

THE PATIENTS OF THE BRISTOL LUNATIC ASYLUM IN THE
NINETEENTH CENTURY 1861-1900

PAUL TOBIA

A thesis submitted in partial fulfilment of the requirements of the
University of the West of England, Bristol for the degree of Doctor
of Philosophy

Faculty of Arts, Creative Industries and Education

March 2017

Word Count 76,717

Abstract

There is a wide and impressive historiography about the British lunatic asylums in the nineteenth century, the vast majority of which are concerned with their nature and significance. This study does not ignore such subjects but is primarily concerned with the patients of the Bristol Asylum. Who were they, what were their stories and how did they fare in the Asylum and how did that change over our period. It uses a distinct and varied methodology including a comprehensive database, compiled from the asylum records, of all the patients admitted in the nineteenth century. Using pivot tables to analyse the data we were able to produce reliable assessments of the range and nature of the patients admitted; dispelling some of the suggestions that they represented an underclass. We were also able to determine in what way the asylum changed and how the different medical superintendents altered the nature and ethos of the asylum. One of these results showed how the different superintendents had massively different diagnostic criteria. This effected the lives of the patients and illustrates the somewhat random nature of Victorian psychiatric diagnostics.

The database was also the starting point for our research into the patients as individuals. Many aspects of life in the asylum can best be understood by looking at individual cases. Our database and other records will tell you the extent of epilepsy at the asylum but only individual case studies will show the suffering and life changing effects of that illness. Contributing to these stories are our collection of the patients photographs and although their value as hard evidence is disputable, they do aid our historical imagination in understanding their humanity and suffering.

This study is hopefully a useful adjunct to a growing historiography which offers a more nuanced view of the asylums and brings the lives of patients to the forefront.

Contents

	Page
Acknowledgements	4
Introduction	5
Chapter 1: Literature, Methodology and Evidence	11
Chapter 2: Local and National Contexts: The Rise of Asylums and the Case of Bristol	33
Chapter 3: The Composition of the Asylum Population	60
Chapter 4: The Patients' Experiences of the Asylum	104
Chapter 5: Diagnosis, Illness and Treatment	148
Chapter 6: The Photographs of the Asylum Patients	195
Conclusions	247
List of Illustrations and Tables	257
Bibliography	267
Guide to Appendix 1: The Database of all Admissions to the Asylum in the Nineteenth Century	296
Appendix 2	297
Appendix 3	297

Acknowledgements

Firstly, I would like to thank my supervisor Michael Richards for his help and support. He finally got me to overcome my aversion to academic rigour. My database is an important part of this study and without the technical expertise of my friend Charles McFeely it would have been much less effective. The staff at the Glenside Museum have been very supportive especially the indefatigable Stella. Most of my evidence is from the Bristol Record Office whose staff were always helpful. Lastly, I would like to acknowledge the patients at the Bristol Asylum as their humanity was the inspiration for this study.

Introduction

This study is about the patients of the Bristol Lunatic Asylum between its opening in 1861 and 1900. It is about who they were and their experiences in the asylum. It is a record of their suffering and sometimes their recovery.

One patient who did not recover was George Joseph Silman. From his medical notes we know that he was admitted to the Bristol Lunatic Asylum on 8 March 1890 and he was a 35-year-old shipwright. He lived in Clifton, a prosperous area of Bristol, he had black hair and was 5 feet 4 inches tall. On admission he said there was a battery in his head that had been turned on. He was also hearing voices. He had gone to the police station and told them the battery was killing him. His wife said he had been behaving oddly for about 8 months. His delusion about the battery stayed with him for the rest of his life. His diagnosis was dementia but a few years later this was changed to mania. He is pictured below in 1905 when he had been in the asylum for about 15 years.

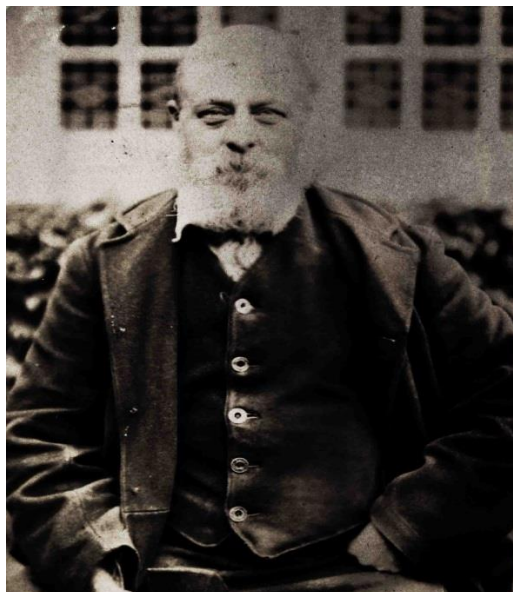


Fig. 1 George Joseph Silman in about 1905¹

After admission he initially made some progress and said the battery was only working some of the time. However a few weeks later he complained of voices coming to him in the night. On 23 May 1890 he escaped but was later found in Wine St, Bristol. He said he was sorry he escaped and came back willingly. His wife and sometimes his children visited him but on one occasion he tried to go home with them and had to be pulled apart. He was started on hyoscine (a sedative) which seemed to calm him but he maintained his delusions.

He was obviously unhappy but he ate well and did some dusting on the ward. In 1893 he was reported as being very browned by the sun but he said it was not the sun that caused his tanning but rather cosmetics that are being worked into his system. His mental state continued the same, he was mostly in good physical health and lived until 1926 when he died aged 71.²

In many ways George was ordinary, not rich and not poor. His photograph shows a fairly typical Victorian man, who could probably be termed 'respectable working class'. This study contends that his story along with many others is valuable. In recent years a number of historians including those associated with the 'History from Below' movement have championed the importance of studying the poor and dispossessed.³ As we shall see, many asylum patients like George did not come from a particularly poor background but once incarcerated they were certainly dispossessed. Their lives were impoverished partly by the nature of the institution but also by the nature of their conditions. A number of authors, including Andrew Scull, Louise Hide and Pamela Michael, offer excellent evidence about the nature of the asylum and its effects on its

¹ Source: Admission book BRO 40513/C/2/8, 161. Admission 8/3/1890, discharge (died) 28/9/1936.

² Ibid.

³ The phrase first came into general historiographic use after E.P. Thompson's article 'History from Below,' *Times Literary Supplement*, 7 April, 1966, 279–280. A review of this approach can be found in Tim Hitchcock, 'A New History from Below,' *History Workshop Journal* 57 (Spring 2004): 294–298. It was Roy Porter who first suggested that the approach could be used in the study of patients in 'The Patient's View: Doing Medical History from Below,' *Theory and Society* 14(2) (March 1985): 175–198.

inmates but they rarely mention their psychiatric conditions. If they are mentioned it is usually in terms of their diagnoses rather than their often horrendous symptoms.⁴ If like George Silman you felt you had a battery inside you and it was draining the life out of you, this would have a major effect on your life wherever you were.

To aid our study of the Bristol patients, a detailed and substantial database has been produced onto which the details of all the nineteenth-century patients who were admitted to the asylum will be entered. Information about individual patients has been obtained and analysis made of their characteristics as a population, using pivot tables. Further information comes from the asylum's records, which are quite extensive. These include the patients' medical notes from which the database is compiled, plus records of other aspects of the asylum, including supplies, wages, correspondence and maps. All of this evidence was written by the staff of the asylum and bears their imprint and prejudices. It therefore has to be treated with caution, but much of the information consists of basic biographical and medical facts about the patient, which are likely to be accurate. Other entries, such as diagnosis and opinions about the patient, have to be analysed more carefully. We do, however, have some evidence from the patients themselves, mostly in the form of letters but also an autobiographical book written by John Weston about his time as a patient in the asylum.⁵

This study is not a generalised history and asks certain specific questions about the patients of the asylum. These are:

1. Did the patients represent a cross-section of Bristol society? It has been suggested by authors such as Andrew Scull that the asylum's population was largely composed of troublesome sections of society's lower orders, but this has been challenged by authors including Walton and Wright.⁶

⁴ Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London: Allen Lane, 1979); Louise Hide, *Gender and Class in English Asylums 1890–1914* (Basingstoke: Palgrave Macmillan, 2014); Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800–2000* (Cardiff: University of Wales Press, 2003).

⁵ John Weston, *Life in a lunatic asylum: an autobiographical sketch* (London: Houlston and Wright, 1867).

⁶ Scull, *Museums of Madness*, 242; John Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848–50,' *Journal of Social History* 13(1) (1979): 10; David Wright, 'Getting out of

The analysis of our database should find evidence relevant to this controversy. In addition, analysing the database should tell us more generally what sort of people were admitted in terms of gender, age and class and how each of these groups fared once admitted.

2. How did the asylum change over our period and how did these changes affect the patients' lives? During our period of 39 years there were many changes which affected the asylum. As Louise Hide has recently demonstrated, attitudes and ideas about insanity changed during the second half of the nineteenth century, leading to a medicalisation of the treatment of lunacy.⁷

The asylum itself grew beyond the intentions of its founders. The medical superintendents of the asylum changed, a factor other studies seem to have ignored, but this seems to have had a significant effect on the Bristol Asylum.⁸ Using a combination of individual accounts, asylum reports and statistical analysis we will attempt to discover the relationships between these changes and their effects on the patients.

3. How did the patients' symptoms and diagnoses affect their experiences in the asylum and did being in the asylum have a positive effect on these symptoms? There are a number of factors which were likely to influence a patient's experiences in the asylum and the probability of their recovery. It is suggested in this study that the mental problems that the patient suffered from were the biggest factor in both the nature of their experiences and the likelihood of recovery. Whatever the influence of the asylum, for good or ill, it was a secondary effect. This places a different emphasis to much of the literature on the subject, which will be discussed in Chapter 1.

To answer these and other questions about the asylum and its residents, it will be necessary to determine how typical our asylum was. Where typicality can be proven, our evidence

the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century,' *Social History of Medicine* 110 (1997): 153.

⁷ Louise Hide, *Gender and Class in English Asylums, 1890–1914* (New York: Palgrave Macmillan, 2014), 19–22.

⁸ An exception to this is James Gardner, *Sweet Bells Jangled out of Tune: A History of the Sussex Lunatic Asylum* (Brighton: Self Published, 1999). He shows in much detail how staff changes affected the running of the Asylum, especially in the second half of the nineteenth century. Other works, including Andrew Scull, seem to characterise the superintendents as 'aloof' and the attendants as 'ill suited': Andrew Scull, *Museums of Madness*, 122.

can be used to suggest generalisations about the asylum system. In areas where the asylum does not seem typical this may be evidence of diversity in the system or that more research may be needed.

In addition to these specific questions, this study hopes to produce a sense of the lives of these patients and to capture an appreciation of their individuality. Using their photographs, the asylum casebooks and other sources, we hope to bring to life some of the forgotten residents of this asylum.

The study will consist of six chapters with conclusions to follow. The first will examine the literature of lunacy and lunatic asylums along with a detailed account of our methodology and sources. Chapter 2 shows the contexts of the study. These include the changing views on insanity, its organisation and regulation. We will also consider local issues and the process by which people were admitted to asylums. The following chapter looks at the characteristics of the Bristol Asylum population, using statistics from our database and individual examples. Chapter 4 focuses on the patient's experiences in the asylum. This includes the work that they were encouraged to participate in, their leisure activities and the food which was provided. It also looks at how men and women were treated, noting differences and similarities. The effects on the patients of the environment of the asylum is also considered. The relationship between staff and patients affects any institution and we have some evidence of this, including John Weston's book. The main omission in terms of patient experience is the effect of their mental symptoms which caused them to be admitted. This is the subject of Chapter 5 and this starts with a review of the patient's diagnoses and includes evidence of the superintendents' differing diagnostic criteria. It then looks at the different conditions with both a statistical analysis and individual's experiences. During the 1890s many of the patients were photographed just after admission and most of these are preserved in the patient admission books. Chapter 6 considers the use of these photographs as evidence of individual patients and the asylum population in general. Our conclusions include a

discussion of how our various research questions have been answered, how this relates to other studies and what the study might indicate for further research.

Lastly it must be noted that this study uses the terms lunacy, insanity and madness. These are terms that were used by writers and doctors of the period studied. Like many other authors, our use of these terms does not imply an acceptance of the medical model which utilises such terms. Similarly, the study uses nineteenth-century diagnostic terms but, as Chapter 5 shows, this does not imply an uncritical acceptance of these terms.

Chapter 1: Literature, Methodology and Evidence

The lunatic asylum has attracted much discussion. The reasons for their formation, their role in a capitalist society, how they treated their patients and the nature of their afflictions, have all been the subject of much critical debate. The historiography of the asylums can be viewed in a number of ways. Chronologically there are three distinct eras when a specific approach has dominated. Sarah York has classified these as 'whig', 'radical' and 'revisionist'.¹ The controversies can also be divided along lines according to the discipline of the writer. The 'whig' interpretation of history which sees history as an inevitable progression towards greater liberty and enlightenment has often been adopted by writers from the medical profession.² An example very pertinent to this study is Dr Donal Early who wrote the most detailed study of the Bristol Asylum.³ 'Radical' writers, often social theorists or sociologists, such as Foucault, Goffman and Scull, have tended to view asylums as objects of oppression and madness as socially constructed.⁴ Historians have often been critical of the somewhat fundamentalist positions of the 'radicals' and have taken a more empirical approach. These disputes are relevant to this study and will be discussed but it is less concerned with the nature of these institutions and more concerned with its inhabitants, their lives and problems.

Lastly, there are the writers, usually professional historians, including Melling and Forsythe, Pamela Michael and most recently Louise Hide who are from what can be seen as a 'revisionist'

¹ Sarah York, *'Suicide, lunacy and the asylum in nineteenth-century England.'* PhD thesis, University of Birmingham, 2010: 8.

² The author most commonly referred to as having a 'whig' approach is Kathleen Jones who was not from a medical background, Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early Eighteenth Century to the 1990s* (London: Athlone Press, 1993) Authors from a medical background include T. Turner, 'A Diagnostic Analysis of the Case Books of Ticehurst House Asylum, 1845-1890', *Psychological Medicine Supplements*, no.21 (1992) and J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylums – St John's* (London: Gaskell, 1990).

³ Donal Early, *'The Lunatic Pauper Palace' Glenside Hospital Bristol 1861 – 1994* (Bristol: Friends of Glenside Museum, 2003).

⁴ Michel Foucault, *Madness and Civilization* (London: Random House, 1965); Erving Goffman, *Asylums: essays on the social situation of mental patients and other inmates* (Garden City, NY: Doubleday, 1961); Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London: Allen Lane, 1979).

orientation who accept the need for theoretical rigour but criticise Foucault and the 'radicals' for their empirical weaknesses.⁵ Their studies are often based on research completed at a single or two asylums and as such are most pertinent to this study of the Bristol Asylum. The use of a single asylum begs the question of how typical were each asylum, a question that needs to be addressed in this study. Lastly there are a number of studies which relate to particular aspects of nineteenth century mental health. These subjects include gender, class, the admission process and the Poor Laws.

The author most commonly referred to as having a 'whig' approach is Kathleen Jones who was not from a medical background. Sarah York suggests her work is an account of 'the inevitability of progress' in the treatment of the insane.⁶ Although Jones does see the York Retreat as an example of progress, her analysis of the years 1845-1946 suggests that legal issues and the prominence of a medical approach, triumphed over a social approach.⁷ She can however be criticised for ignoring the economic and cultural forces behind changes to the treatment of the mentally unwell.⁸

Of the historians from a medical background, perhaps the most interesting are Richard Hunter and Ida Macalpine.⁹ Although their work remains within the 'whig' paradigm, they adopted a more vigorous empirical approach. Unlike most studies by historians they acknowledge the illnesses and symptoms which blighted the lives of the asylum patients. An example is their discussion of the delusions exhibited by the patients, a subject avoided in most studies but dealt with in this study in chapter 5.¹⁰

⁵ Joseph Melling and Bill Forsythe, (eds.) *A Social History of Madness in Comparative Perspective*, (London: Routledge, 1999), Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800–2000* (Cardiff: University of Wales Press, 2003), Louise Hide, *Gender and Class*.

⁶ Sarah York . 'Suicide, lunacy and the asylum in nineteenth-century England.' PhD thesis, University of Birmingham, 2010,4.

⁷ Kathleen Jones, *A History of the Mental Health Services*, 153-181.

⁸ Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Y.U.P., 1993), 10.

⁹ Richard Hunter and Ida Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum- Friern Hospital 1973* (London: Dawsons of Pall Mall, 1974)

¹⁰ Ibid, 190-193.

The work nearest in subject matter to this study is Dr Donal Early's 'The Lunatic Pauper Palace', which is a general history of the Bristol Lunatic Asylum which was later renamed the Glenside Hospital.¹¹ Dr Early was a consultant psychiatrist at Glenside from 1941 until his retirement, shortly before the hospital closed in 1994. His study lacks theoretical depth but is at its strongest when dealing with the trials and tribulations of the chief medical officers. Most of the book is about the staff and the running of the hospital. The patients are mentioned but are not given prominence. Although this can be seen as a criticism, it was in part due to his wanting to protect the anonymity of the patients and the effect of the 100-year rule, which prevented him making public information on specific patients from the last 100 years.¹² This study hopes to redress this balance and thus confines itself to the nineteenth century. Other local studies of relevance are Susan Marshall's heartfelt but somewhat uncritical history of the Mendip Hospital, which was the nearest public asylum to Bristol¹³, and David Large's impressive study of the Bristol Council which has valuable information on the, sometimes acrimonious relationship, between the Asylum and the Council.¹⁴

Any literature review of the role of the lunatic asylum and its patients has to evaluate Michel Foucault and his highly influential 'Madness and Civilisation' which was first published in France in 1961 under its French title 'Histoire de la folie'.¹⁵ It was first translated and published in English in 1965 in an abridged form. It aroused tremendous praise and criticism and was avidly taken up by the anti-psychiatry movement as evidence that madness was a social construct that has been medicalised by the psychiatric establishment. It is highly relevant to our study, in that much of our evidence should be viewed in the context of Foucault's ideas about madness and

¹¹ See Donal Early, *Pauper Palace*.

¹² See 'Public Records Act 1958,' Legislation.gov.uk, accessed April 11, 2016, <http://www.legislation.gov.uk/ukpga/Eliz2/6-7/51>.

¹³ Susan Marshall, *Mendip Hospital: An Appreciation* (Ely: Melrose Press, 2006).

