
 3. TUKE, D.H.: Insanity in Ancient and Modern Life, with chapters on its prevention. 1878, pp.98-9.
 4. MELLETT, D.J.: op.cit, p.83.
 5. ibid., p.207.
 6. ROGERS, Joseph: Reminiscences of a Workhouse Medical Officer, 1889, pp.145-151.

of general paralysis of the insane, accounted for some 7% - 8% of all admissions.⁽¹⁾ Crimes even more trivial might send a person from the police-court to the asylum. These might include the use of obscene language, violent behaviour or merely vagrancy. Under section 68 of the 1853 Lunacy Act a magistrate was entitled to send all such cases to the asylum.

In practice, therefore, the routes of segregation operating through the Poor Law and the criminal law both passed through the hands of the local magistrate, whose signature was required for certification. In one sense, this compounded segregation for the asylum with segregation for the prison. In 1863 Mary Ann Ford was convicted of using obscene language and sent to Dorset gaol. There she was certified insane and sent to the local lunatic asylum as a criminal lunatic.⁽²⁾ But such incidents were rare. The magistrate was more commonly rubber-stamping a segregation for the asylum already made, either by the workhouse authorities or by the police.

(iii) Working Conditions

This segregation, or initial marking off from society, might also have been made either by circumstances around the workplace or by other members of the family. These two might often be indistinguishable in effect, as with domestic servants, whose "family" were also their employers, or when working conditions have created distinct styles of domestic life, as in mining and textile communities, where the organisation of industrial labour had penetrated every corner of working family existence. In circumstances such as these the community itself may have been strong enough to have coped with the problems presented by those who fell foul of indus-

1. See Chapter 4.

2. Records of the Commissioners in Lunacy, 1863/4. PRO, MH51 58.

trial authority and so were unable to satisfy employers, whether through absurd behaviour or any other cause. Equally, such a community would have operated standards which themselves might have led to an initial marking off as an aberrant person someone who did not fit common perceptions of "normal" behaviour.

The best study of this situation has been done by John Walton.⁽¹⁾ His conclusions are that the incidence of admission varied with the type of area. Most admissions, by proportion, were found in new comurbations which lacked community cohesion and must have contained a proportionately higher number of single people, who were, of course, more mobile. Agricultural areas produced a lower incidence of admission, whilst lowest of all were the well-established textile communities. Walton suggests that in these areas the "operation of unusually supportive networks of kin and neighbours" acted to shield individuals from those agents of selection which would otherwise operate.

The significance of these findings is that family and community structures could act as an independent variable in the segregation of "lunatics". This is not to say that those structures might not also be agents of segregation: only that they were separate from the formal agencies of employers and other local men of power. Walton goes on to refer to the degree of contact which ordinary people had with such men, arguing that where this "vertical contact" is highest, so too might be the risk of falling foul of an identification as a "lunatic". This view seems inherently attractive, indeed obvious, if identification and segregation are to be seen as acts of practical social regulation. Yet they could not operate in this manner if "lunacy" were not already recognised and accepted by all

1. WALTON, John: Lunacy in the Industrial Revolution: a study of Asylum Admissions in Lancashire, 1848-50. Journal of Social History, 13, 1, 1979.

as a real deviancy requiring some sort of special treatment. A great many asylum inmates were beyond doubt bizarre or awkward people who posed problems - to themselves or others - and who demanded some response. Ultimately, it was selection at the level of the family and kinship community which acted as the most crucial mechanism for setting individuals on the road to the asylum.

(iv) Kinship

We have seen this at work already in the case of Rachel Grant-Smith.⁽¹⁾ Here, a woman suffering the effects of the sudden loss of her husband was encouraged to take a "rest", to get away from it all, in a modern asylum. No doubt her friends felt they were acting in her best interests. But Grant-Smith was a superior sort of woman. What went on in working-class families remains an unknown factor to historians of lunacy. Walton⁽²⁾ suggests, plausibly, that such families would have been exceedingly reluctant to turn to the asylum as a means of solving their problems since it was linked with the hated Poor Law and was in any case the creation of a class with authority over their lives.

Yet who else could they turn to in time of great distress? Reluctant as they must have been to use it, it was not only the last resort, but, indeed, the only recourse outside of private care. The forbidding nature of the institution must have inhibited many who were in need, just as the workhouse discouraged pauper relief, but it is hard to see what else they could have done. If they could not, or would not, send relatives directly to the asylum then the poverty which must have ensued (if the problematic individual was not earning) would have brought them to the local relieving officer in any case. This consideration in itself poses a

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1. See Chapter 5.
 2. WALTON, John: op.cit.

particular de facto mechanism for selecting out as "insane" - the inability to earn sufficient money. In industrial communities where the quality of housing, of food and of all social amenities was regulated by wage-levels and market forces, need we be surprised if the avoidance of the label "lunatic" also had its price?

As with so much else in the society of which they were an essential part, working people had no control over the forms and categories of deviance which had official sanction. "Lunacy" which passed as such in the asylums came into their world from the conceptions of those who had charge of such matters. Whether it equated with notions of madness held already in working families we may never know. Yet when dire need intervened they had no option but to take the officially sanctioned arrangements for what they were worth. Their own need, rather than that of the "lunatic", was perforce the main criterion.

All these means of segregation, therefore, operated at the point of disruption to "society" - be it pauper administration, law and order, industrial regulation or family and community networks - rather than at the level of a recognised "insanity". This decision was made later, by doctor and magistrate, though often pre-empted by those who brought such candidates to their attention. The ultimate "type" of insanity was not framed until the lunatic was already inside the asylum. In the end, it was the needs of outside society which had identified him and placed him there.

d) SOCIAL STRUCTURING WITHIN THE ASYLUM

Once inside the asylum it was the expectations of society on the outside as to how institutionalised paupers should be allowed to exist which overwhelmingly determined his (or her) lifestyle there, rather than their

needs as "patients" (for the term had little more validity than as a piece of medical jargon). We have seen how the benign response of medicine, the early passion for the curative ideal, was now nothing other than a routine categorization of certain "sick" paupers as deserving of slightly better conditions than the rest.⁽¹⁾ Even so, asylum inmates were in many ways more "pauper" than "patient".