¹⁴ David Large, *The Municipal Government of Bristol 1851–1901* (Bristol: Bristol Record Society, 1999).

¹⁵ Foucault, *Madness and Civilization*.

power, the medicalisation of insanity, and what he viewed as the abuses of the Moral Treatment movement.

Foucault's ideas will also be explored in other chapters but much of the other historiography of madness needs to be seen in relation to Foucault. Indeed, an examination of almost any work on the history of insanity or the lunatic asylums will include the writer's position in relation to Foucault.¹⁶ Fairly typical is the reaction of Michael Macdonald: 'Anyone who writes about the history of insanity in early modern Europe must travel in the spreading wake of Michel Foucault's famous book, *Madness and Civilization*'.¹⁷ Put simply, Foucault saw insanity as a relative term which was defined by the dominant intellectual and economic systems of a particular era. He suggests there were three eras which saw madness in very different ways. In the Renaissance period madness was seen as a freedom from reason but the insane were treated as a valued part of society. The 1965 translation stated the mad often had 'an easy wandering life', a statement that was slated by several critics as romanticised and blatantly untrue.¹⁸ This, however, according to Colin Gordon, turns out to be a mistranslation and it should have read 'the existence of the mad could easily be a wandering one'.¹⁹ Thus in some instances his English-speaking critics attack ideas he did not actually hold. The second era, which was from the 1660s to the end of the eighteenth century, is characterised by Foucault as 'The Great Confinement', when the insane along with other 'deviant' classes were confined away from society. This period ended when, prompted by the ideas of Pinel in France and Tuke in England, madness became mental illness and psychiatry became the dominant controller of the insane in asylums built to house them.

¹⁶ The exception to this tends to be works by psychiatrists such as Donal Early, *The Lunatic Pauper Palace*.

¹⁷ Michael MacDonald, *Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth-Century England* (Cambridge: Cambridge University Press, 1981), 9.

¹⁸ Foucault, *Madness and Civilization*, 20.

¹⁹ Colin Gordon, 'Histoire de la folie', in *Rewriting the History of Madness: Studies in Foucault's Histoire de la folie* eds. Arthur Still and Irving Velody (New York: Routledge, 1992), 33.

Criticism of his work came from several quarters. Psychiatrists and conservative historians such as Lawrence Stone could not be expected to agree with Foucault. Stone accuses Foucault of producing 'a dark vision of society which accords with only some of the historical facts'.²⁰ Other historians, although sympathetic to Foucault's wider perceptions about the influence of capitalist society in producing the conditions for the introduction of the asylums, have disputed some of Foucault's ideas, particularly his idea of a 'Great Confinement' in the eighteenth century.²¹ Roy Porter who has written extensively on this period argues that, in Britain at least, confinement was of only a very small minority and produces figures which persuasively back up his argument.²² Gary Gutting has suggested that Porter's claims show the difference in their use of examples. Porter uses his facts and examples to support his argument whereas Foucault uses examples to illustrate an argument. Basically this is the difference between the empiricist and idealist conceptions of history.²³ In practice, however, the distinction is not so fundamental as empiricists use ideas and idealists use evidence. This is a valid point but if the 'Great Confinement' did not actually occur or occurred a century later, surely this undermines his more general thesis.

Foucault's assertion of the medicalisation of insanity in the nineteenth century is not in dispute, though the process by which this occurred certainly is, as are the results of this process. He sees it resulting from the work of Pinel and Tuke who were instrumental in the idea of 'Moral Treatment' of the insane. Scull, in many respects a supporter of Foucault, claims that Pinel, despite his medical background, thought that medicine was all but useless in treating madness.²⁴ Moral Treatment, with its advocacy of fresh air, pleasant surroundings and the value of work,

²⁰ Lawrence Stone, 'Madness,' *New York Review of Books*, December 16, 1982, accessed December 3, 2014, <http://www.nybooks.com/articles/1982/12/16/madness/>.

²¹ Foucault, *Madness and Civilization*, Chapter 2.

²² Roy Porter, 'Foucault's great confinement,' in *Rewriting the History of Madness: Studies in Foucault's Histoire de la folie*, eds. Arthur Still and Irving Velody (New York: Routledge, 1992), Chapter 10.

²³ Gary Gutting, 'Foucault and the History of Madness,' in *The Cambridge Companion to Foucault (Cambridge Companions to Philosophy)*, ed. Gary Gutting (Cambridge University Press: Cambridge, 1994), 63–66.

²⁴ Andrew T. Scull, 'A Failure to communicate? On the reception of Foucault's *Histoire de la folie* by Anglo-American Historians,' in *Rewriting the History of Madness: Studies in Foucault's Histoire de la folie*, eds. Arthur Still and Irving Velody (New York: Routledge, 1992), Chapter 13.

might have been patriarchal and controlling but not terribly medical. Whether madness is a social construct or an illness has been much debated over the last 50 years and Foucault's work is central to this debate though many, including this author, would not accept such an either/or proposition. Many of the aspects of insanity are very different from the usual conceptions of an illness and psychiatry's attempts at categorisation have been problematic at best but to term the very real sufferings of the people in this study as purely socially constructed seems to be at odds with the evidence. Insanity is obviously affected by political and social conditions but the fact that it has existed over many centuries with very different political and economic conditions, suggests, at least to this author, that factors other than social control are relevant. These other factors would include both a biological disposition to mental health problems and childhood experiences.²⁵

Another influential writer from the 'radical' perspective was Erving Goffman whose book 'Asylums' with its central idea of the lunatic asylum as a 'total institution' was taken up by many critics of the Asylums and their later counterparts.²⁶ Goffman rightly stressed the tendency of institutions to bureaucratise and control their inhabitants but in lumping together lunatic asylums and prisons he seems to have ignored their differences. Goffman based much of his study on St Elizabeth's Hospital in Washington DC. Other writers including Matthew Gambino have studied this institution and found a less controlling environment. He concludes that the basic fault was Goffman's failure to appreciate fully the capacities of his subjects.²⁷

²⁵ This is a very contentious area and as it is not central to this study, we will suggest an approach to the aetiology of insanity that believes there is no single cause but rather several causes depending on the individual and their experiences. This is in line with authors such as Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2003). For a critical analysis of this approach see Tomi Gomory, David Cohen and Stuart A. Kirk, 'Madness or Mental Illness? Revisiting Historians of Psychiatry,' *Current Psychology* 32(2) (2013): 119–135.

²⁶ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (London: Penguin, 1961). He derived his idea of a total institution from the term totalitarianism which was a Cold War concept supposed to prove how both Nazi Germany and Soviet Russia totally controlled their populations. Apart from its dubious politics this idea seems flawed as most studies of these situations including asylums, show their control was never total. For a criticism of the concept see Slavoj Zizek, *Did Somebody Say Totalitarianism?: Five Interventions in the (Mis)Use of a Notion* (London: Verso, 2001).

²⁷ Matthew Gambino, 'Erving Goffman's Asylums and Institutional Culture in the Mid-twentieth-century United States,' *Harvard Review of Psychiatry* 21(1) (January/February, 2013): 52.

Andrew Scull was a sociologist and can be seen as a 'radical' and was influenced by Foucault. His ground-breaking 1979 book 'Museums of Madness' was very influential and unlike Foucault, combined theoretical and empirical rigour to great effect.²⁸ One of his central ideas was to propose that one of the prime instigators in the expansion of the asylum system were the psychiatrists, anxious to enlarge the power and prestige of their nascent profession. More recently other historians have questioned whether the primacy given by Scull to the role of the psychiatrists could be justified. Elaine Murphy wrote on the previously underplayed influence of the Lunacy Commissioners.²⁹ Peter Bartlett showed the influence of the Poor Laws in the admission process and David Wright stressed the importance of families in getting their relatives admitted and discharged.³⁰ Although he does seem to have ignored the influence of the role of other parties, his analysis of how the expansion of the asylum system was related to the needs of a capitalist system remains a powerful argument.³¹

Another author who can be seen as a 'radical'; is David Mellett. His most significant work, 'The Prerogative of Asylumdom', is on the treatment of the insane in the nineteenth century. Unlike authors such as Kathleen Jones he sides with Foucault in emphasising the negative aspects of the York Retreat. He argued that the Retreat stressed 'the relationship between wrongdoing and retribution in a manner specifically orientated to the position of the madman'.³²

'Revisionist writers, often from a historical background, acknowledge the role of economics and the state in the establishment of the asylums but they reject the idea of a medical

²⁸ Andrew Scull, *Museums of Madness: The social Organisation of Insanity in Nineteenth Century England*. (London: Allen Lane, 1979).

²⁹ Elaine Murphy, 'The Lunacy Commissioners and the East London Guardians, 1845–1867,' *Medical History* 46(4) (2002): 495–524.

³⁰ Peter Bartlett, *Poor Law of Insanity: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London: Leicester University press, 1999), 238–253; David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century,' *Social History of Medicine* 110 (1997): 137–151.

³¹ His arguments have been developed in several works including, Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (London: Y.U.P., 1993) and Andrew Scull, *The Insanity of Place/The Place of Insanity: Essays on the History of Insanity* (Abingdom: Routledge, 2006).

³² David J. Mellett *The Prerogative of Asylumdom: Social, Cultural and Administrative Aspects of the Treatment of the I=Insane in Nineteenth Century Britain* (New York:Garland Publishing, 1982), 24.

and political hegemony controlling society's undesirables and offer a more nuanced analysis of the establishment and role of the asylums.³³ They show factors such as family involvement, the Poor Laws and the Lunacy Commissioners affected aspects of the nature of asylums a more subtle causal analysis has been formulated than the broader generalisations of Foucault and instead have affirmed what Susan Lanzoni has labelled 'negotiation' as being a key concept.³⁴ A series of different participants with varying degrees of power negotiate over admission, treatment and discharge. This seems to be a subtle and persuasive argument but no doubt further research will change our perceptions. A number of our individual examples in this study will show this process of 'negotiation', especially in the admission and discharge processes.

These studies do not conform to a single template but many are studies of one, two or in one case, four asylums. As this study is also on a single asylum, these are particularly relevant. As they often make judgements on issues such as class and gender in the asylum system, it is important to evaluate the typicality of their asylums and the limitations that might have on their analyses. This also needs to be asked of this study.

Some of these studies emphasise the locality of the asylum and the differences this might have on the nature of the asylums. Steven Cherry in his study of the Norfolk Asylum stressed the importance of locality and how differing perceptions of insanity co-existed and changed over time.³⁵ Pamela Michael in her study of the North Wales Lunatic Asylum stressed the differences and similarities between the care and treatment of the mentally unwell in the asylums of North Wales.³⁶

³³ These authors include David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century,' *Social History of Medicine* 110 (1997): 137–151, John Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848–50,' *Journal of Social History* 13(1) (1979): 1–17 and Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London: Leicester University Press, 1999)

³⁴ Susan Lanzoni, 'The Asylum in Context: An Essay Review,' *Journal of the History of Medicine and Allied Sciences* 60(4) (October 2005): 499.

³⁵ Steven Cherry, *Mental healthcare in Modern England: The Norfolk Asylum/ St Andrews Hospital 1810-1998* (Woodridge, Suffolk: The Boydell Press, 2003), 6.

³⁶ Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800–2000* (Cardiff: University of Wales Press, 2003).

Other studies of particular asylums have used their evidence to discuss and evaluate particular aspects of asylums. Two studies are particularly important partly for the quality of their scholarship and their relevance to this study. Joseph Meliing and Bill Forsythe have written about four asylums in Devon in a work entitled 'The Politics of Madness'³⁷ This ambitious book looks at the reasons for the massive increase in asylum care in the nineteenth century. It concludes that 'Rather than the asylum simply imposing a dominant or hegemonic model of treatment on distinctive localities, we suggest that the identities of gender, class and race were negotiated by the rules of the asylum and that a variety of groups were involved in the disposal and retrieval of the pauper lunatic'.³⁸ It could be argued that such a conclusion should not be inferred from the study of four asylums from one area, however they do examine the specifics of locality. They stress the importance of the local landed gentry in the affairs of the asylums.³⁹ Thus their asylums would have differing influences to somewhere like Bristol whose elite were mostly not landed gentry. Unlike many asylum studies they do consider the lives of the inmates and they compare the experiences of those in the pauper and private asylums.

Louise Hide's recent (2014) book on gender and class in English asylums is based on evidence from two London asylums.⁴⁰ This begs the question as to how much the experiences in our capital can be similar to the provinces. The book's great quality is in explaining how class or gender affected the experiences of the staff and patients at these asylums. She convincingly suggests that class is a somewhat loose term 'imbued with different meanings born of ever shifting social and cultural contexts'.⁴¹ She is particularly good at examining the role of the medical superintendents and the routines of ward life.⁴² One criticism is that like many of these

³⁷ Joseph Mellings and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845-1914* (London: Routledge, 2004).

³⁸ Ibid. 6.

³⁹ Ibid, 6, 29-30.

⁴⁰ Louise Hide, *Gender and Class in English Asylums 1890-191*. (Basingstoke: Palgrave Macmillan, 2014).

⁴¹ Ibid. 22.

⁴² Ibid. 40-64, 145-170.

studies, she attributes many factors to the effects of the institution rather than the effects of the patients' illnesses. For instance, she suggests the reason that some patients did not engage with the asylum was their forcible confinement. This was undoubtedly a factor but someone who is severely depressed or hears voices is probably not going to engage whatever their situation.⁴³

These studies have been criticised for being 'particularist' but this study contends that only by examining the particular, whether that is a particular asylum, doctor or patient, can you understand the nature of asylums, albeit in their political, cultural and social contexts.⁴⁴ It is however necessary to evaluate the typicality of the asylum you are studying. Cherry and Melling's and Forsythe's studies are based on asylums with a largely rural population, whereas Hide's and this study explore asylums from urban areas. The issue of typicality will be assessed both in chapter 3 and in our conclusion.

Various aspects of the admission process have been widely studied. David Wright was one of the first to identify the family as being very significant in the admission process.⁴⁵ His work and that of John Walton refuted Scull's contention that capitalist development had resulted in families becoming more reluctant to tolerate unproductive, or disturbed family members and thus more likely to get them admitted to an asylum.⁴⁶ Walton's study of the Lancaster and Haydock Lodge Asylums in Lancashire is particularly relevant to this study as it quantitatively assesses the admissions to the asylums and thus his statistics can be compared to this study's findings⁴⁷.

Another area in which studies have shown to be important in the admission of patients, is the effects of the Poor Laws and its officials. These influences have been most extensively

⁴³ Ibid. 177.

⁴⁴ Jonathon Andrews and Anne Digby, *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British Psychiatry* (New York: Rodopi, 2005), 13.

⁴⁵ David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century,' *Social History of Medicine* 110 (1997): 137–151.

⁴⁶ Ibid. John Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848–50,' *Journal of Social History* 13(1) (1979): 1–17, Scull, *The most Solitary of Afflictions*, 31-45.

⁴⁷ John Walton, 'Lunacy in the Industrial Revolution'.

examined by Peter Bartlett. In his most renowned work 'The Poor Law of Lunacy', he argues that 'county asylums are to be understood in the context of nineteenth century Poor Law'.⁴⁸ In these negotiations Bartlett claims that, contrary to Scull's suggestion, the medical superintendents were fairly powerless.⁴⁹ This might seem exaggerated but apart from the relatively small number of private patients, admissions to an asylum resulted from negotiations based on Poor Law legislation and were carried out by its officials. Also, as this study will confirm, the superintendents often bemoaned the quality of their admissions (see Chapter 4). Of particular relevance to this study is Bartlett's observation that although these institutions were labelled 'pauper asylums' the people admitted represented a broader cross-section of the population than that term implies.⁵⁰ In most asylums, including the one at Bristol, nearly all the patients, except for a few who paid, were designated as paupers because they could not afford to pay for long-term asylum care. These criteria would include most the population.

Carol Berkenkotter's work, particularly her paper 'Occult Genres and the Certification of Madness in a 19th-Century Lunatic Asylum' offer a very different account of the admission process.⁵¹ Unlike the other admission studies which are mostly by historians and are very empirically based, Berkenkotter's studies' borrow from linguistics and has an elaborate theoretical basis. It looks at the medical certification of the admission process to a private asylum. The author argues that 'these institutional texts are "occult genres" that function as complex acts of argumentation, whose illocutionary force depends on the success of their felicity conditions'⁵². This seems to mean that the paperwork has an almost mystical power which if correctly applied gives legitimacy to the admission. The question is: what does that tell us that we didn't know

⁴⁸ Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London: Leicester University Press, 1999), 238

⁴⁹ Ibid. Scull *The Most Solitary of Afflictions*, 45.

⁵⁰ Peter Bartlett, 'The asylum and the Poor Law: the productive alliance,' in *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective*, eds. Joseph Melling and Bill Forsythe (London: Routledge, 1999), Chapter 3.

⁵¹ Carol Berkenkotter and Cristina Hanganu-Bresch, 'Occult Genres and the Certification of Madness in a 19th-Century Lunatic Asylum,' *Written Communication* 28 (2011): 220.

⁵² Ibid. 220.

already and is the theoretical jargon illuminating or obscuring? In many ways, this is a shame, as the authors make a number of relevant points about documentation and its functions.

Berkenkotter only uses two examples for her argument and they are both from a private asylum, thus making generalisations about admissions to asylums somewhat contentious. It is tempting to study material from the private asylums, as their inmates were more colourful and the written material more extensive but these institutions only catered for a wealthy minority of those considered insane and the reasons for their admissions and the paperwork used were different. Thus Berkenkotter's arguments do not seem to be based on sufficient evidence

A major difference between those works and this is that this study does look at the institution in general terms but also examines the lives of individuals within it. It thus has a strong narrative or biographical element. In this it relates to two studies by Allan Beveridge which examine life in the Royal Edinburgh Asylum and had the advantage of a number of patients' letters as source material.⁵³ His source material is very impressive and is probably the best collection of patients' letters from any British asylum. One study is of the patient's observations and complaints about life in the institution and the other is about the symptoms which they are experiencing. The problem with this division between his two studies is that, in the former, you would not know why they were incarcerated. They complain about the boredom, they praise or vilify certain members of staff and discuss the attractiveness of the female nurses.⁵⁴ This does show the patient's humanity and illustrates the controlling aspect of asylum life but Beveridge deliberately omits all references to their illnesses. Whilst it is difficult to infer a diagnosis from a patient's testimony, to omit such references gives a false impression of asylum life. The other study is largely aimed at showing that the symptoms of patients in the nineteenth century asylum are the same as found in what is currently termed as schizophrenia. The author is a doctor and

⁵³ Allan Beveridge, 'Life in the Asylum: patients' letters from Morningside, 1873–1908,' *History of Psychiatry* 9 (1998): 431–469; and 'Voices of the mad: patients' letters from the Royal Edinburgh Asylum, 1873–1908,' *Psychological Medicine* 20(4) (1997): 899–908.

⁵⁴ *Ibid.* 454–456. He shows the male patients lusting after the nurses and the female patients were attracted to the exclusively male doctors.

the study provides insights into the nature of nineteenth-century psychiatric diagnosis but it does little to convey the suffering caused by these symptoms.⁵⁵ Chapter 5 will document this suffering using a number of examples.

Gender Studies

Lunatic asylums have also been examined from a gender perspective. Elaine Showalter suggested that insanity was considered as a largely female complaint by the male-dominated power structure and this was shown by the preponderance of female patients in the large psychiatric institutions.⁵⁶ This view has been criticised by authors, including Anne Shepherd, as being based on inadequate empirical evidence. However, there undoubtedly were differences between the treatment and attitudes to women and men in the asylums and this will be one of the themes of this study.⁵⁷ Showalter also considered those with conditions such as hysteria and anorexia nervosa as feminist heroines, claiming 'whether the disorder was anorexia, hysteria or neurasthenia, English psychiatric treatment of nervous women was ruthless, a microcosm of the sex war intended to establish the male doctor's total dominance'.⁵⁸ Women were undoubtedly often treated very badly by male doctors and their actions originated from a very patriarchal perspective; however, Jane Ussher makes the excellent point that labelling a condition as resulting from male dominance does not stop the suffering of those afflicted. Their symptoms were real.⁵⁹ Both Showalter and other writers such as Lisa Appignanesi tend to rely on the experiences, at the hands of the male establishment, of a few well-known female authors such as Virginia Woolf and Sylvia Plath as evidence of the creative female being driven to insanity and

⁵⁵ Beveridge, *Voices*. In this study the headings are mostly a list of the symptoms used currently to diagnose schizophrenia.

⁵⁶ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture 1830–1980* (London: Virago, 1987).

⁵⁷ Anne Shepherd, 'The Female Patient Experience in Two Late-Nineteenth Century Surrey Asylums,' in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British Psychiatry*, eds. Jonathan Andrews and Anne Digby (New York: Rodopi, 2004), 223–248.

⁵⁸ Showalter, *Female Malady*, 137.

⁵⁹ Jane Ussher, *Women's Madness: Misogyny or Mental Illness?* (Hemel Hempstead: Harvester Wheatsheaf, 1991), 247.

suicide. As Lesley Hall points out they could easily have used Richard Dadd or Vincent Van Gogh.⁶⁰ More recent studies have explored gender issues surrounding the history of asylums and have shown how women's experiences, although not a simple result of male domination, did differ from their male counterparts. Pamela Michael's study of Welsh asylums shows how they, like their English counterparts, were organised so that the genders did not mix, with the male staff or patients not being allowed into the female section. Even the medical superintendent had to be accompanied by a female nurse.⁶¹ Joan Busfield has produced perhaps the most comprehensive and balanced account of gender and mental health, arguing that the 'different structural and material circumstances of men and women and the differences in power and status are highly pertinent to understanding men's and women's mental disorder'.⁶² Her conclusions may be in part similar to Showalter but she does not resort to the unproven generalisations that mar Showalter's work. This study will examine how these gender differences manifested themselves at the Bristol Lunatic Asylum.

Many historians, including Bartlett, Wright and Lanzoni, have produced perceptive work which shows why the asylums were built and how they operated but, just as writers from a medical background had little knowledge of society's wider influences and tended to ignore them, these historians probably had little knowledge of the patients' illnesses and thus tend to underplay their influence.⁶³ An example is from Bartlett's book 'The Poor Law of Lunacy', an exemplary work in many ways which deepens our understanding of how the Poor Laws affected the treatment of lunatics. It does, however, hardly mention the different illnesses from which the patients suffered. The index does not mention dementia, mania or melancholia, the three main

⁶⁰ Lesley Hall, 'Does Madness have a Gender?' *History of Psychiatry* 20(4) (2009): 497–501.

⁶¹ Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800–2000* (Cardiff: University of Wales Press, 2003), 58.

⁶² Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (Basingstoke: Palgrave Macmillan, 1996), 236.

⁶³ Bartlett, *The Poor Law of Lunacy*; Lanzoni, 'The Asylum in Context'; and Wright, 'Getting out of the Asylum'.

categories of mental illness in the Victorian era.⁶⁴ Perhaps because the medical jargon of the nineteenth century is unfamiliar, the lives of the inmates have been seen largely in terms of how they have been affected by the institution. These studies are primarily interested in the aetiology and significance of the formation of the asylums but this study is primarily concerned with the experiences of those who lived in the asylums. It is the contention of this study that it is the interplay of the individual, the institution and his or her illnesses that has formed the basis of what life was like for these patients.

Methodology and Evidence

This study is blessed with access to a considerable quantity of evidence. The most important of the primary sources used in this study are the admission books of the hospital which are kept at the Bristol Records Office. They provide most of the information both for the database and the individual histories. They consist of notes made on admission with categories such as age, sex, diagnosis etc. They are completed by the admitting doctor. One section includes information given to the doctors by relatives, reinforcing the point made by Wright about the importance of families in the admission and discharge of patients.⁶⁵ Each patient record also contains ongoing information about their stay in the hospital. Although very useful, these records are problematic when used as evidence. They are often difficult to read, they are invariably incomplete and they use many terms which today have different meanings. An example is the term 'excitement' which in Victorian times was considered a negative term, whilst today is used more approvingly. It is usually used in the notes as a descriptive term and the phrase 'very excited today', occurs

⁶⁴ Peter Bartlett, *Poor Law*, 306–309. These categories are very vague but there was a considerable difference in the symptoms, experiences and prognosis of someone with melancholia compared to someone with mania.

⁶⁵ David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century,' *Social History of Medicine* 110 (1997): 141–143.

frequently. The main problem, however, as noted by Jonathan Andrews in his perceptive study of the use of case notes as historical source material, is that they 'convey more about the preoccupations of the asylum's medical regime than about the patients and their histories'.⁶⁶ There may be an element of hyperbole in this assertion but these records certainly need to be critically 'read' using knowledge of the prevailing medical theories and social views.⁶⁷

Case notes are the principal source from those working inside the hospital, thus having an insider's perspective. Other hospital records emanating from the hospital staff include special reports on patients, administrative records and records of the differing departments. For instance, the budget statement of 1894 shows that more money was spent on bedding than pharmaceuticals, a situation that would be dramatically reversed nowadays.⁶⁸ This illustrates that drug treatment played a fairly minor role during this period. The Visiting Committee reports also provide valuable information. The committee consisted of various eminent men (there were no women until the twentieth century) including aldermen, JPs and sometimes the Mayor of Bristol. The reports also contain contributions from the chief medical officer and statistics compiled by the hospital. These contain perceptions and biases which result from a combination of the composition of the committee as part of Bristol's elite and their position as outsiders from the asylum who had privileged access to the asylum and its records.⁶⁹

Sources from outside the asylum include the census returns, which help with the backgrounds of the patients, and newspapers, which had their own viewpoints on the asylum, but did report various events from suicides to concerts which took place at the asylum.⁷⁰ Some

⁶⁶ Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century,' *Social History of Medicine* 11(2) (1998): 265.

⁶⁷ Jonathan Andrews, *Case Notes*, 260.

⁶⁸ Visiting Committee Report 1894, BRO 35510, 34–35.

⁶⁹ The Committee reports regularly mention the facilities, the work of the patients, their food and entertainment but rarely anything psychiatric. Whether this is because they feel unqualified in this field or for other more political reasons is hard to determine: see BRO M/BCC/MEH/3/1-6 (Bristol Records Office, 1862–1895).

⁷⁰ The composition and views of the Bristol Press varied during the second half of the nineteenth century: see John Penny, *All the News that's Fit to Print: A Short History of Bristol's Newspapers since 1702* (Bristol: Bristol Historical Association Pamphlet, 2001).

information in the notes was gained from outside sources including the police, friends and family. The doctor who would write these notes would choose what information was valuable and would tend to include facts which conformed to his own perspective. Thus these aspects of the records would be influenced by outside and inside perspectives and this has to be taken into account when using these records as evidence.

When researching the nature of asylum life, evidence from the patients themselves is often scarce. Beveridge uses patients' letters from the Morningside Asylum in his study⁷¹ and Wannell has used letters from patients' relatives in her work on the York Retreat.⁷² These are rare and valuable examples of evidence from the patient or a relative. As both authors concede, these letters are not representative, as the more educated are more likely to write letters but they are the only resource available that comes directly from patients. This study has utilised some letters as source material. Patients' letters, usually written to the chief medical officer, were sometimes placed in the notes at the Bristol Asylum and these do reveal some of the patients' concerns. However, usually they would only write to the doctors if they had a complaint and most often that complaint was that they wanted to be discharged. Thus positive comments are rarely found and the nature of their illness often makes them perceive reality in an unusual way but they do make a good counterweight to the often sycophantic comments of the Visiting Committee.⁷³ They will often reveal facts about their lives in the asylums and their relationships with other patients. We may also learn what they thought of the staff and even their more bizarre comments often reveal an underlying emotion. Our section on delusions in Chapter 5 discusses their value as evidence. Paranoid delusions, for instance, often suggests an underlying insecurity. This study also

⁷¹ Beveridge, *Life in the asylum*.

⁷² Louise Wannell, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat 1875–1910,' *Social History of Medicine* 20(2): 297–313.

⁷³ In particular although they sometimes criticise conditions and the attendants there are no examples in these reports of a criticism of the medical staff.

uses a book which a patient, John Weston, wrote about his time in the asylum.⁷⁴ This provides much information from a patient perspective.

Another methodological consideration is the author's own experiences which will inevitably influence this study. The author's background includes a history degree and a career in psychiatric nursing. During the 1980s he worked for a year as a healthcare assistant at the Bristol Lunatic Asylum which by this time had been renamed Glenside Hospital. This background gives the benefit of insider knowledge and perhaps makes it easier to empathise with the situation of this study's subjects. It does, however, have the danger of opinions gained from these experiences biasing the evaluation of the sources. This is one reason the author chose to only study the nineteenth century asylum and thus is chronologically far removed from his own experiences.

It was necessary to design a methodology which utilised our sources and to try and answer the research questions posed. However, before considering the details of our methodology we need to consider the epistemological background to this study. Post-modernism has taught us to beware of grand narratives but this study rejects the post-modern idea that history is a series of almost random events with no underlying structure or meaning.⁷⁵ Historical events are caused by a multitude of factors which may relate to particular historical contexts. Chapter 2 of this study examines the various contexts of the subject and this will allow us to critically examine our sources and make sense of what actually happened.

Post-modernism, by giving all viewpoints equal weight, does suggest that disadvantaged groups should be studied.⁷⁶ This study, however, places more weight on the idea that the disadvantaged should be studied not because every viewpoint has equal weight but rather because, in order to understand a particular society, all aspects need to be studied. This idea has

⁷⁴ John Weston, *Life in a Lunatic Asylum* (London: Houlston and Wright, 1867).

⁷⁵ Susan Stanford Friedman, 'Making History: reflections on feminism, narrative and desire,' in *The Postmodern History Reader*, ed. Keith Jenkins (London and New York: Routledge, 1997), 231–236.

⁷⁶ Keith Jenkins, ed., *The Postmodern History Reader*, 2–3.

been promoted by historians writing what has been termed 'History from Below'.⁷⁷ It was instigated by Marxist and neo-Marxist British historians, particularly E.P. Thompson and Eric Hobsbawm.⁷⁸ It championed the dispossessed and the downtrodden. Roy Porter has suggested the idea of using patient histories as a form of 'History from Below' and this study can be seen as following these ideas.⁷⁹ It rescues the lives of many ordinary people with extraordinary stories. Most ordinary people in the nineteenth century have left few sources which historians can use to discover their life histories but those in the asylum were documented. Thus, although most of the evidence is about them rather than produced by them, these documents do give a voice to these patients.

We thus have a range of sources and a commitment to illuminate the lives of this disposed group. To achieve this, it seems logical to study them as a group but also as individuals. Quantitative methods will produce generalisations about the group as a whole but we also need to look at individuals. Many histories of the asylums, such as Frank Crompton's study of admissions to the Worcester Asylum, have used quantitative methods including charts and statistics as well as brief mentions of individuals.⁸⁰ In this study we often use longer individual examples in order to show a patient's background and their progress during their stay in the asylum. It is the contention of this study that our particular methodology will enable us to gain a fruitful interaction between qualitative and quantitative methodologies.

Our database uses information from the asylum admission books. There are 36 fields with biographic details such as the patients' occupation or religion, plus details of their reason for admission and its result. Many of the categories are fairly straightforward in terms of evidence.

⁷⁷ For an update on the original 'History from Below', see Tim Hitchcock, 'A New History from Below,' *History Workshop Journal*, 57 (Spring 2004): 294–298.

⁷⁸ E.P. Thompson, 'History from Below,' *Times Literary Supplement*, April 7, 1966, 279–280.

⁷⁹ Roy Porter, 'The Patient's View: Doing Medical History from Below,' *Theory and Society* 12(2) (1985): 175–198.

⁸⁰ Frank Crompton, 'Needs and desires in the care of pauper lunatics: Admissions to Worcester Asylum 1852–1872,' in *Mental Illness and Learning Disability Since 1850*, eds. Pamela Dale and Joseph Melling (London: Routledge, 2003).

There is no reason to suggest that their date of admission, address or sex would be incorrect. Other categories have to be treated with more caution. As we shall see in Chapter 5 psychiatric diagnosis is very contentious and unreliable. The database was designed so that some of the fields, such as length of stay and category of occupation, are calculated automatically. Even allowing for this 150,000 entries were recorded by hand. The database was also designed so that the different fields could be compared using pivot tables.⁸¹ Thus using the fields 'diagnosis', 'occupation' and length of stay, you could ascertain whether patients' diagnoses or occupation had a greater effect on their length of stay in the asylum. This relates to one of our core research questions of whether class or illness was a greater determinate of the likelihood of admission and the progress of their stay. This methodology should be of great benefit in trying to answer our research questions and it also means that certain ideas which arise during the research could be tested. Whilst compiling the database it was apparent that there were certain trends, in particular relating to diagnosis, that needed analysis, and using our pivot tables we were able to test their nature and degree (see Chapter 5).

The database also helped in our studies of individual patients. From the database, particular individuals who either seemed representative of a type, or were exceptional in some ways, could be identified. Their backgrounds and progress in the asylum could then be found using the asylum records and other sources. In our conclusion we will examine whether the aims and expectations of our methodology were realised.

When evaluating the success and originality of our methodology it is important to compare our methods with other studies particularly those based on one or two asylums. Hide's study of two London asylums is excellent but largely does not use quantitative methods. It is

⁸¹ See 'Guide to Excel Pivot Tables', Chandoo.org, accessed May 28, 2014, <http://chandoo.org/wp/excel-pivot-tables/>.

ethnographically based and focuses on the details of asylum life.⁸² It is thus only comparable to aspects of this study, particularly our case studies.

Databases have become increasingly used in asylum studies. Some like the Ontario Asylum Database, are aimed mostly at the general public and are very basic with little biographical information.⁸³ Some studies have used databases with varying degrees of information given as to their specifics. Frank Crompton, in his study of admissions to the Worcester Asylum has used an interesting approach. He produced a database of 3,000 patient records and applied a textual search to each patients records to determine key words and phrases used to describe them and their actions. From this he hoped to link diagnostic terms with particular words and descriptions.⁸⁴ Other databases vary in sophistication; the one for the study of the Hampshire Asylum by Susan Burt is more sophisticated, having 30 different fields, but seems to lack the interactive ability of this study's database.⁸⁵ Pamela Michael gives much information about her evidence and methods. She produced a database which, similarly to this study, is based largely on the patient case notes. It is a 10% sample of all the patients admitted between 1875 and 1937.⁸⁶ A 10% sample is sufficient for some evaluations such as the percentage of people with a common diagnosis but would not be sufficient if the aim is to break this down into individual years, which this study does in chapter 5.

Of the studies we have discussed, the book by Melling and Forsythe is the most comprehensive and sophisticated in terms of its quantitative methods. They mostly used Microsoft Access rather than Excel which was used for this study. Their initial database consisted

⁸² Hide, *Gender and Class*, 3.

⁸³ 'Upper Canada (Ontario) Insane Asylum Inmates,' Michael Stephenson, accessed July 14, 2014, http://www.ontariogenealogy.com/insaneasylum/insaneasylum_part1.html.

⁸⁴ Frank Crompton, 'Needs and Desires in the Care of Pauper Lunatics: Admissions to Worcester Asylum, 1852-1872' chapter 3 in Pamela Dale, and Joseph Melling, (eds.) *Mental Illness and Learning Disability Since 1850* (London: Routledge, 2006), 48.

⁸⁵ Susan Burt, "'Fit Objects for an Asylum" The Hampshire County Lunatic Asylum and its Patients, 1852–1899' (Doctoral thesis, University of Southampton, 2003), accessed June 21, 2015, <http://eprints.soton.ac.uk/194555/1.hasCoversheetVersion/00250119.pdf>.

⁸⁶ Pamela Michael, *Care and Treatment*, xi-xiii.

of 13,000 patients admitted to the Exminster Asylum between 1845 and 1914. This only contained basic information for each patient but a sample of 4,000 of these patients was produced with more biographical and medical information and may have been not dissimilar to our own database. They did a further analysis of the patients admitted between 1880 and 1882 which they used to compare with the census records of the local area for 1881. They also produced data sets for the other local asylums at Wonford House, Digby's Field and Moorhaven. These were used for comparisons with the Exminster Asylum. Statistical packages were used to analyse their results. This work is very impressive but our study has the advantage of using pivot tables to examine our data which would not have been available when their work was completed (published 2006)⁸⁷.

⁸⁷ Joseph Melling and Bill Forsythe, *The Politics of madness: The state, insanity and Society 1845-1914* (Routledge: Abingdon, 2006) xvi-xvii.