This emerges when we examine the three main fears surrounding the Victorian asylum which erupted as perennial concerns in the middle-class periodicals. The first which we shall consider was the fear of "false incarceration". It related to the use of asylums as places of social segregation. The second was the fear of the growing tide of lunacy as inmates numbers rose, along with the extent of social expenditure. The third area of concern also dealt with the fear of rising costs, yet at the same time tried to confront the asylum in its benign form, as a place of cure. This was the concern with lunatics still held in workhouses. We shall take them in turn.

(i) False Incarceration

Although not directly concerned with cost or with the status of paupers, the fears which the image of the asylum could conjure up in more educated minds did involve a fear, not uncommon in outside society, of the common masses. The possibility of being incarcerated along with such people arose because of the insistence of medical men that lunacy be dealt with as soon as possible if cure were to be effected⁽²⁾ and because a

1. See Chapter 3.

2. "It is well known that the curability of the disease depends on its being treated early", said Andrew Wynter in an article in the 'Edinburgh Review'. Yet the same article contained no hint of what form the cure might take beyond fresh air, exercise, and the absence of chains and manacles. See, Non-Restraint in the Treatment of the Insane, Edinburgh Review, CXXXI, April 1870, p.446.

necessary part of this process was certification as a lunatic, which J.T. Arlidge described as a kind of "civil death".⁽¹⁾

So great were fears of such a loss of liberty that a society was formed to combat false allegations of lunacy. This was the Alleged Lunatics' Friend Society which was founded in 1845 by John Percival following his own unfortunate experiences in an asylum.⁽²⁾ In 1873 it became the Lunacy Law Reform Association, whose secretary Louisa Lowe, published a vehement condemnation of the asylum system in "The Bastilles of England", in 1883. Lowe attacked the business of locking people away without trial on the grounds of an alleged lunacy, arguing that such coercive treatment should be used only when actual acts committed by a person demanded it. Her main invective, however, was reserved for the medical profession itself which appeared to her to be acting in compliance with those who wanted to lock away unwelcome individuals according to their own interests or moral conscience. This theme found a ready echo in popular novels, such as Charles Reade's "Hard Cash" and remains still a common response to the institutional treatment of "insanity".⁽³⁾

Medical men countered by claiming such people were depriving the sick of their "right" to be cured by elevating their "so-called civil rights above the rights of a sick man".⁽⁴⁾ "Early removal to an asylum", wrote David Skae in the North British Review,

"has been proved to be the most provident means of treatment, as being the readiest mode of obtaining a cure for the disease".⁽⁵⁾

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1. ARLIDGE, J.T.: op.cit, p.150.
 2. HUNTER, R. and I. MacALPINE: John Thomas Percival (1803-1876); Patient and Reformer. Medical History, 6, 1962, pp.391-5.
 3. See Thomas Szasz's work, for example, particularly "The Myth of Mental Illness", 1961. Outraged middle-class sensibilities lurk behind much of the anti-psychiatry enthusiasm of the 1960s, re-echoing original Victorian responses.
 4. WINSLOW, Forbes: The Parliamentary Enquiry. Journal of Psychological Medicine, XIII, 1860, p.67.
 5. SKAE, David: Lunacy Legislation, North British Review, XXXVI, May 1862, p.475.

Andrew Wynter assured readers of the Edinburgh Review in 1860 that

"we know full well that at least eighty per cent of cases of insanity are curable if treated early; and we also know that of those received into the great county asylums scarcely ten per cent ever recover". (1)

On the face of it, the protesters of the ALFS and LLRA seemed to have a fair case. Being less enthusiastic than doctors about the powers of psychological medicine they suspected that medical authority knew little enough about human behaviour and still less about common rights. Extracts from one or two text-books on lunacy add to the grounds for this mistrust. Following the suicide of a chancellor Wynter writes,

"It was stated that he had been troubled in his mind for several days previous to the catastrophe by an error of 2s. 7d. which he had made in his diocesan accounts. This symptom of a departure from the well-known ordinary masculine tone of his mind would have suggested to any skilful physician the necessity for having him placed under surveillance". (2)

Mental physicians also displayed a remarkable ability to stand figures on their head. Faced with a 10% cure-rate in asylums, they claimed that actually 80% of insanity was curable if treated early. Yet given that they also claimed that asylums were an essential part of such cure there remained some doubt as to how this figure of 80% had been derived. Clearly, the demand for swift removal to an asylum was part of the doctors' strategy for explaining the low cure-rate which asylums actually achieved. ALFS and LLRA resisted this steam-rolling tactic. (3)

Yet the truth is that the critics of false incarceration were less concerned with the failings of medicine than with their own likely associa-

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1. WYNTER, Andrew: Brain Difficulties. Edinburgh Review, CXII, Oct. 1860, p.527.
 2. WYNTER, Andrew: Brain Difficulties, op.cit, p.536.
 3. Kathleen Jones has it the other way round. For her, doctors' orders were paramount and critics of the asylum were legalistic obstructors of the path of medicine. See JONES, K: Mental Health and Social Policy, 1845-1959. 1960.

tion with a degraded class of lunatics. They revealed little enough concern for the plight of pauper inmates condemned by exactly the same criteria of "insanity" as those whom the critics defended. Their campaign was conducted primarily against "abuses" in private asylums, where corruption and greed overturned consideration of proper care, and against the doctors, who were keen to shut away people by the score since they were all "crotchet-mongers, each with his peculiar fad on the subject of lunacy".⁽¹⁾ J.T. Arlidge shared this reaction to the possibility of being associated with the common run of lunatics.

"For it is irritating to the minds of certain classes of the insane to know that they are accounted lunatics by law equally with the most degraded victims of mental disorder with whom they may find themselves associated".⁽²⁾

In short, as Mellett⁽³⁾ says, they were products of "middle-class radical protestanism". Theirs was a special pleading which actually tended to create a double-standard in lunacy. By her preoccupation with individual corruption Lowe undermined her criticism of the laws themselves. Moreover, by stressing the unsavoury nature of lunacy the critics accepted by default the conditions which prevailed most commonly inside county asylums. Their complaint was of having to be confined with the rest in this way. Their solutions, apart from more rigorous checks on certification and wider inspection of asylums, included the setting up of a different type of asylum, for "nervous" disorders, as Arlidge put it, in which the minds of certain classes of the insane need not be afflicted by lunacy in its grosser forms.

Thus the protagonists of the "false incarceration" debates displayed an implied acceptance of incarceration for the many - the true lunatics who

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1. LOWE, Louisa: The Bastilles of England: or, the Lunacy Laws at Work. 1883, p.7.
 2. ARLIDGE, J.T.: op.cit, p.166.
 3. MELLETT, D.J.: The Prerogative of Asylundom, op.cit, p.165.

need to be kept out of harm's way at least - and a rejection of asylum conditions when they were applied to those special cases whom they chose to champion. This double-headed response actually took its shape from the unresolved paradox between concern for society and the concern for the individual, the former requiring the confinement of true lunacy, the latter expressed in the plight of the "nervous" who might nevertheless fit that category.

(ii) The Increase in Lunacy

The contradictory attitudes expressed toward confinement were even more significant in the case of pauper lunacy. Here, the predominating concern was not with the loss of individual rights but with the extent of public expenditure. Caught between the threat to civil order apparently posed by a rising tide of madness and the more tangible threat to public spending involved in the maintenance of its victims, middle-class Victorian society understandably felt that increasing pauper lunacy touched a raw nerve. From both afflictions cure was the obvious deliverance. Unfortunately, it did not appear to exist. Doctors may not have been able to point to any therapy that worked, but they could certainly point to reasons why no cures were forthcoming.

The reasons were implicit in the findings of various medical researches and of the Parliamentary Report on the Increase of Lunacy 1897. Many causes were advanced for the rise in pauper lunacy. That it merely reflected a general population rise was argued⁽¹⁾ but had to be rejected in the face of evidence to the contrary. The theory that civilisation itself involved a risk to mental health was a common one with obvious

1. For example, by Mortimer-Granville. See GRANVILLE-MORTIMER, J: Is Insanity Increasing? Nineteenth Century, Vol.5, March 1879.

attractions for a medical profession that could hardly be expected to take on the whole world!⁽¹⁾ On this point there was some difference as to whether the effects of civilisation fell more heavily upon the wealthy or the poor. The notion of a competitive, market-centred society, geared to the constant profit and loss of business and finance and set in a noisy, hurried urban world made some sense to readers of medical literature whose world that largely seemed to describe, yet if the increase was amongst the pauper classes who had no knowledge of or sensitivity to such things, how could it apply?

If the civilisation-lunacy link was untenable, then improvements in the detection of mental disease might be the answer. Andrew Wynter advanced this idea and it was taken up by others, since it reflected well on their profession.⁽²⁾ A variant of this idea was that medicine was improving in other directions and so "uncovering" more insanity, which allowed one writer to remark, sagely,

"People must die of something, and if we prevent their escaping by one door, they must get away by another".⁽³⁾

A third variant of this theme was that the label of "insanity" was being placed upon a wider selection of odd behaviours. "Each year", wrote J. Mortimer Granville in Nineteenth Century,⁽⁴⁾

"someone discovers a new form or variety of mental disease, or gives a wider interpretation to an old definition".

In consequence,

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1. See Chapter 2, pp. 37-39
 2. WYNTER, Andrew: Lunatic Asylums. Quarterly Review, Vol.101, April 1857. This view of an improving science of insanity is implied in most of the text-book writings on the subject and follows from the creation of "mental science" by a body of professional mental physicians. (See Chapter 2).
 3. ALLBUTT, T. Clifford: Nervous Diseases and Modern Life. Contemporary Review, Vol.67, Feb. 1895, p.215.
 4. GRANVILLE-MORTIMER, J: Is Insanity Increasing? Nineteenth Century, 5, March 1879, p.531.

"the crowding of imbecile paupers, troublesome old people of both sexes and all grades, eccentric, delirious and indolent men, especially personages with 'fads' and 'crazes', harmless enough but sufficiently strange for the purposes of a certificate fully accounts for the so-called increase of insanity".

Alongside all these explanations was the view, obvious from so many reported details, that asylums were filling up with

"chronic and incurable cases, many of whom are quiet and harmless, and that the continuing growth of the population of our asylums results from an accumulation and storing up of this class of the insane". (1)

If only these people had been removed to the asylum in good time, so the familiar cry went, they could have been treated while they were still "curable". It was not the doctors' fault if the strictures of the lunacy laws stood in the way of this. This growth in the inmate population was exaggerated by adding the elderly who were alleged to be living longer in asylums than they would have done outside,⁽²⁾ so remaining to inflate the population figures.

All this left the medical profession in a reasonable light but did nothing to calm the fears of the ratepayers, who had to foot the bill for this inflation. With cures frustrated, lunacy could only be contained by ever higher costs. How could these be reduced? The answer seemed to lie in the doctors' own distinction between the curable and the incurable. As the Commissioners in Lunacy accurately pinpointed in their Report of 1868,⁽³⁾

"It is the presence in costly establishments of so many insane persons, to whom a less elaborate provision would be more suitable, that constitutes the real grievance to the ratepayers It is undoubtedly not less true, that their continued presence and accumulation in asylums constructed for the treatment of cases of a more difficult

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1. MITCHELL, Arthur: The Increase of Lunacy. North British Review, Vol.50, March 1869, p.131.
 2. See the findings of the Select Committee on Lunacy Increase, 1897.
 3. Twenty-Second Report of the Commissioners in Lunacy, 1868, p.85.

character, has had the effect of excluding such cases, comprising the most recent and acute forms of insanity, from the benefit of the immediate asylum treatment which to them is indispensable".

It was to be the old formula: special treatment for the "curable" few, cheap warehousing for the rest. If the Commissioners had any reservations about such a solution they did not express them. In any case, their hands were tied. Pauper insanity was funded through the Poor Law and the county rates, whose respective guardians' ideas on the subject coincided very well.