Chapter 2: Local and National Contexts: The Rise of Asylums and the Case of Bristol

Nineteenth-century Ideas about Madness

To understand why the nineteenth-century asylums were built, we must examine several factors which coalesced to bring about this phenomenon. Firstly, ideas as to what constituted madness changed so that the idea of incarcerating people in a large institution to cure or control them became an accepted idea. In Elizabethan times nervous disorders were often associated with an imbalance of humours or a divine retribution.¹ Skultans argues that, from the Elizabethan age to the institutional era of the second half of the nineteenth century, there were numerous theories on the nature and causes of madness. Some were physical, such as the effect of problems associated with the spleen. Other ideas were of a religious nature and often cited the influence of the devil. In practice, however, the treatment of the insane remained fairly constant certainly until the nineteenth century.² This seems at odds with Foucault's idea that the Enlightenment saw a dramatic change in both ideas and treatment of the insane.³ In terms of this study, four approaches or ideas were important in the establishment of the asylum system. These were Moral Treatment, the medicalisation of insanity, the rise of social Darwinism and the influence of ideas associated with Jeremy Bentham.

Moral Treatment is thought of as being instigated by Pinel in France in 1793, when he removed the chains from the inmates at the Bicêtre in Paris and suggested the insane should no longer be restrained.⁴ Similar developments took place in England and the United States. Its characteristics were a belief in removing the mad to an institution, an absence of restraint, a

¹ Vieda Skultans, *English Madness: Ideas on Insanity 1580–1890* (London: Routledge & Kegan Paul, 1979), 17–26.

² *Ibid.* 26–51.

³ Michel Foucault, *Madness and Civilization* (London: Random House, 1965), 35–61.

⁴ Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Athlone Press, 1987), 6.

therapeutic optimism about recovery and the value of work and pleasant surroundings.⁵ Its ideas were certainly influential at the Bristol Asylum, especially in its early years. Judgements on Moral Treatment vary enormously. Most nineteenth-century writers, such as Ellice Hopkins writing in 1877, viewed it as a great humanitarian step forward. She praised the reformers as ‘those noble men who have removed one of the darkest blots from our common human nature and have shown love victorious over fear, neglect and cruelty’.⁶ Yet it is also seen as part of the medicalisation of insanity and an extension of social control.⁷ Certainly its emphasis on incarceration in some ways paved the way for the large asylums but its intentions were certainly not medical or scientific and Scull has argued that its demise later in the century was because it did not fit in with the advancing medicalisation of insanity.⁸ Moral Treatment was most famously practiced at the York Retreat. Its aims and achievements were promoted by its founder William Tuke, and his ideas were expounded by his son Samuel in his book *Description of the Retreat* in 1813.⁹ The Retreat certainly offered a very specific, Quaker-influenced treatment with what would now be described as a behaviourist approach. Rewards and fear were used to modify the inmates’ behaviour.¹⁰ Most historians, including Digby, Scull and Porter, would agree that it was more successful than other contemporary forms of treatment.¹¹ They certainly did impose their own religious and class values on the patients in a similar way to much Victorian philanthropy, but if you were a patient it would seem to be a far better place than some of the poorly run private ‘mad houses’ whose conditions were documented in several reports.¹²

⁵ Robert Sprafkin, ‘The Rebirth of Moral Treatment,’ *Professional Psychology: Research and Practice* (May 1979): 161–170.

⁶ Ellice Hopkins, ‘The Moral Treatment of Insanity,’ *Fraser’s Magazine* 15(88) (1877), 444-459.

⁷ Foucault, *Madness and Civilization*, 241–261.

⁸ Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London: Allen Lane, 1979), 132–141.

⁹ Samuel Tuke, *Description of the Retreat* (London: Process Press, 1996).

¹⁰ Louis Charland, ‘Benevolent theory: moral treatment at the York Retreat,’ *History of Psychiatry* 18(61) (2007), 32.

¹¹ Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat* (Cambridge: Cambridge University Press, 1985), 29–39; Andrew T. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700–1900* (New Haven and London: Yale University Press, 1993), 148–155; Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2003), 105–115.

¹² William Parry-Jones, *The Trade in Lunacy*, 16.

The other change in how madness was perceived was in the perception of it as an illness. Before the nineteenth century, it was sometimes seen as a medical condition but this idea was in competition with several other religious and moral theories. What set the nineteenth century apart was the increasing dominance of the medical model and the rise of its practitioners, the psychiatric profession. Psychiatry became a branch of medicine and psychiatrists, or medical superintendents as they were then known, became very powerful figures. It was certainly an influence at our asylum with increasingly categorised diagnoses and increased training for the doctors and nurses (see Chapter 3). Diagnosis, an essential element of the medical model, became an important aspect of determining treatment and the problems with diagnosis will be discussed in Chapter 5. Certainly, the fallibility and stigma associated with diagnosis are one of the major problems with viewing insanity in medical terms.¹³ The asylum system has been seen by authors such as Szasz, on the libertarian right with their distrust of state control, as part of a state attack on individual liberty. Authors on the left, such as Scull, saw it as an inevitable product of the nature of capitalism.¹⁴ With madness viewed as an illness, doctors were given much power over the sufferer. Psychiatric diagnosis was, as we shall see, very uncertain and treatments in the Victorian era were largely ineffective. Although the treatments rarely worked, people often did improve perhaps because many mental health conditions are either cyclical or temporary. The problem with this, mostly justified, criticism is that these critics did not suggest an alternative treatment. The social control thesis seems flawed. The very real suffering, resulting from their mental conditions, of those sent to the asylums in Victorian era, seems to demand a causal explanation that is neither exclusively medical nor social. Hopefully studies such as this will be a step forward towards such an explanation.

¹³ For a philosophical discussion on the merits and assumptions of the medical model see Tejas Patil and James Giordano, 'On the ontological assumptions of the medical model of psychiatry: philosophical considerations and pragmatic tasks,' *Philosophy, Ethics, and Humanities in Medicine* 5(3) (2010), 1-7.

¹⁴ Thomas Szasz, *The manufacture of madness* (London: Routledge & Kegan Paul, 1971); Scull, *Museums of Madness*.

The late nineteenth and early twentieth centuries saw the rise of the eugenics movement, a form of social Darwinism. It was initially formulated by Sir Francis Galton, a Victorian polymath who thought humanity could be improved by selective breeding. These eugenicists thought that if you could determine the genetically poorest members of society and stop them having children then 'the fittest' would dominate.¹⁵ This idea allied to other scientific and psychiatric thinking, would later be taken up by many unpleasant groups and would find its ultimate expression in the Nazi movement¹⁶. It is important for our study for two reasons: firstly, it may have been one of the reasons for photographing asylum patients, which was practised at the Bristol Asylum (see Chapter 6). Galton himself took a number of photographs of the patients at the Bethlem Asylum in furtherance of his studies.¹⁷

Sexual segregation had long been the norm in British asylums but the eugenics movement might have reinforced this trend. Asylums certainly did not want the patients breeding. Evidence for this is scarce but Louise Hide's study of the Claybury Asylum suggested that 'the authorities were obsessive about keeping the sexes apart'.¹⁸

Jeremy Bentham, the English theorist of utilitarian philosophy, was thought by writers, including Foucault, to be one of the originators of ideas which led to the social control of deviants, including the insane. Bentham had very distinct ideas on the poor and in 1798 wrote a paper entitled 'Pauper Management Improved', which was a plan of workhouses for the poor and emphasised the need for discipline and compulsory work. It was very influential but was attacked by contemporaries, such as Dickens, as being inhumane.¹⁹ Bentham also invented the Panopticon, a design for a building to house prisoners or lunatics. It had a central observatory with several

¹⁵ Roger Sandall, 'Sir Francis Galton and the Roots of Eugenics,' *Society* 45(2) (2008): 170–176.

¹⁶ Bernard A Fischer, 'Maltreatment of People With Serious Mental Illness in the Early 20th Century: A Focus on Nazi Germany and Eugenics in America' *The Journal of Nervous and Mental Disease*, 12/2012, Vol. 200, Is. 12, 1096-1100.

¹⁷ Colin Gale and Robert Howard, *Presumed Curable* (Petersfield: Wrightson Biomedical Publishing, 2003), 11–13.

¹⁸ Louise Hide, *Gender and Class in English Asylums, 1890–1914* (New York: Palgrave Macmillan, 2014), 95.

¹⁹ Peter M. Stokes, 'Bentham, Dickens, and the Uses of the Workhouse,' *Studies in English Literature, 1500–1900*, 41(4) (Autumn 2001): 711–727.

long thin cells emanating from the centre and a circular perimeter. The design was accepted by Parliament but never built. It became an influence on institutional architecture. In line with his utilitarian views, it was in some respects efficient: one person can observe all the inmates. Jacques Miller rather eloquently describes the design: 'This configuration sets up a brutal dissymmetry of visibility. The enclosed space lacks depth; it is spread out and open to a single, solitary, central eye. It is bathed in light. Nothing and no one can be hidden inside it – except the gaze itself, the invisible omnivoyeur.'²⁰ It was thus a particularly effective method of control which Foucault saw as influencing not only institutional architecture but also state and corporate management of their workforce.²¹ None of the Victorian asylums were built to this design, including Bristol, but the ability to observe the patients was certainly an aspect of their design. This is controlling but would anyone suggest designing a hospital where patients (many of them suicidal) could not be observed?²²

Bentham can thus be seen as one of the originators of the idea of social control of the mentally ill. His uncompromising and harsh ideas were the antidote to Victorian philanthropy and the humane viewpoints epitomised by both Dickens and the tenets of Moral Treatment. When viewing the rise of the asylums and the way they operated, both aspects were influential. At the Bristol Asylum, the two aspects will be shown in varying degrees, both in the way it was run and in the views of its staff and regulators (the Commissioners and Visitors).

The Rise of the Asylums

²⁰ Jacques-Alain Miller and Richard Miller, 'Jeremy Bentham's Panoptic Device,' *October* 41 (Summer, 1987): 3–29.

²¹ Stephen Fox, 'The Panoptican: From Bentham's Obsession to the Revolution in Management Learning,' *Human Relations* 42(8) (1989): 717–739.

²² Even general hospitals are designed so that the nurses can view the patients. Every time there is a suicide in a psychiatric hospital, the investigation following always considers how well that patient was being observed. It is always a fine line between giving patients freedom and keeping them under observation. The author worked on a ward where patients were mostly given responsibility for their own actions. Mostly this worked well but this policy was ended after a couple of suicides.

The expansion of the asylum system occurred in the second half of the nineteenth century, and was characterised by a huge increase of their number and size. This phenomenon was produced in part by the aforementioned intellectual ideas, but there were a number of other more material factors which set this expansion in motion. The first factor, which is emphasised by the asylum system's defenders and largely ignored by its critics, was the problems with the old system. In the early nineteenth century those with mental health problems would usually be treated in private asylums, the workhouse or they stayed at home. A number of reports by the Lunacy Commissioners criticised the care provided, both in the private 'mad houses' and the workhouse.²³ The private asylums catered for a much wealthier clientele. As Charlotte Mackenzie, in her study of the Ticehurst Asylum, has emphasised, there was a fundamental difference between these private and state asylums in their reliance on market forces and the expectations of their rich clients.²⁴ From this it could be argued that the state asylums had more freedom to operate how they thought best, though they did have to answer to the local council. It must also be noted that the private asylums were very diverse in terms of facilities and therapeutic orientation.²⁵

Conditions in the workhouse produced much criticism and the *Times* newspaper, between 1827 and 1832, published 14 reports of unfair separations, 32 accounts of cruel punishments, 14 mentions of overcrowding, 24 cases of inadequate diets, 10 cases of diseased conditions, and 7 reports of 'workhouse murders'.²⁶ An Assistant Commissioner wrote: 'our object is to establish a discipline so severe and repulsive as to make them a terror to the poor'.²⁷ Recently historians

²³ Anthony Ashley Cooper Shaftesbury, 'Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor : presented to both houses of Parliament by command of Her Majesty' (London: Bradbury and Evans, 1844), D.J. Mellett, 'Bureaucracy and Mental Illness: The Commissioners in Lunacy 1845–90,' *Medical History* 25 (1985): 221.

²⁴ Charlotte Mackenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London: Routledge and Keegan Paul, 1992), 216.

²⁵ William L Parry-Jones, *The Trade In Lunacy: A Study of Private Mad-Houses in England in the Eighteenth and Nineteenth Centuries* (London: Keegan Paul, 1972), 318-322.

²⁶ David Roberts, 'How Cruel Was the Victorian Poor Law?' *The Historical Journal* 6(1) (1963): 98.

²⁷ Quoted in E.P. Thompson, *The Making of the English Working Class* (London: Penguin, 1963), 295.

have questioned this view of the workhouse as a place of unbridled horrors as suggested by these contemporary reports and by Charles Dickens in 'Oliver Twist' and 'Our Mutual Friend'.²⁸ Smith, Thornton, Reinartz, and Williams have suggested that the diet in the workhouses could at least be considered as adequate.²⁹ This view has been supported by the work of Anne Digby but Ian Miller suggests that the argument for the adequacy of the diet is based on scant evidence and further research is needed.³⁰

Generally, the insane were not segregated but at St Peter's in Bristol they were housed in their own ward.³¹ Despite having three wards for lunatics, the conditions were still deplorable. Patients were housed in pens 7 feet by 3 feet and were often kept in chains and muzzles.³² Leonard Smith in an as yet unpublished article shows how improvements were made to the care of the mentally unwell in the lunatic asylum based at the St Peter's workhouse but its location in the heart of a crowded port meant that it never attained the standards of the newly built county asylums, based in the countryside.³³ Advocates of the asylum system may have exaggerated some of the workhouse problems in order to facilitate the building of new asylums but there can be little doubt that they were grim places for all their inhabitants, but perhaps especially for the mentally unwell.

Private asylums, or 'mad houses' as they were called, varied enormously as William L. Parry-Jones has shown.³⁴ Some, like the Ticehurst Asylum were quite grand however even here

²⁸ Peter M. Stokes, 'Bentham, Dickens, and the Uses of the Workhouse,' *Studies in English Literature, 1500–1900*, 41(4) (Autumn, 2001): 711–727.

²⁹ Sue J. Thornton, Jonathan Reinartz, and Andrew N. Williams, 'Please, Sir, I Want Some More,' *British Medical Journal* 337 (2008): a2722.

³⁰ Anne Digby, *Pauper Palaces* (London: Routledge and Keegan Paul, 1978), 146 and Ian Miller, 'Feeding in the Workhouse: The Institutional and Ideological Functions of Food in Britain, ca. 1834–70' *Journal of British Studies* 52 (October 2013): 940–962.

³¹ Roy Porter, *A Social History of Madness: Stories of the Insane* (London: Weidenfeld & Nicolson, 1996), 118.

³² Donal Early, 'The Lunatic Pauper Palace' *Glenside Hospital Bristol 1861 – 1994* (Bristol: Friends of Glenside Hospital Museum, 2003), 4–5.

³³ Leonard Smith, 'Lunatic Asylum in the Workhouse: St Peter's Hospital, Bristol, 1698 – 1861' awaiting publication in *Medical History*.

³⁴ William L. Parry-Jones. *The Trade in Lunacy*.

the recovery rate was no better than most county asylums.³⁵ In other, less salubrious private asylums, the facilities and care were dreadful and were exposed in numerous tracts. One written by John Mitford detailed the abuses at Warburton's private mad houses at Hoxton and Bethnal Green.³⁶ This tract was quite influential and helped in the introduction of new regulations for these establishments in 1828. It is argued by Sarah Wise in a recent book that these establishments seem to have encouraged somewhat dubious admissions, usually for material gain.³⁷ She does document several of these cases but Charlotte Mackenzie's rather more extensively researched work suggests that in general relatives were reluctant to place their relatives in private asylums. Abuses that were documented by Wise rarely occurred in the asylums for the poor, as there was little financial gain to be had from inappropriate admissions.³⁸ Other private asylums for the well-to-do had better reputations and certainly better facilities, but even such places as Ticehurst and Brislington House in Bristol had their detractors. The most notable of these was John Perceval, a son of a British Prime Minister, who wrote a book condemning his treatment at Brislington House.³⁹

The contemporary intellectual ideas on insanity of the time and the scandals of the current system led to pressure for the state to provide more institutional care for the insane. The state duly provided the legal framework for this to happen with a series of Parliamentary Acts. The Madhouses Act of 1774 had been very ineffective in terms of capacity and effective regulation, and thus by the start of the nineteenth century more legislation was required. There

³⁵ Charlotte Mackenzie, *Psychiatry for the Rich*, 61-96.

³⁶ John Mitford, 'Part second of the crimes and horrors in the interior of Warburton's private mad-houses at Hoxton and Bethnal Green and of these establishments in general, with reasons for their total abolition : also an account of the manner of treating His late Majesty, by Warburton's keepers, and the dismissal of Davis for kicking and striking the king! : dedicated to the Lord Chancellor and the Honourable Henry Grey Bennett M.P.,' *Hume Tracts* (1820).

³⁷ Sarah Wise, *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England* (London: Bodley Head, 2012).

³⁸ *Ibid.* It should be noted that Wise does concede this point but the way the book is presented gives the opposite impression.

³⁹ John Perceval, *Perceval's Narrative: A Patient's Account of His Psychosis, 1830-1832* (Redwood City: Stanford University Press, 1961). His account is interesting and he makes some valid points about his incarceration but he was a terrible snob and at least some of the time suffered from paranoid delusions.

were public asylums before the nineteenth century (Bedlam was founded in 1247) but as Leonard Smith has emphasised, the first wave of large asylums across Britain started after the County Asylums Act of 1808.⁴⁰ This Act allowed and encouraged the building of asylums and was implemented by county magistrates through Quarter Sessions but there were no penalties if they were not provided. This was the catalyst for much asylum building but by the middle of the century many municipalities, including Bristol, had still not acted, so further government action was needed. The two 1845 acts of parliament, the Lunatic Asylums and Pauper Lunatics Act and the Lunatics Act were the result. The first established a legal obligation for the counties to build municipal asylums and the second established the Lunacy Commission to enforce their construction and then to regulate their administration.⁴¹

The 1845 Acts are particularly relevant to this study because, firstly, the element of compulsion established the legal necessity for Bristol to have its own county asylum and, secondly, the Lunacy Commissioners were the body which could override Bristol's reluctance to build one. The acts also established a very centralised administrative system for the asylums, with the admission process and record keeping becoming highly regulated.⁴² One of the reasons many county asylums seem quite similar is that they were all subjected to the same bureaucratic system enforced by the Commissioners. Kathleen Jones sees the 1845 reforms as important humanitarian reforms which were later betrayed by what she terms the triumph of legalism⁴³. Mellett offers a different perspective in suggesting that, 'the Commissioners, as minders of the "prerogative of asylumdom", were crucial in ordering the processes involved in the medicalization of insanity'.⁴⁴ The Lunacy Commission can be viewed in two ways: firstly, as the asylum system was the reason for its existence, it was bound to promote asylum building, but, secondly, it can also be seen as

⁴⁰ Leonard Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* (London: Leicester University Press, 1999).