(iii) Lunacy and the Poor Law

The story of the difficult relations between the Commissioners and the Poor Law authorities is one of the more commonly told episodes in the history of lunacy.⁽¹⁾ It shows well the collision of interests which occurred between the ideal of "cure" and that of low cost and the necessary compromise which needed to be worked out. No doubt some of the stamina with which the Commissioners investigated workhouse conditions owed something to the similarity between conditions which they found and those which were encountered when the asylum system was first being set up. In Manchester, for example, Commissioners found thirty-seven workhouse inmates who were forced to sleep in

"dark, cold, miserable, single cells, without means of warmth, without proper ventilation, and cut off from their dayroom by a staircase so steep as to be ascended only with the greatest difficulty by anyone in weak health". (2)

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1. HODGKINSON, R.K.: Provision for Pauper Lunatics, 1834-71. Medical History, 10, 1966, is the seminal work on this which uncovers much of squalor in which workhouse lunatics were kept. More recent work has dealt with relations between the two bodies in more detail particularly MELLETT, D.J.: The Prerogative, op.cit, pp.134-158, and McCANDLESS, Peter: Build! Build! The Controversy over the Care of the Chronic Insane in England, 1855-70. Bull.Hist.Med., Vol.53, 1979, pp.553-574.
 2. Twenty-First Report of the Commissioners in Lunacy, 1867, p.22.

In many places visited they found poor dietary, inadequate medical care, poor quality "attendants" - usually elderly inmates working to earn some beer or more food - bad hygiene, shoddy clothing, insufficient exercise and not enough bed space. The wards were generally gloomy, small and lacking in even basic furniture so that inmates had to squat by the walls and eat their food on their knees. Moreover, and this raised echoes of the early campaigns of the 1830, and 40s, mechanical restraints were in use, a thing which county asylums had acquired great credibility by rejecting.⁽¹⁾

The Poor Law authorities took a characteristically penny-pinching view of the whole matter. It was their business to keep down the cost of pauperism, something which they did with obstinacy and apparent success. The barrages of complaints which the Commissioners directed at them were invariably stone-walled by replies that insufficient evidence had been sent and that in any case the alleged abuses referred to were untypical. More information was required before any action could be taken.⁽²⁾ These exchanges were generally at cross-purposes since the Poor Law authorities did not recognise "insanity" as a category within the meaning of the term "pauper". For them, the relevant classifications were either "aged, disabled and infirm" or "sick and injured".⁽³⁾ The guardians' blindness to the central concern of the Commissioners seems more than a little willful. Such stubborn attitudes, however, were encountered by all who had dealings with the Poor Law authorities.

Unfortunately for the Commissioners, they were not on the winning side of the encounter. It was useless for them to complain that work-

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1. Supplement to the Twelfth Report of the Commissioners in Lunacy, 1858.
 2. See Weekly Meetings of the Commissioners in Lunacy. PRO MH50 1-30.
 3. See MELLETT, D.J: The Prerogative, op.cit, p.134.

house detention

"not only deteriorates the more harmless and imbecile cases to which originally they are not unsuited, but has the tendency to render chronic and permanent such as might have yielded to early cure". (1)

They had no power to resist the Poor Law authorities and remove inmates to an asylum against their wishes. Their powers were limited to inspection only. It was for this reason that in 1874 a four shilling grant to encourage the authorities to remove patients to the asylum despite the slightly higher costs there to the ratepayers.⁽²⁾ Nevertheless, workhouse lunatics remained a considerable problem for both sides despite the measure.

It is temptingly easy to see this conflict as a struggle for medical advance against an atavistic legalism.⁽³⁾ In the process historians have been misled into taking the language of the Commissioners at face value and taking their side against the Poor Law authorities. Mellett, for example, says that the immediate result of the latter's decision to build monster institutions at Leavesden and Caterham in the wake of the 1867 Metropolitan Asylums Act, to provide cheap accommodation for workhouse lunatics was

"a repetition of the consequences of the 1845 Acts: chronic patients were shovelled into institutions intended for the curable. Since there was no discrimination between transfers, recent cases were often detained too long and deprived of their chance of cure". (4)

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1. Eleventh Report of the Commissioners in Lunacy, 1857, p.16.
 2. The Commissioners and some doctors disputed the argument that paupers were more cheaply kept in workhouses than in asylums, pointing out that the two were costed quite differently. Workhouse costing excluded the cost of overheads such as furniture, fuel and salaries. Moreover, they included many children, at lower cost than adults. It is curious and informative that such concern with penny-pinching coincided with inadequate accounting methods. Poor Law parsimony was less a financial calculation than may be supposed. See Supplement to the Twelfth Report, op.cit, p.33, and ARLIDGE, J.T.: op.cit, pp.40-7.
 3. Kathleen Jones would take this view. See JONES, K.: op.cit.
 4. MELLETT, D.J.: The Prerogative, op.cit, p.151.

This interpretation of events, drawn from an understandable aversion to Poor Law attitudes, has tended to cast the Commissioners in an unduly favourable light. In reality, they had less to offer than it appeared. Moreover, their opposition to the Poor Law Board was not as uncompromising as has been supposed. We have seen already and at great length that medical men had little enough ground to speak of "cures".⁽¹⁾ Their definition of the terms "curable" and "incurable" was constructed on a more doubtful principle than that of therapeutic science. At the conclusion of Chapter 2 we discussed the value of the latter term to professional medical men in the face of apparent failure to achieve the cure-rates which had earlier been claimed. The argument that supposedly "curable" patients were denied asylum treatment until too late served the same purpose. In practice the overwhelming majority of patients were judged "incurable" because doctors had no idea how to cure them. The "curable" by contrast, languishing in workhouses, were never put to this medical test.

There was a further complication behind the Commissioners' language. To a large extent their dialogue with the Poor Law Board was at cross-purposes. The Board took their cue from section 45 of the 1834 Poor Law Act, which deemed that a "dangerous Lunatic, Insane Person, or Idiot" could not be kept in a workhouse. The Crown Law Officers interpreted the word "dangerous" to apply to all three categories, which effectively meant that such people were passed on to asylums while all "harmless" inmates were retained in the workhouse.⁽²⁾ Thus against the Commissioners' "curable" and "incurable" categories the Board recognised only the "harmless" and the "dangerous".

In practice, there was room to compromise between these two positions.

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1. See Chapter 3.
 2. MELLETT, D.J.: *The Prerogative*, op.cit, pp.134-158.

If the Commissioners did not want the "incurable" and the Poor Law authorities preferred to keep the "harmless", then those who could be described as "harmless chronics" (which was most of them)⁽¹⁾ could safely remain elsewhere than in the asylum, should pressure of population upon those institutions become too great. Having soundly rejected the notion of boarding-out (more common in Scotland) as a solution in all but a very few cases⁽²⁾ this left no alternative but the workhouse.

This was, in fact, the nature of the compromise worked out between the two bodies. The Commissioners had no real objections to farming out "harmless" inmates to workhouses while at the same time campaigning for those same workhouses to send their "curable" patients to the asylum. The superintendent of West Riding Asylum noted that after the 1874 grant facilitating admissions from workhouses they received

"a larger proportion of patients in whom the mental disease was of recent origin, than was formerly the case, and we have therefore obtained better results from the treatment employed". (3)

Similar comments were made concerning the admission of "curable" patients over the years. However, by 1885 the superintendent was noting that

"of the nine patients chargeable to [Settle] Union five were sent to the care of the Union Authorities as perfectly inoffensive and manageable". (4)

Over the following three months thirty-seven "harmless cases" were returned to the workhouse.⁽⁵⁾

Pressure of population, it was argued, necessitated this process.

1. Asylum inmates, writes Andrew Wynter, were usually to be found "seated round the fire or lolling about in a dreary sort of way, perfectly quiet" These constituted "90 per cent" of cases. See WYNTER, Andrew: Non-Restraint, op.cit.
2. McCANDLESS, Peter: Build! Build! op.cit, pp.563-4.
3. Quarterly Meeting of the West Riding Lunatic Asylum, 29th October 1874.
4. ibid., 29th January 1885.
5. ibid., 30th April 1885.

The Commissioners had always complained that the concentration of the wrong sort of patient in asylums was crowding out those for whom the asylums were properly intended and many doctors advocated "chronic" asylums as a second tier to the system.⁽¹⁾ The idea was that if the "incurable" could be kept out of the way of the "curable" then the latter group would disappear from the asylums, making way for fresh "curable" cases. But as we have seen, "curable" and "incurable" were protean concepts. Moreover, they tended to be conflated with terms like "manageable" and "harmless". Whatever the reality behind them was, the Commissioners were clearly accepting an essentially double standard of care: the asylum for cases which the medical profession favoured - whether because they tended more to cure or were simply more amenable to asylum discipline - and cheaper institutional care for the unfavoured at the hands of the Poor Law Board.

(iv) Conclusion

Overriding all other considerations of care for the insane was the fact that cure was to take place inside the walls of an asylum of some kind, whatever category was considered. Segregation was the logic of the background of social organisation upon which psychological medicine was placed. Before anyone was marked as a lunatic they had first been separated out from society by a selection process operating at the point of social disruption. Placing and keeping such people inside the asylum was the necessary extension of this process.

1. e.g. Dr. Yellowlees in a paper read to the Poor Law Conference in 1884: "Chronic cases should be drafted off as they arise, to the other and larger asylum This plan would secure at once, I believe, the greatest benefit to the patients and the least expense to the rate-payers". See YELLOWLEES, D: Lunacy and Pauperism. Glasgow, 1884, p.11. The new "chronic" asylum at Lancashire (Winwick) was designed for 2,000 "of the chronic and quiet class" all of whom were to be farmed out from the "proper" asylum. See, Fiftieth Report of the Commissioners in Lunacy, 1896, p.14.

The Poor Law was clearly of major importance in underpinning this pattern because of its adherence to the principle of giving only indoor relief as far as it could. Controlling costs was not the only purpose of such strict conditions of relief. The Poor Law was intentionally regulative of society, seeking to secure stable function upon a market economy in which cost-control held as much a social-ordering purpose as an economic one.⁽¹⁾ The various institutions whose inmates were supported by it were more overtly regulative - of the inmates themselves, whom they sought to remodel as acceptable citizens.⁽²⁾

The lunatic asylum was no exception in this regard. Its specific purpose of restoring aberrant individuals to acceptability was contained within the constraints of legal and social segregation and of regulative social policies operating through sources of funding. That psychological medicine retained its apparent scientific detachment despite these constraints should not be surprising. The compromise worked out between the medical profession and those who organised and funded the asylum system - through their social agencies, the magistrates and Poor Law administrators (often one and the same) - enabled both "medical" and "societal" purposes to continue operating each with its own rationale. "Harmless chronics" and other burdens on society could still be made subject to the rigours of pauperdom while the "curable" and favoured cases could be brought into the benign care of enlightened medicine.

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1. Ann Crowther makes this point well. Curiously though, she does not see the institutions built upon the Poor Law as extending this function, beneath whatever particular rationale each held. See CROWTHER, Ann: The Workhouse System 1834-1929, the History of an English social institution. 1981.
 2. This, at least, was their assumed purpose. The principle of "reformation" was popular in the nineteenth century combining as it did the exercise of power with the ideology of personal improvement. See IGNATIEFF, Michael: A Just Measure of Pain. The Penitentiary in the Industrial Revolution, 1750-1850. 1978.

Both parties gained advantages from this relationship. Psychological medicine was allowed a sphere of influence in the lunatic asylums, where career-structures and professional activities such as research and therapy could be carried on, while the regulators of social policy could draw upon the profession's credibility to legitimate the wider purposes which the asylums also served. Medical theories relating to insanity thus became one of the official ideologies behind strategies for the institutionalisation of the socially aberrant.

This is not to say that psychological medicine was no more than a rationalisation of the social forces for segregation and control of deviant populations. It was that in effect, but only because of the accommodation between mental physicians and those for whom they worked, and the dependence of the former upon the latter. Both the concern for individual suffering and the few technologies which they had acquired were independent factors that could operate in a great many different societies. Their actual uses - and the purpose of their uses - depended, however, upon the given social organisation of the time. Thus both their application and the value set upon it in various circumstances were regulated by specific social structures. These determined the occasion for medical intervention by a regulation of who was deemed an aberrant person suitable for this means of restoration to acceptability and when such acceptability existed, and the circumstances of medical intervention by regulation of the means of financial support both for the individual incapacitated from society and for the enterprise itself.