⁴¹ Andrew Scull, *Museums of Madness*, 112.

⁴² Kathleen Jones, *A History of the Mental Health Services* (London: Routledge & Kegan Paul, 1993), 148.

⁴³ *Ibid*, 163

⁴⁴ D.J. Mellett, 'Bureaucracy and mental illness: the Commissioners in Lunacy 1845–90,' *Medical History* 25(3) (July 1981): 247

safeguarding patients' rights. The Commissioners were criticised by the nascent psychiatric profession and there seems to have evolved a battle for control of patients' rights between the psychiatrists and Commissioners.⁴⁵ Of course, the patients themselves were not consulted. This study will later reflect on the Commissioner's influence on the building of the Bristol Asylum and then in its regulation.

The thriving capitalist society of nineteenth-century Britain has been seen as a prerequisite for a large asylum system. Some authors, such as David Mechanic, have viewed industrial societies as being inevitably less tolerant of deviant behaviour, which led to an institutional response.⁴⁶ Andrew Scull has produced a more nuanced and in many respects more plausible account of how the nature of capitalism led to the rise of the asylums. He notes capitalism's intolerance of those who can't or don't want to work and how feudal ties, which did include some assistance by the wealthy for the poor and infirm, had been replaced by market mechanisms, which allowed no such niceties. He also shows how capitalism's tendency towards centralisation made the state powerful enough and wealthy enough to effect a nationwide asylum system.⁴⁷ It is undoubtedly true that without the advent of a capitalist system, the nationwide system of asylums would not have been built, but Scull's argument seems to be based on a rather simplistic cause and effect. Other material and intellectual factors were surely relevant. Wright's work on the influence of the family in getting their insane relatives admitted, and the influence of ideas such as those suggested by Galton, Bentham or Tuke, suggest that it was an interplay of factors which caused the rise of the asylums.⁴⁸ The nature of capitalism affected all these factors but a simple cause and effect analysis is not sufficient. Also open to doubt is Scull's and Foucault's

⁴⁵ *Ibid*, 221–25.

⁴⁶ David Mechanic, *Mental Health and Social Policy* (Englewood Cliffs, New Jersey: Prentice Hall Inc., 1969), 54.

⁴⁷ Andrew T. Scull, 'Madness and Segregative Control: The Rise of the Insane Asylum,' *Social Problems* 24(3) (1977): 337–351.

⁴⁸ David Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847–1901* (Oxford: Oxford University Press, 2001).

insistence of the importance of the insane's inability to work as a cause of their incarceration.⁴⁹ This seems to be not totally supported by the empirical evidence and this assertion will be examined in this study.

Another factor in the establishment of the asylums was that they could act as a power base for the nascent psychiatric profession. Scull has stressed the pivotal role played by the psychiatrists but other studies, such as those by Wright and Bartlett, have suggested that in terms of admissions they had little power. Admissions were often a negotiation between the Poor Law authorities and the patient's family.⁵⁰ Once the patient was admitted, the psychiatrists were fairly omnipotent, their power only limited by the Lunacy Commissioners and Visitors. Scull sees the psychiatrists as pivotal in the promotion of the asylum system because it provided them with a base where they could exercise their power separate from other competing authorities such as the Poor Law Commissioners. However, it seems that there were many causal factors in the establishment of the asylums of which this was one, but perhaps it was not as important as Scull suggests.⁵¹ Thus although the psychiatrists became a powerful voice in the maintenance of the asylum system, they were probably not that influential in its establishment. Later in this study we hope to show how the views and characters of the Medical Superintendents affected the way the Bristol Asylum was run and the lives of those incarcerated there.

What cannot be denied is that the second half of the nineteenth century saw a huge increase both in the number of asylums and the number of those classified as insane. As the chart below shows, the 1808 County Asylums Act was only partially successful and by 1827 there were only nine such institutions, but after the Acts of 1845 and 1848 they flourished and the end of the century saw the number rise to 77. Also, once built they expanded: in 1827 there were only 116 patients per asylum but this increased to nearly a thousand by 1900.⁵² The increase in those

⁴⁹ Scull, *Museums of Madness*, 242–344.

⁵⁰ Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London: Leicester University Press, 1999); Wright, *Mental Disability*.

⁵¹ Scull, *Museums of Madness*, 164–180.

⁵² Kathleen Jones, *A History of the Mental Health Services* (London: Routledge & Kegan Paul, 1993), 116.

designated as insane aroused much controversy in the nineteenth century. Francis Scott, writing in the *Fortnightly Review*, thought that ‘undoubtedly inebriety is a considerable factor and it can hardly be denied that it has a close connection with the rise in wages’.⁵³ In other words, if you gave the workers more money they would drink themselves insane. The debate as to the reasons for the rise of the asylums has continued to this day with authors, most notably Walton, examining whether it was an inevitable result of industrialisation. Walton suggests if we look at the wider results of industrialisation, particularly the effect on family structure, then there was a connection between the increase and economic developments.⁵⁴ A factor seemingly ignored by most commentators was that once the asylums were built, families had an alternative. Before, they either put up with a family member whose behaviour was bizarre, frightening or disruptive, or they threw them out. With the advent of asylum care, the family could be relieved of the problem and hopefully the asylum would provide a cure.

Year	County Asylums	Patients	Average number of patients
1827	9	1,046	116
1850	24	7,140	297
1860	41	15,845	386
1870	50	27,109	542
1880	61	40,088	657
1890	66	52,937	802
1900	77	74,004	961

Fig. 1 The growth of the asylums⁵⁵

Bristol in the Second Half of the Nineteenth Century

⁵³ Francis Scott, ‘County Asylums,’ *Fortnightly Review* 32 (July 1879): 119–143.

⁵⁴ John Walton, ‘Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848–50,’ *Journal of Social History* 13(1) (1979): 1–22.

⁵⁵ Source: Jones, *A History of the Mental Health Services*, 116.

British asylums were similar in several ways, but if we are to understand the establishment and nature of the Bristol Asylum, the local context also needs to be considered. When assessing the nature of the Bristol Asylum it will be necessary to consider how typical it was among nineteenth century British asylums. In what way did the characteristics of Bristol during this time affect both the nature of the asylum and the composition of its inhabitants? In the eighteenth century, Bristol was an economically vibrant city. It was, according to Daniel Defoe, 'the greatest, the richest and the best port of trade in Great Britain, London excepted'.⁵⁶ There followed a period of relative decline with its port overtaken by Liverpool, however, in 1847 it still paid more tax than any other city apart from London.⁵⁷ The second half of the nineteenth century saw it emerge as a more typical modern city with its economic growth characterised as a 'microcosm of recent British economic experience'.⁵⁸ Particularly relevant to this study is the development of areas with very distinctive characteristics, with the working class concentrated in areas such as Bedminster and St Philips, whilst the wealthy concentrated themselves in areas such as Redland and Clifton. Our study will examine the numbers of patients from these districts which will help to show the social composition of the asylum's population. All these areas saw considerable development in the nineteenth century, however, the central districts tended to stagnate and possessed some of the worst environmental conditions. Just before the start of our period, Sir Henry Thomas De la Beche and Dr Lyon Playfair produced their 'Report on the Sanitary Condition of Bristol', which affirmed that the city's worst conditions were in its central districts where overcrowding and poor sewerage made for a very unhealthy environment.⁵⁹ The Victorians

⁵⁶ Daniel Defoe, *A Tour through the Whole Island of Great Britain*, quoted in Kenneth Morgan, 'The Economic Development of Bristol, 1700–1850,' in *The Making of Modern Bristol*, eds. Madge Dresser and Philip Ollerenshaw (Tiverton: Redcliffe Press, 1996), 48.

⁵⁷ A.D.M. Phillips and J.R. Walton, 'The distribution of personal wealth in English towns in the mid-nineteenth century,' *Transactions of the Institute of British Geographers* 64 (1975): 42.

⁵⁸ Philip Ollerenshaw and Peter Wardley, 'Economic Growth and the Business Community in Bristol since 1840,' in *The Making of Modern Bristol*, eds. Dresser and Ollerenshaw, 124.

⁵⁹ Sir H.T. De la Beche and Dr Lyon Playfair, 'Report on the Sanitary Condition of Bristol,' in *Health of Towns Commission – Report on the State of Bristol, and other Large Towns*, Sir Henry T. De la Beche (London, HMSO, 1845), 8 (Royal Commission on the Health of Towns 1843–8 (XVIII, 1, 299)).

seemed to think a nation's progress was defined by the number of reports they produced, and another was produced in 1850 by George Clark which spelt out in fairly colourful terms the poor conditions in parts of Bristol. Of Bedminster he stated, 'It is difficult to convey in words, a correct impression of the condition of a place which, for the most part, is low, ill-built, and crowded together with a large proportion of the inhabitants poor.'⁶⁰ Of St Philips he commented, 'As to roads, sewers, water supply, scavenging and offensive trades it is worse than any other suburban district.'⁶¹ Although each district had its own distinct character they should not be seen as completely homogenous. An example is that the lower areas of Clifton around Hotwells were considered quite unsavoury.⁶²

The distinctions between the different districts are well illustrated by the table in Fig. 2. It shows the mortality rates for infants and death by disease or violence. Of the four districts chosen, Clifton was considered the wealthiest, Bedminster and St Philips were solidly working class whilst St James was a particularly deprived central area. The figures confirm the differences between the areas, with Clifton having the lowest mortality rate in each category. Most striking are the differences in violent death, with the rate for Bedminster and St Philips being more than Clifton, but St James having a rate 20 times greater. The rate for St James was the equivalent of contemporary Bristol, having 2000 murders a year. Between 2004 and 2013 there was an average of 5.1 murders.⁶³

Thus as we have the population statistics and an idea of the characteristics of different areas or parishes, we can use them to compare the asylum population with that of Bristol and provide evidence as to whether the asylum population was part of a 'deviant' underclass.

⁶⁰ George C. Clark, *Report to the General Board of Health on a preliminary inquiry into the city and county of Bristol* (London: HMSO, 1850), 37.

⁶¹ *Ibid.* 178.

⁶² P.S. Brown, 'The providers of medical treatment in mid-nineteenth-century Bristol,' *Medical History* 24 (1980), 152-168.

⁶³ 'Murders in the UK – Location, Rate and Victim Profile of Murder, Homicide and Fatal Violence,' Citizens Report, accessed August 12, 2014, <http://www.citizensreportuk.org/reports/murders-fatal-violence-uk.html>.

Area	Population	Death by disease per 1000	Violent death per 1000	Infant mortality per 1000 births
Bedminster	44,759	1.34	0.5	124
Clifton	28,695	0.48	0.24	105
St Philips	50,108	3.82	0.31	140
St James	8,420	5	5.12	183

Fig. 2 Areas of Bristol by population, disease, violent death and infant mortality in 1881⁶⁴

Two further aspects of Bristol's nineteenth-century society also need to be considered in terms of providing care for the insane and they can be summed up in two words: parsimony and philanthropy. These represented two aspects of the attitudes and activities of the Bristol elite. The miserliness is evidenced in views submitted to the local newspapers and by the actions of the council and will be dealt with in the next section. Philanthropic activity by an elite was not peculiar to or initiated by Bristol's elite in the nineteenth century but, as Mellor suggests, in the nineteenth century: 'philanthropic activity provided the background to the response of 'social citizenship', the clearest ideological response of the elite of a modern city'.⁶⁵ In Bristol, as Martin Gorsky's study has shown, this was very tied to the influence of non-conformist Protestant religion, which had been adopted by many of Bristol's elite.⁶⁶ Gorsky has been rightly criticised for downplaying the role of women in this philanthropic activity, but, as we shall see, they seem to have had less impact in aiding the insane than in other areas.⁶⁷ Those active in philanthropic work may not have been that influential in the establishment of the Bristol Asylum, but in the work of

⁶⁴ Source: 'History of Bristol in Gloucestershire | Map and description, *A Vision of Britain through Time*,' Great Britain Historical Geographical Information System (GBHGIS), University of Portsmouth, accessed March 24, 2015, <http://www.visionofbritain.org.uk/place/843>; for the recent Bristol statistics on violent death see 'Firearms Offences and Murders in Bristol 1999–2013,' Avon and Somerset Constabulary, accessed January 13, 2016, <https://www.avonandsomerset.police.uk/about-us/freedom-of-information/previous-foi-requests/firearmslicensingweapons/firearms-offences-and-murders-in-bristol-1999-2013/>.

⁶⁵ Helen Meller, *Leisure and the Changing City, 1870–1914* (Boston: Routledge & Kegan Paul, 1974), 75.

⁶⁶ Martin Gorsky, *Patterns of Philanthropy: Charity and Society in Nineteenth-Century Bristol* (Martlesham: Boydell, 1999).

⁶⁷ Moira Martin, 'Single Women and Philanthropy: a case study of women's associational life in Bristol, 1880–1914,' *Women's History Review* 17(3) (2008): 395–417.

the asylum Visitors they were very active in its regulation. Whether their motives were philanthropic or financial is probably unanswerable but it is likely that both motives played a part.

Bristol Council and the Establishment of the Lunatic Asylum

In the early nineteenth century those in Bristol who suffered from mental conditions and were from a wealthy background were well catered for within several prestigious private establishments. The picture below shows one such institution, Northwood Asylum, which was near Winterbourne and, as its advertisement states, catered 'for the higher classes of society' (Fig. 3).⁶⁸ More well-known was Brislington House which was started by Edward Long Fox, one of the pioneers of Moral Treatment.⁶⁹



Fig. 3 The Northwoods Asylum⁷⁰

Less well catered for were those who could not pay the fees of such establishments, which meant the vast majority of Bristol's citizens. If they were considered to need institutional treatment they were sent to the workhouse, the most prominent of which in Bristol was St Peter's. In 1844 the Metropolitan Commissioners in Lunacy, led by the 7th Earl of Shaftesbury,

⁶⁸ Source: 'Northwoods Asylum BS36,' Paul Townsend, accessed September 16, 2013, <https://www.flickr.com/photos/brizzlebornandbred/10097423535/>.

⁶⁹ Leonard Smith, 'A Gentleman's mad-doctor in Georgian England: Edward Long Fox and Brislington House.' *History of Psychiatry* 2008 Jun;19(74 Pt 2):163-84.

⁷⁰ 'Northwoods Asylum BS36,' Paul Townsend, accessed September 16, 2013, <https://www.flickr.com/photos/brizzlebornandbred/10097423535/>.

reported on conditions there and suggested it was ‘totally unfit for an asylum’. St Peter’s had a separate ward for lunatics and it was found to have a very high death rate. In 1847 27 of the 64 patients admitted there died within 13 months.⁷¹ This amounts to a yearly death rate of about 40 per cent which compares to the asylum’s death rate of about 15 per cent.⁷² The Commissioners produced another scathing report which concluded that ‘the wards are totally unfit for purpose’ and ‘the present arrangement is utterly disreputable and unless the Bristol Corporation takes measures for its amendment, the condition of the insane poor of Bristol will require the intervention of some higher authority’.⁷³ This set the stage for a conflict between the Bristol authorities and the government that would last for the next 14 years. As Large points out, the fact that Bristol was designated as a county meant that it had to adhere to the conditions of the 1845 County Asylums Act which made county asylums compulsory.⁷⁴

Various council members and employees made a series of arguments as to why they could not afford to build an asylum. These included the costs incurred in the rebuilding of the Guildhall, improvements to the port, the widening of streets and new sewers.⁷⁵ Thus provision for the mentally unwell was not considered as high a priority as other costs – a situation that remains to this day. Bristol also suggested providing new provisions for the insane by extending the Stapleton Workhouse, but this was rejected by the Commissioners. The situation was exacerbated by the Corporation, now having to house the insane from the Clifton and Bedminster areas who had previously been sent to the asylums at Gloucester and Wells. In 1853 the Home Secretary issued an order which stated that Bristol was required to ‘erect or provide a fit and proper asylum’.⁷⁶ In line with national guidelines the Council formally took over responsibilities for the

⁷¹ Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor : presented to both houses of Parliament by command of Her Majesty, 1844, 13.

⁷² Figure calculated using an average from the medical superintendents’ yearly reports: Wellcome Library WLM28.BE5B86, 1861–1869, 1870–1880 and 1881–1898.

⁷³ Quoted in Early, *Pauper Palace*, 5.

⁷⁴ David Large, *The Municipal Government of Bristol 1851–1901* (Bristol: Bristol Record Society, 1999), 151.

⁷⁵ *Ibid.* 152.

⁷⁶ *Ibid.* 153.

care of the insane from the judiciary. To oversee this duty they appointed a Visiting Committee which was chaired by William Herapath, the then well-known chemist and political reformer.⁷⁷ Although they were to later provide many valuable services to the asylum, the Committee's first act was to try and delay its construction. In this they were supported by the local press who feared it would add 8d in the pound to the local rates.⁷⁸

In other parts of the country local authorities had acted much more speedily to implement the Lunacy Acts. Between 1845 and 1852, 13 county asylums were opened including the Exminster Asylum and the nearest comparable asylum, the Somerset County Asylum (later known as Mendip Hospital) which opened in 1848, 13 years before its Bristolian counterpart.⁷⁹ Despite this, resistance to building an asylum continued. The physician at St Peter's suggested that the costs outweighed the benefits because only one in ten were likely to be cured.⁸⁰ This does suggest how poor his own institution was at treating the insane, as the new asylum was to have a recovery rate four times that number (see Chapter 3). It seems that several sections of Bristol's elite, including the press, members of parliament and the chamber of commerce, were all against the proposal to build an asylum and suggested cheaper alternatives.⁸¹

The Bristol press were divided on political lines with the *Bristol Mirror* and the *Western Daily Press* being Liberal and the *Mercury* being Conservative, but on the issue of the building of an asylum they were united in their opposition⁸². Most strident was the *Bristol Mirror* whose 1855 editorial stated, 'We are asked to provide pauper lunatics with a palace that will cost from 320 to £700 per idiot or madman. It must be a pleasure to be out of one's mind in the present day'.⁸³

⁷⁷ 'William Herapath,' Barton Hill History Group, accessed March 7, 2014, <http://www.bhhg.co.uk/showfiles.php?files=williamherapath>.

⁷⁸ 'Pauper Lunatic Asylum,' *Bristol Mercury*, November 3, 1855, 2.

⁷⁹ 'The Time Capsule', accessed 16.2.17, <http://thetimechamber.co.uk/beta/sites/asylums/asylum-history/the-asylums-list> Susan Marshall, *Mendip Hospital: An Appreciation* (Ely: Melrose Press, 2006).

⁸⁰ 'Bristol Town Council,' *Bristol Mercury*, April 7, 1855, 6.

⁸¹ Large, *The Municipal Government of Bristol*, 155.

⁸² John Penny, *All the news that's fit to print: A short history of Bristol's newspapers since 1702* (Bristol: Bristol Historical Association, 2001): 21-26. At the start of our period there were six weekly Bristol based newspapers but by the 1870's two had merged and two had ceased publication leaving the *Western daily Press*, the *Bristol Times and Mirror* and the *Bristol Mercury*.

⁸³ *Bristol Mirror* editorial October 10 1855.

Bristol's reputation for philanthropy, which in many respects was deserved, did not seem to extend to the care of the mentally unwell, at least not if it meant dipping into their pockets.

The Poor Law Board, supported by the Lunacy Commissioners, rejected all alternative suggestions as inadequate; the council capitulated and in May 1856 the process of finding a site for the new asylum was begun. Several sites were considered, including locations at Horfield and Bedminster, which were rejected as being too near the city or not having enough space.⁸⁴ The Commissioners suggested 30 acres were needed as current ideas on asylums stressed the need for exercise and places where the patients could work. The site which was closest to being acceptable was offered by a Mr Yalland at Fishponds and, although this was only 23 acres, the Commissioners, not wanting to delay things further, accepted this suggestion.

Tenders were drawn up for the asylum and £100 was offered for the successful bid. Twenty-seven plans were submitted and the plan by local architect T.R. Lysaght was declared the winner. It was suggested the cost was to be £30,000 but the final cost was £34,189. The build took longer than expected with the masons going on strike four times, but finally in December of 1860 the architect told the council that the asylum could start to receive patients, although there were minor works yet to be finished.⁸⁵ Bristol finally had a new asylum and in March of 1861 the first patients were transferred from St Peter's.

The Admission Process: The Workhouse, the Poor Laws and the Asylum

Before we examine the composition of the patients in the next chapter, it is necessary to explain the process of how they would have been admitted to the asylum. In order to understand the complexities of the admission process, it will be necessary to consider the roles of the workhouse, the Poor Laws and their administrators, patients' families and the physicians. The

⁸⁴ The idea that large grounds were conducive to recovery continued into the twentieth century and in the 1930s Barrow Hospital was built with extensive space for patient recreation. However, the most recent psychiatric hospital to be built in Bristol a few years ago is somewhat cramped and Barrow was sold for housing.

⁸⁵ Large, *The Municipal Government of Bristol*, 156–157.

starting place for any mental health problems was usually the family. Some admissions resulted after the individual had contact with the police or courts, but even these events were usually the culmination of troubles which affected the family of the individual. Wright has persuasively argued that most care for those with mental health problems was provided within the family and only severe behavioural disturbances caused that care to break down.⁸⁶ As we shall see from our individual case studies, families did not instigate an asylum admission unless there had been severe problems and they often stated that the situation had become untenable. They often feared for the safety of either the patient or their family.

If the situation had become severe, their first port of call would usually be the Poor Law relieving officer. For the vast majority of the population the alternatives, such as private care in the home or in a private asylum, would not be affordable. For those who needed help caused by poverty or insanity, two types of support were possible: assistance in the home (outdoor relief), or admission to a workhouse or county asylum (indoor relief). Some authors argued that insufficient outdoor relief was driving the poor and insane into the workhouse or asylum.⁸⁷ In Bristol the numbers receiving indoor and outdoor relief were usually fairly equal. In the area of the Bristol Union (central Bristol) in January 1890, there were 166 receiving indoor relief compared to 148 receiving outdoor relief.⁸⁸ Though the family was usually the instigator of an admission, it can be argued that changing family structures as a result of industrialisation, as documented by Anderson, had meant that families were less able to cope with an insane family member than in previous times.⁸⁹

The relieving officer would negotiate with a local magistrate as to whether the person was considered insane and which choice was appropriate. Thus the asylum was only involved

⁸⁶ David Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847–1901* (Oxford: Oxford University Press, 2001).

⁸⁷ W. Chance, 'Indoor versus Outdoor Relief,' *National Review* (July 1895): 667–689.

⁸⁸ Ian Archer, Spencer Jordan and Keith Ramsey, *Abstract of Bristol Historical Statistics Part 1: Poor Law Statistics 1835–1948*, Bristol Historical Database Project (Bristol: University of the West of England, 1995).

⁸⁹ M. Anderson, *Family structure in nineteenth-century Lancashire* (Cambridge: Cambridge University Press, 1971).

once the magistrate and Poor Law official had decided that the person was insane and that asylum treatment was the best option. In 1860 about 50 per cent of patients were sent to an asylum, a figure which rose to about 75 per cent by the end of the century. In 1860 25 per cent were sent to the workhouse, a proportion which dropped to 20 per cent in 1900. This means that at the start of our period 'outdoor' relief still accounted for about a quarter of those assessed, but this had dropped to only 5 per cent by 1900. Institutional care had become the norm, though a number of writers had begun to suggest that the asylum system was not working.⁹⁰ Miller has argued that the vast majority of those sent to the workhouse were suffering from what we would now term as learning difficulties but were then classed as 'idiots' or 'imbeciles'.⁹¹ This may not have been the case with Bristol as most of the admissions sent from the workhouse were not given these diagnoses; only 9.13 per cent of these admissions had such a diagnosis (see Chapter 3).

Thus the admissions had little to do with the asylum's officials, and this is evidenced by Bristol's medical superintendent Dr Thompson, who often moaned about the quality of the admissions which clearly he did not control.⁹² Thus we can agree with Walton that 'the key policy decisions in particular cases were made in the local communities where what counted was the degree of inconvenience or danger presented by a patient's behaviour and whether anyone was willing to look after him or capable of controlling him outside an institution. So the pattern of admissions to asylums in early Victorian England was largely independent of any objective analysis of well-defined disease entities by competent practitioners.'⁹³

A Brief History of the Bristol Asylum

⁹⁰ E. Miller, 'Variations in the official prevalence and disposal of the insane in England under the poor law, 1850–1900,' *History of Psychiatry* 18(1) (2007), 26–30.

⁹¹ *Ibid.* 26.

⁹² Early, *Pauper Palace*, 20.

⁹³ John Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848–50,' *Journal of Social History* 13(1) (1979): 4.

This study is primarily about the asylum's patients and so is not a general history. However, to contextualise some of our findings about the patients, it is useful to briefly survey how the asylum changed over our period. For a fuller history please refer to Donal Early's work.⁹⁴ The asylum opened in 1861 and, on 26 February, 50 male patients were admitted, being transferred from the designated lunatic asylum which was part of the Bristol workhouse; 63 females followed in March. A few weeks later the Commissioners visited and reported the patients were already improved and they 'could hardly recognise the patients before them as the same company who they had visited in St Peter's'.⁹⁵ Dr Stephens, the newly appointed medical superintendent, claimed that almost every patient had improved mentally and physically. Considering the far superior conditions, this was not surprising and the Commissioners, having spent years trying to get the asylum built, were unlikely to concede the asylum had not improved them. The council, however, were less happy, as fewer patients than expected were admitted and therefore the cost per patient was higher, so they suggested there should be more admissions.⁹⁶ This penny-pinching attitude was to prove detrimental to the asylum as it continually expanded, with the medical staff often bemoaning the unsuitability of some of the admissions.⁹⁷ This situation was mirrored in other asylums including Exminster.⁹⁸

The asylum implemented many of the ideas of Moral Treatment with restraint abolished, employment encouraged and an attitude of what might be termed therapeutic optimism was adopted. They thought they could cure madness. In Chapter 4 we will see how this manifested itself and how the attitude changed. The local press were very supportive, albeit in a very patronising way. A report in the *Bristol Mercury* on the midsummer ball in 1863 was titled 'A Night Amongst the Mad Folk'. In the article we are told Dr Stephens 'keeps his great mad family in the most perfect order' and that the great ball was 'looked forward to with the keenest expectation

⁹⁴ Early, *Pauper Palace*.

⁹⁵ *Ibid.* 10.

⁹⁶ Large, *The Municipal Government of Bristol*, 158–159.

⁹⁷ Early, *Pauper Palace*, 14.

⁹⁸ Melling and Forsythe, *The Politics of Madness*, 27.

and taken part with the greatest delight'.⁹⁹ The patronising attitude of the writer to the patients can also be seen with the assertion that 'most of them are deficient in education, scant in ideas, members of the under-stratum of society, and to them the careful supervision and constant attention of their guardians is a boon'.¹⁰⁰ The *Bristol Times* and Felix Farley's *Bristol Journal* adopted a very similar attitude with its report on the yearly ball being entitled, 'Mirth in Madness' and went on to compare the asylum favourably to St Peter's.¹⁰¹

The Bristol Asylum, like many similar institutions, did not always live up to the promise of its beginnings and the tone of its own reports and those of the Commissioners and Visitors became less self-congratulatory, though its rates of recovery did not change that much (see Chapter 3).¹⁰² The job of medical superintendent seems to have been a demanding one with all three suffering bouts of illness. Dr Stephens seems to have suffered from the disappointment that his asylum was not more successful. The admissions exceeded the deaths and discharges each year by about 5 per cent (see database) and he continually complained to the Commissioners about the quality of the admissions.¹⁰³ Dr Stephens became unwell and was diagnosed by the eminent Dr Long Fox as suffering from melancholia.¹⁰⁴ He retired in 1871 and died in 1881.

In 1868 the asylum was enlarged with the addition of 35 beds which, by the works completion, was already not enough to accommodate the increased number of patients. Overcrowding became a habitual problem with patients sleeping on landings and in corridors. This must have been detrimental to the well-being of the patients. Dr Thompson, the new superintendent who has been described by Early as eccentric and pompous, seemed to have a harsher view of his charges and reduced what he deemed as luxuries, including tobacco and beer.¹⁰⁵ Up until 1871, the medical superintendent was the only doctor, assisted by female and

⁹⁹ 'A Night Amongst the Mad Folk,' *Bristol Mercury*, July 16, 1863.

¹⁰⁰ Ibid.

¹⁰¹ The *Bristol Times* and Felix Farley's *Bristol Journal* July 20 1862, 5.

¹⁰² Medical Superintendents' Reports, Wellcome Library WLM28.BE5B86, 1860-1869 and 1870-1899.

¹⁰³ Early, *Pauper Palace*, 14.

¹⁰⁴ Large, *The Municipal Government of Bristol*, 162.

¹⁰⁵ Early, *Pauper Palace*, 18.

male attendants who until 1894 received no training and usually did not stay long. In 1885 most staff had been there less than a year. In 1894 they began to be trained, taking the Certificate of Proficiency in Nursing the Insane. The handbook for this qualification seems remarkably modern and fairly similar to psychiatric nurse training in the 1970s.¹⁰⁶

Overcrowding continued and a far more extensive expansion was completed by 1877 by which time there were 30 more patients than beds. The respite from overcrowding did not last long and more land had to be purchased. Two large wings were completed adding a further 172 beds. This extension cost what was then an enormous sum of £65,676.¹⁰⁷

Several changes occurred in 1890. Dr Thompson retired and was replaced by Dr Harry Bentham, whose older brother William had been an assistant to Dr Thompson. New building works were started but halted by a strike of the builders. This was followed by a strike of the male attendants who were all instantly dismissed. These two events should be seen in the context of a wave of strikes in Bristol and other cities during 1889 and 1890 and part of a more confident labour movement. However, the result of the attendants' strike shows the perils they faced.¹⁰⁸ A new Lunacy Act was also passed in 1890. This Act was extremely detailed and was intended to provide safeguards for virtually any contingency.¹⁰⁹ Thus patients' rights were enshrined in law but in practice, for those who had to operate its edicts, it proved a bureaucratic nightmare. Kathleen Jones suggests 'it was to hamper the mental health movement for nearly 70 years'.¹¹⁰ It should, however, be noted that Jones' view of our period was that legalism triumphed over care and, although she has a point, the legal framework was the end product of a number of other

¹⁰⁶ The Medico-Psychological Association, *Handbook for Attendants on the Insane*, 5th ed. (Chicago: Chicago Medical Book Co., 1909). The author trained in the 1980s when the training had become more psychologically based, but training literature from the previous decade was similar to the earlier handbook with an emphasis on biological functions.

¹⁰⁷ Large, *The Municipal Government of Bristol*, 165–166.

¹⁰⁸ Mike Richardson, *The Bristol Strike Wave of 1889–1890, Parts 1 & 2* (Bristol: Bristol Radical History Group, 2012).

¹⁰⁹ Hugh Freeman, 'Psychiatry in Britain, c. 1900', *History of Psychiatry* Vol. 21, Is. 3, 312 - 324

¹¹⁰ Kathleen Jones, *A History of the Mental Health Services*, 181.

social, economic and political factors. The asylum continued to grow and, by the end of our period, provided beds for 920 people. Although the asylum became in some ways a less therapeutic environment, there were a number of beneficial changes introduced during our period, including the introduction of gas, electricity and the telephone. More amusements were provided for the patients including billiards, croquet and bowls.¹¹¹

Contemporaries were aware of the problem of overcrowding. This is shown by a paper by Joshua Stallard in 1870 in which he notes pauper officials claiming, 'it has become impossible to obtain a pauper admission anywhere in Middlesex', an observation that would chime with the experience of many current mental health workers.¹¹² The Bristol Asylum's reports frequently refer to this and its effect on the patients. Only two years after opening, Dr Stephens notes: 'In common with almost every other, the Bristol Asylum has been filled with patients much more quickly than anticipated and already it has been found needful to place beds in the day room and dormitory of the female wing.'⁹³ The overcrowding was fairly typical of asylums in this era, Melling and Forsythe document how the Exminster Asylum had to continually expand due to the overcrowding and Hide reports on a similar situation in London Asylums of the period.¹¹³ Thus attempts at providing a restful and therapeutic environment were badly affected by this. Another factor, which got steadily worse during our period, was that patients had to be moved to different asylums or our asylum received patients from elsewhere. The 1898 report notes that 56 females were boarded at the Gloucester Asylum and 29 male patients from London were boarded at Bristol.¹¹⁴ This must have had a detrimental effect on their chances of recovery and made visits by relatives almost impossible. Thirty male patients from the Denbigh Asylum in Wales must have had a particularly difficult time as they mostly did not speak English.¹¹⁵

¹¹¹ Early, *Pauper Palace*, 29.

¹¹² Joshua Stallard, 'Pauper Lunatics and their Treatment,' *History of Psychiatry* 24(3), 356–368.

⁹³ Medical Superintendent's Report 1863, Wellcome Library WLM28.BE5B86, 1862–1868.

¹¹³ Melling and Forsythe, *The Politics of Madness*, 33-34.54-55, Hide, *Gender and Class in English Asylums*, 22.

¹¹⁴ Medical Superintendent's Report 1898, BRO 35510.

¹¹⁵ *Ibid.*

The second half of the nineteenth century is usually seen by writers such as Scull as a time when the ideals of Moral Treatment failed and the asylums of ever-increasing size became dumping grounds for society's unwanted; in Scull's phrase they became 'museums of madness'.¹¹⁶ There is much to commend this analysis but it has serious faults. At Bristol, the asylum did gradually accumulate large numbers of chronic patients. At the start of our period in 1862 there were 122 patients who had been there for more than a year but by the end of our period in 1898 that had risen to 519.¹¹⁷ However, this is slightly misleading because, if we take the admissions as a percentage of the total residents, the figures only change slightly with admissions being 34.1 per cent of residents during the period 1862–1874, 31.4 per cent for 1875–1889 and 31.0 per cent for 1890–1898. Thus, it could be argued it was just a much bigger institution, with long-term residents usually comprising 65–70 per cent of the total.¹¹⁸ In terms of percentage of recoveries the rate does decline but not by that much. The rate was 45.1 per cent for the 1860s, 48.5 per cent for the 1870s, 43.5 per cent for the 1880s and 38.7 per cent for the 1890s.¹¹⁹ Thus from the perspective of the individual, the asylum was always a place where you had a fair chance of recovering. There is evidence that at the very end of our period there were some changes in the asylum's character: the report for 1898 notes that the number of elderly admissions had risen in the last four years from 13 in 1895 to 22 in 1896, 24 in 1897 and 45 in 1898 and the recovery rate for those four years dropped to an all-time low of 29.4 per cent, which certainly seems significant.¹²⁰

There were, however, some beneficial changes. The death rate dropped from 13 per cent in 1862 to 8.9 per cent in 1898, though of course this increased the overcrowding. There were

¹¹⁶ Scull, *Museums of Madness*, 113–117.

¹¹⁷ Medical Superintendents' Reports, Wellcome Library WLM28.BE5B86, 1862–1869 and 1880–1898.

¹¹⁸ Medical Superintendents' Reports, Wellcome Library WLM28.BE5B86, 1862–1869, 1870–1879 and 1880–1898.

¹¹⁹ Figures from database; these do not include those classed as relieved, which varied but on average were about 7–8 per cent.

¹²⁰ Medical Superintendents' Reports, Wellcome Library WLM28.BE5B86, 1880–1898; Medical Superintendent's Report 1898, BRO 35510.

also some material improvements. Our section on leisure documents the various leisure activities that were gradually introduced. The heating was improved and the water supply eventually became plentiful and safe. What is difficult to determine is what the patients who experienced these changes thought of them. The only patient who was resident for our entire period was Robert William Organ, a cabinet maker, who was transferred from St Peter's, where he had been a resident for over ten years, to the Asylum when it opened and he died there in 1906 aged 87.¹²¹ His length of residence makes him atypical. The next chapter will examine the characteristics of the typical patient and suggest whether our asylum was typical and thus be used as an example of a typical asylum.