It was this accommodation taking place over the occasion for medical intervention which we saw taking place in Chapters 2 and 3. The accommodation over its circumstances was a part of the relationship between mental physicians and their social context which we have been examining in this chapter. The potential of psychological medicine was always greater

than the results of this accommodation could allow, resulting in tensions within medical theory - seen in the earlier chapters - and the continuing campaigns by doctors and various others to modify the basis of medicine's practical circumstances. The most tangible achievement during the latter half of the nineteenth century was the elevation of a special category of deserving lunatics against a more general run of hopeless cases. However, despite this attempt mental physicians could not avoid the logic of social segregation because their very enterprise had been founded on that logic. Psychological medicine was thus bound to be over-ridden by the institutional syndrome.

e) THE LUNATIC ASYLUM AS A VICTORIAN INSTITUTION

We should therefore be looking at the lunatic asylum less as a place of medicine and much more as a special form of the Victorian institution. To be sure, the curative ideology persisted as did the humanitarian rhetoric. The emphasis that was given to the "deserving" curable cases helped to preserve the medical profession's expressed concern with high quality curative provision, despite the growing loss of faith in cures, but all that really came of that concern was the acceptance of lunatics as a "sick" category, deserving of some degree of extra comfort and attention.⁽¹⁾ They were still the subjects of institutional rule. This involved two kinds of regulation: one economic, the other behavioural. In truth they were one social process and seen as such, yet we may distinguish these aspects for our analysis.

As recipients of poor relief lunatics were, of course, required to be cheap. In 1857, for example, the lowest average cost per head was 7/1d (35.4p) a week at the York Asylum. The highest was 10/7½d (53p) at

1. See Chapter 3.

Gloucester. The West Riding Asylum maintained its patients at an average of $7/11\frac{3}{4}d$ (39.9p) per week.⁽¹⁾ By contrast, the average convict cost around ten shillings each week to keep in prison.⁽²⁾ By 1883 the average weekly cost for county asylums was $9/2\frac{3}{4}d$ (46.1p) and for those on the borough rates $10/4\frac{7}{8}d$ (52p).⁽³⁾ Seven years later the respective figures were $8/7\frac{3}{8}d$ (43p) and $10/1\frac{1}{8}d$ (50.5p).⁽⁴⁾ The fall in costs over these years no doubt reflects the fall in the price of food and demonstrates the asylum authorities sense of priorities: presented with the possibility of increasing the rations they instead preferred to save ratepayers' money.

These figures were nevertheless misleading. Included in them was the cost of salaries and wages approximately $2/3d$ (11.5p) in 1883 and $2/6d$ (12.5p) in 1890. In 1883, $6\frac{1}{2}d$ (2.7p) was spent on the farms and gardens of the county asylums per inmate each week. $4/3\frac{1}{2}d$ (21.5p) went on food, $8\frac{7}{8}d$ (3.6p) on clothing and $11\frac{1}{2}d$ (4.8p) on fuel for lighting, washing and so on. A meagre $\frac{5}{4}d$ (0.3p) was allocated to "surgery and dispensary".

This was not all. Patients could still be made productive and their labour used to produce goods which could then be sold on the local market, the profit thus defraying some of the maintenance costs. The amount was small - a mere $3\frac{1}{4}d$ (1.3p) per patient per week in county asylums in 1883 - yet again demonstrated an order of priorities. Better inmates should be productive, yielding goods for the market to help support themselves and reduce the burden to ratepayers, than that they should be idle or set about some overtly therapeutic activity. Not all the goods

1. Twelfth Report of the Commissioners in Lunacy, Appendix C, 1857/8, pp.34-5.
2. SCULL, Andrew T: Museums of Madness, 1979, p.215.
3. Thirty-Eighth Report of the Commissioners in Lunacy, 1884, pp.86-7.
4. Forty-Fifth Report of the Commissioners in Lunacy, 1890/1, pp.48-9.

produced by patients were sold in this way. Much of their produce was consumed within the asylum. Yet again, as the fall in maintenance costs paralleling food prices shows, this merely reduced the amount needed from the poor rates.

As well as being cheap and productive, inmates were required to conform to discipline. Part of this discipline was the work routine which enforced productiveness and domestic labour made necessary. Part, too, was seen as a feature of the restorative process by which lunatics would be made acceptable again to society. But many routines of asylum life could by no stretch of imagination be seen as curative. Segregation of the sexes, regimented meals and exercise periods, indeed the whole manner of the doctors' regime which we saw in Chapter 5, were introduced from other institutional models - notably the prison and the workhouse. All these disciplinary purposes were run together without any sense of incongruity in doctors' minds. They added up to the unique phenomenon of the asylum.

Why was the asylum so central to psychological medicine? For the asylum was the cure, in effect. Despite criticism from contemporaries about its counterproductive effects⁽¹⁾ it remained the one dominant idea of the doctors. There were probably two reasons for this. One we can summarise by looking at Daniel Hack Tuke, who speaks pretty well for the whole of his profession:

"Asylums can never be dispensed with - no matter how persistently ignorance, prejudice, or sophistry may declare to the contrary - without retrograding to a greater or lesser

1. See, e.g. WYNTER, Andrew T: op.cit. Wynter was a tireless campaigner against the large asylum. But they did have their defenders. An article in Nineteenth Century saw no harm in them, whilst they could provide greater facilities and a more effective "moral treatment". See ANON: A Court of Lunacy, Nineteenth Century, February 1886.

extent to the conditions of a past period with all the inhumanity and barbarity connected with it." (1)

For Tuke, the asylum was the guarantee of humane treatment and thereby of the mental physicians' legitimacy of purpose. But the cure, if so we are to regard it, was not humaneness for its own sake but as an aid in an attempt to gain control over patients' behaviour. But when "kindness and persuasion" failed to achieve "authority" over them then other measures were needed to demonstrate that "it is in the power of the superintendent to employ coercion".⁽²⁾ That power would not be possible outside an institution of the kind which the asylum embodied.

But there was an even more important reason for the asylum's indispensibility. The bulk of medical criticisms of the asylum were directed against the consequences of lowering their cost to ratepayers, with the resulting large-scale 'warehousing' that the Commissioners in Lunacy had abhorred. Moreover, both these mammoth asylums - overpopulated even for their size - and the abysmal conditions available under Poor Law regulations were seen as detrimental to any serious attempt at providing cures. These circumstances were due to constraints placed upon those undergoing medical aid by the outside society, through the system of poor relief which in its turn was the lynchpin of a market-oriented society in which the only properly acceptable means by which all but the wealthy could live was by the sale of labour power. However, these constraints were accepted by professional medical men as the natural basis of an ordered society and thus rendered effectively 'invisible'. Consequently, criticisms fell upon specific types of institution as brick-and-mortar realities rather than on the "institution" as such and on the structure of the pauper economy which supported it.

1. TUKE, D.H.: Chapter on the History of the Insane in the British Isles. 1882, pp.457-8.

2. ibid., p.217.

In any case, it was overwhelmingly by falling foul of that society's regulatory constraints that people first became marked and subsequently isolated as lunatics, rather than by any process in which a person's condition led directly to an attempt by that person or by a relative to seek cure. Once inside the asylum the same regulatory force was apparent in determining the nature of the regime there, as we have seen. Yet here is a contradiction: if the person's original identification as a lunatic resulted from their falling foul of societal constraints, how could those same constraints then bring about a restitution? All that they really offered was an intensification of the conditions which had led to the initial disablement, intended now to steer the inmate back towards amenability to industrial or domestic activity. No attempt was made to address his or her personal state. The asylum structure was meant to stamp predictability upon the unpredictable - in a kindly, humane way - and no more. Dialogue with patients - originally, disruptive of "society" at some level - was not conspicuously absent because no other voices but those of societal agency were recognised. Nevertheless, it was absent. Their disruption on the other hand was very much present. Neglecting to treat with patients as persons in their own right, doctors imagined that what suited societal expectation helped the individual: there was an assumed identity of interests between the worlds of those who organised society and those who merely provided labour for it. This was not so and the disruption persisted, the only recourse being the attempt to suppress it. This was the effective function of the asylum and its routines.

In this, the lunatic asylum was a special form of the Institution - the prison, orphanage, industrial school, and increasingly the "homes" for the wayward and awkward, the "inebriate asylums" and the hostels run by charitable societies in collaboration with the Poor Law. All acquired their inmates by a process of selection at the point of disruption to

society, all sought a "reformation" of character, all were run on economic lines strictly in accordance with the pauper economy, all reinforced the ideological values which went with that economy - to be thrifty, to be self-reliant and above all to work for a regular wage, all failed to achieve their stated purpose of reformation, instead growing in size and increasing in cost to the very society which had hoped to avoid it. Like those other examples of brick-and-mortar social policy the lunatic asylum was caught up in a kind of inertia - caused more by the opposing currents within its actual social function than by any failure in its overt medical purpose.

For ultimately, the lunatic asylum was one of a series of institutions designed to police the effects of social dislocation - the isolation of persons from the free market society whose order they had disrupted. Society had officially rejected "interference" in free market operations, particularly in the fixing of wage levels, employment rates and conditions of work, adhering to an economic orthodoxy which the pauper economy of the Poor Law (with its shadow, the charitable societies) upheld. But the pauper economy was itself an intervention. The problem was that in a society based exclusively upon a free market in labour, those who for whatever reason fell outside the market, unable to sell their labour power, had no real place within the society. These people did not, of course, simply disappear. They remained to pose problems, which had to be dealt with in some way.

Government interference, thrown out by one door, thus crept back in by another. The centralised bureaucracy of the Poor Law Commissioners had intended the deterrent workhouse to police demand for poor relief. When demand upon society took more problematic forms such as theft and other crimes against the social order, physical incapacity, orphanage or even bizarre, disruptive or unmanageable behaviour, these were progressively

segregated out and sent into appropriate institutions. These were in practice extensions of the pauper economy - even though, as with the lunatic asylum, the buildings themselves were maintained and inspected by a different authority - since each inmate was supported as a pauper. The overt rationale of each of these institutions was reformatory. It would not be too rash a generalisation to assert that it was their social logic to correct individual deviance in pursuit of the forcible restoration of free market operations.

But the logic of those same operations set limits to that reformatory process. It was not only that the process had to be cheap but also that cheapness was itself seen as an ideological virtue. Thus the discipline of market forces underpinned the ideological discipline within the institution, which could then only lock away the effects of the original dislocation from society. The whole venture was precisely self-defeating. Having no control over the initial segregation, yet bound by the same social strictures in its operations, these brick-and-mortar edifices had no option but to mark time.

The Victorian Institution thus stood upon a profound irrationality within free market society. The Victorian lunatic asylum could no more successfully restore dislocated labour to fruitful activity than society itself could care for and adequately maintain its own population.

CHAPTER 8: CONCLUSION

In 1878, Daniel Hack Tuke, in his book "Insanity in Ancient and Modern Life", made the following observation upon the utility of psychological medicine:

"A great saving will be effected for British ratepayers when that [lunacy] which is preventable shall have been reduced to a minimum by the widest extention of a thorough, but not too oppressive or too early commenced education, by the practical applications of the ascertained truths of psychological and medical science, and by the influence of a Christianity, deep in proportion to its breadth, which shall really lay hold of life and conduct and mould them in accordance with itself." (1)

For Tuke, as for other writers of his time, the questions posed by lunacy were set full square amid other major concerns of contemporary society. In particular, and the nobility of such ideals as basic education and an elevating - not to say didactic - religious influence may obscure the importance of the fact for us, the concern that all these essential matters and medical science besides should work for no higher ideal than to secure a reduction in the rates. There was little objection to this ordering of priorities in or out of the profession.

We have seen in the course of this thesis that such questions as how lunacy and lunatics themselves were to be fitted into society as part of its self-organisation cannot be divorced from purely "medical" considerations. It is not enough to analyse medical theory on insanity and its treatment without placing the construction of that theoretical body of "knowledge" within a wider framework of occupational development within medicine and of lay administration. The very maintenance of the insane constituted more of a problem, and was in fact a greater influence upon their lives and treatment, than the teachings, such as they were, of psychological medicine. This dimension of pauperdom, itself part of the politi-

1. TUKE, D.H.: Insanity in Ancient and Modern Life, with chapters on its prevention. 1878, pp.127-8.

cal considerations of a society built upon a free market in labour from which some (in practice, many) individuals were unavoidably excluded, brought about the main conditions of psychological medicine's operation. When the achievement of that medicine was as slight, in its own terms, as we have shown it to be in this thesis then those wider social conditions of its operation were by far the most significant part of the subsequent growth of "psychiatry", at least insofar as such growth was not introduced from outside this social context.