¹²¹ Admission Certificates BRO 40513/R/2/3. Admitted 26/2/1861, discharged (died) 9/11/1906.

Chapter 3: The Composition of the Asylum Population

This chapter looks at the backgrounds of patients in the asylum. In particular, it looks at whether the patients could be considered to represent a cross-section of Bristol society. This will be achieved mostly by using our database. We will examine the patients' backgrounds in terms of age, gender, occupation, address and education and where possible compare findings to those of Bristol's broad population. Our conclusions should possess a greater degree of certainty than those of other studies: firstly, because we have data on all the patients from the nineteenth century and secondly, by examining several categories which can be cross-referenced we can provide a more comprehensive account of the patients' characteristics.¹

Our quantitative considerations should produce considerable evidence about the characteristics of the patients in general terms, but to really understand what sort of people they were we will also have to look at individuals, their backgrounds and experiences. Thus we will choose patients from a variety of backgrounds in line with each of our categories, choosing those whose stories illuminate our themes, and sometimes show how some individuals' experiences contradict generalisations. We will also look at two particular groups: those admitted from the workhouse and the private patients. Examining these two groups should be instructive, as they would seem to be at either end of the social make-up of the asylum population.

The chapter will end with a discussion of the quantitative and qualitative evidence, what this tells us about the patients and whether this reflects or contradicts existing historiographical wisdom.

¹ We can, for instance, look at whether patients from a particular area with a particular diagnosis were more likely to be from a particular occupational background. This would be very difficult and time-consuming without pivot tables.

Age

The asylum catered for virtually all ages; the youngest admission was six years old and the oldest ninety-three. However, as Fig. 1 shows, the ages twenty to fifty predominated.² There were several elderly people admitted but the over-60s only amounted to 11.9 per cent of the admissions. For the adult population of Bristol the over-60s constituted about 8 per cent during this period.³ Thus the elderly were over-represented but, considering that conditions such as senile dementia afflicted only the elderly, the asylum cannot be considered as a repository for society's unwanted elderly. However, it can be argued that most of the patients were unwanted. Their families or community could not cope with them, usually for good reasons. These results are in line with other studies, such as those by Walton⁴ and Dale and Melling, whose review of several studies concluded that older people were not over-represented.⁵ More females were admitted who were over seventy but that can be explained by women's general longevity over men.

Age	Female	Male	Grand Total
0 to 10	2	8	10
11 to 20	203	165	368
21 to 30	604	564	1168
31 to 40	573	688	1261
41 to 50	484	530	1014
51 to 60	330	314	644
61 to 70	202	211	413
71 to 80	104	67	171
81 to 90	13	11	24
91 to 100	0	1	1
not known	7	31	38
Grand Total	2522	2590	5112

Fig. 1 Age of patients on admission by decade⁶

² These figures are for the ages on admission. As the asylum filled up with chronic patients the average age of the residents would be much higher.

³ Source: 'History of Bristol in Gloucestershire | Map and description, *A Vision of Britain through Time*,' Great Britain Historical Geographical Information System (GBHGIS), University of Portsmouth, accessed December 8, 2014, <http://www.visionofbritain.org.uk/place/843>.

⁴ John Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848–50,' *Journal of Social History* 13(1) (1979): 1–17.

⁵ Pamela Dale and Joseph Melling, 'The Politics of Mental Welfare,' in *Mental Illness and Learning Disability Since 1850*, eds. Pamela Dale and Joseph Melling (London: Routledge, 2012), 1–23.

⁶ Source: Pivot table from database using categories 'decade' and 'sex'.

If the elderly were not vastly over-represented in terms of admissions, in terms of their post-admission experience, they fared rather poorly. From Fig. 3 below we can see that up until the age of thirty most of those admitted recovered, the exception being those ten admissions of the under tens. These poor unfortunates were mostly severely brain damaged and either died at a very young age or needed a lifetime of care. An example of such a case was Frank Willoughby Jones, who was admitted in 1896 at only eight years of age. He came from the Barton Regis Workhouse and little is known of his family background. From a very young age he had suffered from epilepsy and was classed as a 'congenital idiot', probably due to brain damage brought about by his fits.⁷ He was very aggressive and the workhouse could not control him. He also bit people who came near him. The asylum tried to help him; he was taught to feed himself but his fits were often described as 'very strong'. He survived until his death in 1905 aged seventeen, a short and sad life (see Chapter 6 for his photograph).⁸

For those over sixty, few would recover. The recovery rates calculated from Fig. 3 (below) are 28 per cent for the 61 to 70 age group, 16 per cent for the 71 to 80 group and 12 per cent for the 81 to 90 group. There are probably several reasons for this; firstly, conditions such as senile dementia were and are incurable and progressive, and also most of the elderly were probably in a worse physical state than their younger counterparts. There was also probably less expectation of a cure, both on the part of the staff and of the patients themselves. An example of this was John Chapple (pictured below), a fine-looking elderly man of 74 who seems to have led a reasonable life as a married house painter. However, his wife had died and his mind had deteriorated, leading firstly to the workhouse and then the asylum. There was little expectation of recovery but the asylum was a better place to spend your final days than the workhouse.⁹

⁷ Shawn Masia and Orrin Devinsky, 'Epilepsy and Behaviour: A Brief History,' *Epilepsy and Behaviour* 1 (2000): 27–36.

⁸ Admission book BRO 40513/C/2/11, 14. Admitted 27/5/1896, discharged (died) 24/3/05.

⁹ Admission book BRO 40513/C/2/11, 89. Admitted 18/3/1897, discharged (died) 16/1/1898.

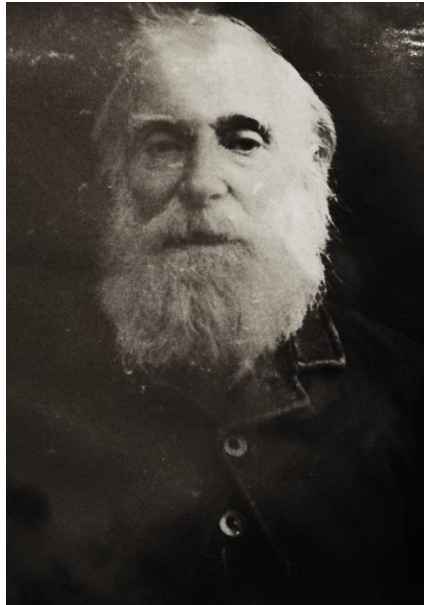


Fig. 2 John Chapple, 1897¹⁰

Age by decade	Died	Escaped	Improperly admitted	Not improved	Other	Recovered	Relieved	Transferred	Grand Total
0 to 10	5	0	0	0	0	1	4	0	10
11 to 20	129	1	0	1	0	190	32	15	368
21 to 30	410	4	0	9	5	506	118	116	1168
31 to 40	565	3	1	1	3	475	94	119	1261
41 to 50	495	2	0	11	2	367	55	82	1014
51 to 60	306	2	0	1	4	236	52	43	644
61 to 70	242	2	0	0	1	116	24	28	413
71 to 80	123	0	0	0	1	28	7	12	171
81 to 90	17	0	0	0	0	3	3	1	24
91 to 100	1	0	0	0	0	0	0	0	1
Not known	19	1	0	0	0	11	3	4	38
Grand Total	2312	15	1	23	16	1933	392	420	5112

Fig. 3 Results of admissions by age in decades¹¹

Gender and Family

As our review of the literature shows, gender has been a very contentious issue in the historiography of lunatic asylums and mental health generally. Showalter's assertion that madness became a 'female malady' has rightly been seen as simplistic. Also, Andrews and Digby

¹⁰ Source: Ibid.

¹¹ Pivot table from database using categories 'age' and 'result'.

have suggested that several early feminist studies were somewhat lacking in academic rigour.¹² This is not to suggest that gender played little part in the experience (see Chapter 4) or illnesses (see Chapter 5) of our patients. The number of men and women admitted to the asylum was fairly equal with 2522 women (49 per cent) admitted in the nineteenth century compared to 2590 men (51 per cent).¹³ However, if we exclude patients whose problems were not primarily psychiatric (in today's terms), then a slightly different picture emerges. Thus, if we exclude the 94 women and 192 men with alcohol problems¹⁴, the 51 women and 284 men suffering from General Paralysis of the Insane (GPI), now known as syphilis,¹⁵ and the 210 women and 352 men suffering from epilepsy,¹⁶ that leaves 2167 women (55 per cent) and 1752 men (45 per cent). Therefore women were 10% more likely to be classified as suffering from what we currently classify as a mental illness. What this does not show is whether there were more women than men who had such a condition or just that more women were thought to need admission. Gender attitudes may well have meant that a woman acting oddly was more likely to be considered for admission than men with the same symptoms. This, however, is far from ascribing a gender to this affliction; 45 per cent of a population cannot just be ignored.

One of the main reasons for the dispute over numbers is that Showalter based her figures on the numbers of women resident in the asylum, whilst her detractors looked at the number of admissions.¹⁷ Our results, which can be seen in Fig. 4, go some way towards explaining these differences. Although the admissions to the asylum saw roughly equal numbers of each sex, women soon outnumbered men in the asylum. In 1881 the proportion of men to women resident

¹² Jonathan Andrews and Anne Digby, eds., *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004), 12.

¹³ See database category 'sex'.

¹⁴ See database category 'character'.

¹⁵ See database category 'physical causes'.

¹⁶ Ibid.

¹⁷ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture 1830–1980* (London: Virago, 1987), 52; Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (Basingstoke: Palgrave Macmillan, 1996), 14.

in the asylum was 100 to 116, but by 1891 it reached 100 to 152.¹⁸ These figures might seem paradoxical as women were considerably more likely to recover than men, with 43 per cent recovering compared to 33 per cent for men. However, Fig. 5 shows that 737 men died within a year of admission compared to 482 women. Many of these deaths were due to GPI or epilepsy. Another factor was that the alcoholics were predominantly male and either died quickly or, having dried out, were speedily discharged. A further cause of female predominance was that they lived longer. These figures are in line with other studies; Anne Shepherd in her perceptive study of two Surrey asylums, found a similar pattern and, interestingly, at the very middle-class Holloway Sanatorium three out of four male deaths were certified as being due to GPI.¹⁹ Thus, whilst not disputing the patriarchal nature of the institution, the numerical dominance of women in the asylum could be said to be less due to male institutional control and more resulting from a male predilection for alcohol and illicit sex.

Result	0 to 1	1 to 3	3 to 12	12 to 36	36 to 120	over 120	Grand Total
Female	158	385	373	824	367	414	2522
died	97	69	173	143	256	330	1068
escaped	0	1	0	0	1	0	2
not improved	1	0	3	4	0	2	10
other	1	1	0	4	0	0	7
recovered	33	264	137	584	57	7	1082
relieved	12	19	34	37	40	60	202
transferred	14	31	26	52	13	15	151
Male	221	446	486	759	323	354	2590
died	128	111	263	235	195	312	1244
escaped	0	1	2	7	3	0	13
improperly admitted	1	0	0	0	0	0	1
not improved	3	4	2	4	0	0	13
other	2	1	0	1	1	3	9
recovered	61	278	109	366	31	6	851
relieved	14	23	24	54	43	32	190
transferred	12	28	86	92	50	1	269
Grand Total	379	831	859	1583	690	768	5112

Fig. 4 Results and duration of admissions in months by gender²⁰

¹⁸ *Glenside Hospital Reports 1861–1961* (Bristol: Friends of Glenside Hospital Museum, 2002), 24.

¹⁹ Anne Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums,' in *Sex and Seclusion, Class and Custody*, eds. Andrews and Digby, 237.

²⁰ Pivot table from database using categories 'sex', 'result' and 'duration category'.

Marriage

Several studies, most notably by Walton, have shown that families played an important role in the admission of patients to the lunatic asylums.²¹ They explain how an often complicated negotiation occurred between families, the Poor Law officials and the asylum, which led to a family member being admitted. Interestingly, Adair, Melling and Forsythe have shown in their study of admissions to the Exminster Asylum that there were very few admissions of people living on their own.²² The causes of this are difficult to fathom; was it that the mad living on their own were ignored, or are families bad for your mental health? Certainly, as Walton suggests, families were a primary instigator of admissions but this is not to suggest they lightly got rid of unwanted members. The evidence in Chapter 5 shows the seriousness of the afflictions from which the patients suffered. A depressed person not caring for themselves or a person with bizarre delusions might go unnoticed if they lived on their own, but not in a family home.²³

This study is less concerned with the admission process but rather concentrates on who the patients were, and their marital status provides some interesting results. The figures in Fig. 5 show the numbers of single and married patients, which are roughly in line with those for Britain's population (with the figures adjusted to exclude children).²⁴ The exception to this are the numbers for single women which amount to 42 per cent of the asylum admissions compared to 38 per cent for the whole population. These figures are in line with the findings of Arieno,²⁵

²¹ John Walton, 'Casting out and bringing back in Victorian England: pauper lunatics, 1840–70,' in *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. II*, eds. W.F. Bynum, R. Porter and M. Shepherd (London: Tavistock, 1985), 132–146.

²² Richard Adair, Joseph Melling and Bill Forsythe, 'Migration, family structure and pauper lunacy in Victorian England: admissions to the Devon County Pauper Lunatic Asylum, 1845–1900,' *Continuity and Change* 12(3) (December 1997), 385.

²³ Walton, 'Casting out and bringing back in Victorian England,' 132–146.

²⁴ 'General report, England and Wales, Vol. IV, 1891: Page 112,' Online Historical Population Reports, accessed April 15, 2014, [http://www.histpop.org/ohpr/servlet/PageBrowser?path=Browse/Census%20\(by%20date\)&active=yes&mn o=68&tocstate=expandnew&tocseq=3900&display=sections&display=tables&display=pagetitles&pageseq=first-nonblank](http://www.histpop.org/ohpr/servlet/PageBrowser?path=Browse/Census%20(by%20date)&active=yes&mn o=68&tocstate=expandnew&tocseq=3900&display=sections&display=tables&display=pagetitles&pageseq=first-nonblank).

²⁵ Marlene Arieno, *Victorian Lunatics: A Social Epidemiology of Mental Illness in Mid-Nineteenth-Century England* (Cranbury, NJ: Associated University Presses, 1989), 76–77.

however, Melling and Forsythe found an even larger percentage of single women.²⁶ The numbers are not terribly large but the recovery figures are not as high as you would expect considering the single women were normally quite young, with 82 per cent being under 40, compared to 41 per cent for married women. Our results given in Fig. 3 show that recovery rates decrease with age. When examining the recovery figures (Fig. 5) for those with different ages and marital status, it shows fairly marked differences in recovery figures. Single patients recover less often than their married counterparts. The reasons for this are unclear. Perhaps if they were single, their fewer family ties meant they did not have family support whilst in the asylum and a suitable discharge destination. Alternatively, husbands may have been instrumental in having their wives committed when they were not that unwell. There is some evidence for the latter assertion in Fig. 6 which shows the length of stay by marital status. In the first three months, 27.6 per cent of married women were discharged, compared to 15.6 per cent of single women. There is, however, a similar finding for men with 31.1 per cent of married men being discharged, compared to 17.5 per cent of single men.²⁷ These figures are mostly similar to those obtained by Melling and Forsythe.²⁸ It therefore seems that those admitted with problems that were not that serious were usually married. This perhaps suggests that if the causes of the admission were located at home then a period away from home would aid recovery.

²⁶ Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845–1914* (London: Routledge, 2006), 136–139.

²⁷ These figures include those who died, which were about 10 per cent of the discharges.

²⁸ Melling and Forsythe, *The Politics of Madness*, 104–112.

Age	Died	Recovered
Married	45.33%	41.77%
11 to 20	10.53%	89.47%
21 to 30	29.01%	54.93%
31 to 40	44.74%	43.20%
41 to 50	51.62%	37.60%
51 to 60	43.42%	40.79%
61 to 70	55.68%	30.11%
71 to 80	75.00%	16.67%
81 to 90	71.43%	0.00%
91 to 100	100.00%	0.00%
Single	42.62%	35.10%
0 to 10	50.00%	10.00%
11 to 20	36.49%	49.71%
21 to 30	37.63%	38.01%
31 to 40	46.20%	27.77%
41 to 50	43.93%	31.80%
51 to 60	54.78%	26.96%
61 to 70	64.38%	19.18%
71 to 80	76.67%	10.00%
81 to 90	50.00%	50.00%

Fig. 5 Deaths and recoveries of admissions by age and marital status²⁹

Marital status	0 to 1	1 to 3	3 to 12	12 to 36	36 to 120	over 120
Female	6.26%	15.27%	32.67%	14.79%	14.55%	16.42%
married	7.16%	20.41%	34.54%	14.52%	10.89%	12.46%
single	4.34%	11.22%	32.22%	15.02%	16.38%	20.81%
Male	8.53%	17.22%	29.31%	18.76%	12.47%	13.67%
married	10.10%	21.03%	30.16%	19.84%	10.18%	8.61%
single	5.46%	12.06%	26.60%	17.53%	16.39%	21.96%

Fig. 6 Duration of admission in months by marital status³⁰

²⁹ Pivot table from database using category 'sex', and examples from the categories 'marital status' and 'result'.

³⁰ Pivot table from database using categories 'sex', 'marital status' and 'duration category'.

The Myth of the Unmarried Mother Committed to British Lunatic Asylums

A common misconception, and one the author has encountered many times, is that women with children out of wedlock were placed in asylums purely because of their unwed status. As Mark Davis in his study of Menston Asylum asserts, 'they were admitted only if they were suffering from a mental illness'.³¹ Hilary Marland, the foremost historian of puerperal insanity, has shown that rather than being castigated or cast out, unmarried mothers during this period were thought of as vulnerable by the asylum doctors. It was only the men who deserted them who were vilified. Thus, it was only unmarried mothers who became mentally unwell who were admitted. This was not to rid society of them, but to care for them.³² This seems to be an area where care triumphs over control. At the Bristol Asylum, there is no evidence of unmarried mothers being admitted for reasons other than clinical. In fact, they seem remarkably absent. Of the 69 cases of puerperal conditions only four were unmarried.³³ This is very different from the findings of the Victorian writer John Connolly who produced the figures of 263 unmarried mothers out of 415 cases of puerperal insanity.³⁴ The disparity of these figures is difficult to explain; Connolly's figures are from the Hanwell Asylum in London where illegitimacy may have been much higher and the catchment area may have contained a high proportion of single households. Other possibilities include differing diagnostic criteria or the deliberate massaging of the statistics to highlight what he saw as a problem. Tuke, a contemporary of Connolly, produced extensive statistical work on puerperal insanity at the Edinburgh Asylum and produced figures of 13 unmarried women out of 93 cases, which is much more in line with the Bristol figures.³⁵ For an explanation of the disparity of these figures further work is needed.