The vital importance of social context is evident not only at the level of lunatics' continued maintenance but also at the level of their original selection from society. This, once we ignore self-selection, which for candidates for the lunatic asylum hardly existed, is obvious. But the grounds for that selection and the agencies of it tell us that not even the nature of what lunacy is can be separated from the living fact of specific selection and identification in each individual case. We have seen this in the section on diagnosis in Chapter 2, pp.62 - 73 (although the whole chapter testifies to the extent of social values in first defining the very idea of insanity), at various points in Chapter 4 where we examine the reasons for admission into the asylum and in Chapter 7, pp.329-337, where we look at the points of identification of a "lunatic", though information on selection is difficult to obtain at any of these levels.

Against this structuring by contemporary society we have consistently upheld the interpretation that individuals did pose problems, to themselves or to others, which could in no way be dismissed as the constructions of social agencies alone. In their turn, doctors did address themselves to some of these problems, though not always with clarity and rarely with effect. That some relief may have been achieved as a result cannot be denied. Neither is it deniable that much was obscured by a medical

approach which was organism centred and did not listen to its patients at a human level.

The fundamental flaw of this medical view - clearly traceable to the social structuring within which the consciously medical enterprise was actually set - was the ambiguity between seeing the individual as sufferer and as social deviant. Because they were, in a sense, only partially conscious of their total social enterprise doctors confused these two ways of seeing their patients entirely. They may themselves have adopted a benign approach and followed it through with all the integrity at their command, yet before, during and after their encounter social structuring beyond their regulation was actually present.

Officially, the medical perspective was adopted to describe what was happening to lunatics. They were "diagnosed", they were "treated", they were "cured" (or not). The same ambiguity is therefore to be found in official attitudes to the medical enterprise. The same words were used on either side of a conceptual division. Doctors followed "humanitarian" purposes, but were they designed to promote a person's well-being and self-control or to take charge of that process and regulate it for the benefit of society (as conceived by its agents) in a way that had social legitimacy? Was an "asylum" a haven of serenity or a place to lock away difficult people who nevertheless did not deserve prison or the workhouse? Was a "cure" the restoration of self-control or the subordination of self to the control of society? Between these two polarities existed a tension. The extent to which this tension amounted to self-contradiction for those psychological medicine was supposed to benefit was a function of the extent to which "society" - in the form of its agencies of medicine, pauper maintenance and regulatory policing - held the strings in the medical encounter. In practice, as we have argued, the policing power of societal agencies was very strong, resulting in an overwhelming concern

with the lunatic as social deviant to be isolated, classified and controlled according to the perceptions of those particular agencies. In consequence of this, the needs of the patient as sufferer were ignored and the restoration of self-control, upon which psychological medicine made so much play, was precisely defeated. The alternative to such restoration, continued incarceration, was nevertheless in keeping with the demands of social organisation as they were conceived and controlled and so persisted, despite its apparent self-defeat.

This is not a simple social control argument. The agencies which first selected the aberrant individual, those which subsequently directed him or her to the status "lunatic", and those which determined what should then happen to a person of this status were at an operational level independent. Yet they were part and parcel of the society which they regulated, as were the people they acted upon. Neither was selection itself a passive process. Individual people had certain characteristics, could be seen as socially incapacitated, and these characteristics provided the active material upon which those agencies operated. The outcome of these processes reflected the distribution of power between social agencies and the people on whom they acted. Once the aberrant individuals had been dislocated from the rest of society and placed within an institution that distribution of power could easily be decided in favour of the institutional authorities. Yet behind these authorities stood the question of the distribution of power within society itself.

Lunatics, along with other institutionalised inmates, were socially and economically marginalised. In a real sense, they were placed outside free market society and held only within the organisation for the maintenance of non-productive people, the pauper economy. They appeared naturally to fall, therefore, away from the realms of that liberal ethic which saw "free" individuals as having ensured rights within society and towards

the domain of the private ratepayer, whose property they effectively became. This relation to the rest of society in which lunatics were placed determined the distribution of power they experienced and thus the outcome of the workings of psychological medicine as we have seen it in this thesis.

From a historical perspective, we have been able to give some flesh to the bones of this interpretation of the social circumstances of the so-called "insane". More work can usefully be done to explore the implications of these. In particular, we have been able to clear the way for a view of late Victorian psychiatry which makes of it a part of the history of institutions themselves, rather than an extension of strictly "medical" history, which in this instance seems scarcely relevant. A closer study needs to be made of the influence of nursing staff upon asylum inmates during the crucial period from the 1880s to the 1930s, when psychiatry began to stand on a firmer footing, to assess how far even this was a product of extra-medical developments. Analysis needs to be made of the development of the doctors in charge, their professional development and their relations with subordinate staff, and some reassessment of prominent historical figures is due. Most important of all, perhaps, is a need to reconsider the impact of changes in the pauper economy, with concomitant shifts in political power, from the Edwardian reforms to the welfare state (and, in view of current events, to what is replacing the welfare state).

The implication for psychiatry in all this is that it does not exist in any fundamental way distinct from its contemporary society. It is intrinsically bound up with questions of the distribution of power in society and especially with that which determines the nature of social support for those under its care. This distribution in its turn is less decided by "medical" concern than by concern in society at large for access

to the means of life for its various constituent groupings. Any practical psychiatry is then inseparable from these social and political circumstances, as personal disablement is inseparable from socially structured disablement. Simple "psychiatry versus society" or "psychiatry versus the free individual" models must be rejected. In the end, we cannot expect more out of a psychiatry than our social and political order will allow. Within this field of view practical medicine may achieve more or less according to a whole range of factors, not least of which is the acceptability to the patients of the social order to which psychiatry must, inevitably, attempt to accommodate them. This limit upon its powers does not mean that we should not do what we can. It simply requires that medical men achieve a clear awareness of the nature of the society in which this accommodation is expected to take place.

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