³¹ Mark Davis, *Voices from the Asylum: West Riding Pauper Lunatic Asylum* (Stroud: Amberley Publishing, 2013), 7.

³² Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (New York: Palgrave Macmillan, 2004), 154–158.

³³ Figures from database using categories 'marital status' and 'diagnosis'.

³⁴ John Connolly, 'Clinical lectures on the principle forms of insanity, delivered in the Middlesex Lunatic-Asylum at Hanwell. Lecture XIII. Description and treatment of puerperal insanity,' *Lancet* 1(1178) (1846): 349–54.

³⁵ Figures reproduced in Marland, *Dangerous Motherhood*, 212.

One of the few unmarried mothers admitted with a puerperal condition was Harriet Palmer (see Fig. 7 below). She was a 31-year-old woman who worked in a flax factory. Both her parents had died and she lived in the less than salubrious district of St Judes. She became pregnant and after the baby was born became very strange. She stopped nursing the child and talked incoherently of streets paved with gold. She was found roaming the streets in her nightdress and on 26 July 1896 she was taken to the asylum. On admission, she claimed she could turn paper into million pound banknotes. She was termed 'violent and excited' and struck two of the nurses. Her diagnosis was puerperal mania. For a few months, she remained in this state but by January had improved and was working in the kitchen. On 8 March, she was discharged as recovered.³⁶ Her story is very similar to many of the women admitted with a puerperal condition. She was obviously very unwell and a danger to herself and possibly her child. Whilst not denying there was prejudice against unmarried mothers, she was not admitted as some sort of punishment; she was admitted using the same criteria as for a married woman.



Fig. 7 Harriet Palmer, 1896³⁷

³⁶ Admission book BRO 40513/C/3/13, 53. Admitted 27/7/1896, discharge (recovered) 8/3/1897.

³⁷ Source: Ibid.

Employment

In trying to ascertain the asylum patients' characteristics, an analysis of their occupations should be revealing. A person's class or status is closely aligned to their employment. It might seem to be self-evident that a population defined as primarily 'pauper' would primarily consist of the lowest echelons of society. According to the Oxford English Dictionary, the word pauper has two meanings: firstly, to have no property or means of support and, secondly, to be eligible for public charity.³⁸ The patients certainly fulfilled the latter definition as their fees for their stay were paid for by the local corporation. We shall, however, see that they often did not come from a very poor background. Authors such as Scull seem to have assumed the latter meaning necessitated the former, claiming that the division between pauper and private patient 'reflected accurately the class divisions of Victorian society'.³⁹ This assertion, though not completely false, is rather simplistic and the findings of this study will show the range of wealth and status of those classed as either a 'pauper' or 'private' patient.

In order to contextualise the findings of the occupations of our patients, we have compared them with the results for Wolverhampton and Bristol, which are taken from the 1881 census. The results for the asylum are based on the figures for the ten years of admissions between 1876 and 1886. Ten years were included to ensure numerical significance; however, it was felt that the quickly changing economic environment of the asylum's Bristolian catchment area would distort the results if we used figures from much later or earlier periods. An examination of our database does show how many new trades were found in the later years, compared to the former.⁴⁰ These figures are mostly problematic for the occupations of the female patients. Generally, census figures, and probably our data, underestimate the employment of

³⁸ 'Oxford English Dictionary,' Oxford University Press, accessed March 7, 2014, <http://www.oed.com/view/Entry/139049?rskey=pIFdJo&result=1#eid>.

³⁹ Andrew T. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993), 354–355.

⁴⁰ This is particularly evident in the newer commercial trades and factory work; see database category 'revised occupation'.

women and female data from the census has been characterised as 'so unreliable as to be almost useless'.⁴¹ Thus any conclusions must mostly pertain to the male population. Many of the patients' occupations produce only very small numbers; it may be interesting that they included a cricketer and a comedian but not statistically significant. Thus Fig. 8 uses occupational categories which are in line with those of the census.

Although we must be very careful in ascribing meaning to these figures, some suggestions do emerge from our table below. Firstly, the figures for the patients' occupational categories show a wide occupational range and one that is not dissimilar to those of Bristol and Wolverhampton. Indeed, it can be argued that there is as much difference between the Wolverhampton figures and those of Bristol as between Bristol and the asylum. The figures for male commercial occupations show Wolverhampton with 9.9 per cent, Bristol 14.3 per cent and the asylum 12.2 per cent. If the asylum had represented an underclass it would be expected that their figures for those without employment would be very high, however, they only account for 11.1 per cent of the male population, compared to about 30 per cent for both the Bristol and Wolverhampton figures. This category does include the wealthy who had no occupation but it is not possible to quantify their numbers. This evidence, however needs to be treated with caution as the asylum figure may be an underestimate of the numbers not employed, as they were asked to state their occupation, rather than if they were currently employed, which would be the census criteria. Another surprising result from our comparison is the high numbers of those with a 'professional' occupation with 10.9 per cent for males and 4.5 per cent for females – more than twice the figures for the two cities. These figures might be an anomaly as the numbers are quite small and Fig. 9, which shows the figures for entire asylum period, produces figures of 6.9 per cent and 3.2 per cent. Looking at the breakdown of individual occupations within the professional category shows the asylum with a large number of teachers and nurses which, although

⁴¹ Bridget Hill, 'Women, Work and the Census: A Problem for Historians of Women', *History Workshop* 35(1) (1993): 78–94, accessed May 23, 2016, www.hwj.oxfordjournals.org/content/35/1/78.extract.

professions in the census definition, they were not of the status of, say, lawyers or doctors.⁴²

These figures then are certainly not definitive, but they do suggest that the backgrounds of the patients covered a fairly wide class spectrum but does not include the upper echelons of society.

The asylum had a small number of private patients and these would be expected to show a very divergent pattern to the 'pauper' residents. Several of them state their occupation as 'gentleman' however their number includes the occupations publican, butler, clerk and grocer's assistant, a list not redolent of a privileged elite.⁴³ Also, there were 15 patients listed as accountants, only one of whom was a private patient, although accountancy was perhaps then a less prestigious occupation. It is evidence that the distinction between private and pauper patient, at the asylum, was not that distinct. The private patients from an institution like the Brislington Asylum, however, would have probably come from a much wealthier class.⁴⁴

It should be noted that a patient's stated occupation does not mean he or she was in that employment immediately prior to admission. Indeed, as Pamela Michael has shown in her study of Welsh asylums, many patients lost their employment and material resources due to mental derangement in the period prior to admission.⁴⁵ This is known as the 'drift hypothesis' and a study of psychiatric patients from the 1970s showed they had drifted to a lower class.⁴⁶ It could therefore be argued that, although from reasonable backgrounds, many of the patients were indeed quite poor at the point of admission. It is debatable whether a short period of not working changes a person's class as this could also be applied to most hospital admissions for a physical illness. It does seem fallacious to suggest that a short period of illness produces a change of a

⁴² Figures from database category 'occupational category'.

⁴³ Figures from database category 'occupation'.

⁴⁴ Leonard Smith, 'A gentleman's mad-doctor in Georgian England: Edward Long Fox and Brislington House,' *History of Psychiatry* 19(2) (June 2008): 163–184.

⁴⁵ Pamela Michael, 'Class, Gender and Insanity in Nineteenth-Century Wales,' in *Sex and Seclusion, Class and Custody*, eds. Andrews and Digby, 109.

⁴⁶ E.H. Hare, J.S. Price and E. Slater, 'Parental Social Class in Psychiatric Patients,' *British Journal of Psychiatry* 121 (1972): 505–531.

person's class. Loss of employment due to mental health problems would, however, increase their distress and their chances of being admitted to an asylum.

Occupations	Wolverhampton male	Wolverhampton female	Bristol male	Bristol female	Asylum male	Asylum female
Total professional	2.20%	1.60%	4.20%	2.30%	10.90%	4.50%
Total domestic	1.20%	11.10%	1.90%	16.20%	1.60%	15.70%
Total commercial	9.90%	0.60%	14.30%	0.20%	12.20%	0.00%
Total agricultural	1.20%	0.07%	1.10%	0.02%	3.60%	0.00%
Total industrial	57.10%	10.50%	47.80%	16.70%	57.60%	21.90%
Without occupation	29.50%	73.90%	31.30%	65.10%	11.10%	52.80%

Fig. 8 Comparison of asylum population's occupations with Bristol and Wolverhampton based on 1881 census⁴⁷

Occupations	Female	Male	Total of the asylum
Agricultural	0.16%	3.51%	1.86%
Commercial	0.95%	17.64%	9.41%
Domestic	25.85%	1.35%	13.44%
Industrial	39.06%	65.41%	52.41%
Non-productive	27.12%	1.43%	14.10%
Professional	3.21%	6.95%	5.11%
Unknown	2.18%	2.66%	2.43%
Illegible	1.47%	1.04%	1.25%

Fig. 9 Asylum occupation categories by percentage for 1861–1899⁴⁸

Our database shows a remarkable variety of careers with 585 different occupations, a testament both to the variety of asylum residents and to the complexity of the Bristolian economy.⁴⁹ Although the numbers for many occupations are very small, it is useful to view certain occupations and to judge their prevalence and significance. Fig. 10 shows a number of occupations and the results of their admissions. From this list, three occupations, that of labourer, hawker and charwoman, are examples of employment which might be considered as synonymous

⁴⁷ Pivot table compiled from 1881 census and database categories 'occupational category' and 'sex'.

⁴⁸ Pivot table from database using categories 'sex' and 'occupational category'.

⁴⁹ See database category 'occupation'. A few of the listed occupations must have been different phrases for the same job, however, it remains an impressive list.

with the very poor. The terms hawker and charwoman do not relate directly to the terms used in the census but with 52 hawkers and 82 charwomen they seem to be fairly generously represented. As Higgs has shown, it is difficult to quantify the number of labourers, as a number of unskilled or semi-skilled jobs might be termed labourers but also could be called factory workers or other terms related to their particular industry.⁵⁰ The numbers of these three occupations which together make up about 11.5 per cent of the admissions do offer some, admittedly small, evidence that there were a fairly substantial number of the very poor in the asylum. For women, the occupation of servant was the most numerous with 380 persons, followed by dressmakers who numbered 104. Servants do seem rather over-represented with about 15 per cent of the female asylum population compared to 12 per cent for Bristol and 9 per cent for Wolverhampton. Melling and Forsythe, in their study of the Exeter Asylum, found an even higher percentage of servants with 20 per cent, which was double the figure for the Exeter area. They also found that domestic servants were more likely to be diagnosed as suffering from mania than the general female asylum population, with 51 per cent compared to 42 per cent, respectively.⁵¹ These figures are similar to those from our study with 44 per cent of domestic servants classified as suffering from mania, compared to 36 per cent for the general female population at the asylum.⁵² Given the problems with diagnosis (see Chapter 5), these figures are somewhat unreliable. There is also little literature on the subject but as several institutions noted a preponderance of domestic servants, the causes for this need to be examined. A full causal analysis would need further research but some tentative explanations can be suggested. Melling and Forsythe found that servants were normally examined in the homes of their employers so it is reasonable to suggest it was the employers who instigated the admissions.⁵³ These employers of servants may have been quicker to send their charges to the asylum than families with closer

⁵⁰ E. Higgs, *Making Sense of the Census* (London: HMSO, 1989), particularly the chapter 'The History of Nineteenth-century Census Taking'.

⁵¹ Melling and Forsythe, *The Politics of Madness*, 158.

⁵² Figures from pivot table using the categories 'sex', 'revised occupation' and 'revised diagnosis'.

⁵³ Melling and Forsythe, *The Politics of Madness*, 160.

emotional ties. They may also have had more influence with the admitting authorities. A further possibility is that the higher incidence of mania might suggest the employers would have less tolerance with a servant displaying manic symptoms and disrupting the household, than one who was depressed.

Occupation	Died	Escaped	Improperly admitted	Not improved	Other	Recovered	Relieved	Transferred	Grand Total
Servant	113	0	0	0	2	191	32	42	380
Male tailor	25	0	0	1	0	16	2	4	48
Female tailor	13	0	0	0	0	21	5	1	40
Labourer	274	5	0	1	4	151	38	59	532
Housewife	160	1	0	1	0	236	22	14	434
Clerk	40	0	0	0	0	21	10	11	82
Accountant	11	0	0	0	0	2	1	1	15
Charwoman	50	0	0	0	0	25	5	8	88
Dressmaker	42	0	0	1	0	50	3	8	104
Hawker	24	0	0	0	1	18	5	4	52

Fig. 10 Occupations and the results of their admissions⁵⁴

The recovery rates of different occupations seem directly related to the numerically dominant gender of that occupation and thus for male tailors 33 per cent recovered, compared to female tailors, who had a 52 per cent recovery rate. If we consider the recovery rates for the different categories of occupation, they generally show the same effects of gender. In Fig. 11, we have the recovery rates for the categories separated by gender. For some of these categories, such as female agricultural workers (4), female commercial workers (24), or male domestic workers (35), the numbers are too small to be significant.⁵⁵ However, if we ignore the sections with low numbers, the recovery rates for the categories are very similar for each gender. For males it only varies between 30 per cent for 'non-productive' men and 35 per cent for agricultural

⁵⁴ The figures for Bristol and Wolverhampton are based on the 1881 census, the figures for the asylum are from the database using the categories 'revised occupation' and 'sex'.

⁵⁵ Numbers from pivot tables using the categories 'sex', 'revised occupation' and 'result'.

workers. For females, it varies between 36 per cent for industrial workers and 52 per cent for women categorised as ‘non-productive’.

Occupation	Died	Escaped	Improperly admitted	Not improved	Other	Recovered	Relieved	Transferred
Agricultural	43.16 %	0.00%	0.00%	1.05%	0.00%	34.74%	4.21%	16.84%
female	50.00 %	0.00%	0.00%	0.00%	0.00%	25.00%	25.00%	0.00%
male	42.86 %	0.00%	0.00%	1.10%	0.00%	35.16%	3.30%	17.58%
Commercial	49.48 %	0.21%	0.00%	0.00%	0.21%	34.30%	6.03%	9.77%
female	25.00 %	0.00%	0.00%	0.00%	0.00%	58.33%	8.33%	8.33%
male	50.77 %	0.22%	0.00%	0.00%	0.22%	33.04%	5.91%	9.85%
Domestic	36.24 %	0.00%	0.00%	0.44%	0.29%	44.98%	9.02%	9.02%
female	36.66 %	0.00%	0.00%	0.00%	0.31%	44.63%	9.51%	8.90%
male	28.57 %	0.00%	0.00%	8.57%	0.00%	51.43%	0.00%	11.43%
Industrial	48.86 %	0.37%	0.00%	0.37%	0.41%	33.52%	8.29%	8.17%
female	50.05 %	0.00%	0.00%	0.41%	0.41%	36.04%	8.63%	4.47%
male	48.17 %	0.59%	0.00%	0.35%	0.41%	32.05%	8.09%	10.33%
Non-productive	38.28 %	0.42%	0.00%	0.28%	0.00%	50.90%	5.55%	4.58%
female	37.43 %	0.15%	0.00%	0.15%	0.00%	52.05%	5.41%	4.82%
male	54.05 %	5.41%	0.00%	2.70%	0.00%	29.73%	8.11%	0.00%
Professional	43.68 %	0.00%	0.38%	1.53%	0.38%	37.16%	8.05%	8.81%
female	35.80 %	0.00%	0.00%	2.47%	0.00%	45.68%	8.64%	7.41%
male	47.22 %	0.00%	0.56%	1.11%	0.56%	33.33%	7.78%	9.44%
Grand Total	45.23 %	0.29%	0.02%	0.45%	0.31%	37.81%	7.67%	8.22%

Fig. 11 Occupation categories and their results by percentage⁵⁶

This piece of research is more comprehensive than other studies, but our results seem to confirm the findings of other studies which have considered the occupation of asylum patients.

⁵⁶ Percentages from pivot tables using the categories ‘sex’, ‘occupational category’ and ‘result’.

John Walton was the one of the first historians to challenge the idea that asylum patients were not the deviant or dispossessed of Scull's characterisation. His work, based on a sample of 600, shows a variety of occupations with only labourers over-represented. They were about twice the number as the admitting area of Lancashire.⁵⁷ This may be due to a preponderance of the poor but may be at least partially due to the indistinct nature of the term 'labourer'. Other historians, including Pamela Michael and Marlene Arieno, have also studied occupation and both stressed the variety of occupations. Arieno's study uses rather bizarre categories, including the rather derogatory term 'dregs', which she describes as vagabonds and the long-term unemployed. She produced figures of 3 per cent dregs, 44 per cent labour and service, 25 per cent trades and clerical and 8 per cent criminal.⁵⁸ Michael's study is more recent, rather more perceptive and less judgemental. Her conclusion was that 'most occupational groups were represented but for women there is a slight over-representation of servants or wives of labourers'.⁵⁹

The general conclusion must be that employment, considered by category or specific occupation, has little correlation with either the admission to a lunatic asylum, or recovery, for which gender plays a much more significant role. Knowledge of the patients' occupations does, however, help in understanding the range and type of people who were sent to the asylum.

Place

When considering a population such as ours, the areas in which they lived will tell us a lot about their backgrounds. It may also suggest how they might react to living in the asylum. If you came from very impoverished circumstances, the accommodation and food provided by the asylum might be a distinct improvement; however, someone from an affluent area like Clifton (see Chapter 2), would probably react differently.

⁵⁷ John Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848–50,' *Journal of Social History* 13(1) (1979): 10.

⁵⁸ Arieno, *Victorian Lunatics*, 79–82.

⁵⁹ Michael, 'Class, Gender and Insanity,' 103.

If we are to examine and compare the patients' addresses, we need to place them in comparable categories and this need has created quite severe methodological problems. The admission books usually provide a patient's address but the entry in the notes might be just an area, a street or a full address. Such diverse entries need to be placed in a single category. It was thus decided to place them all in parishes. With areas, such as Clifton and Bedminster, which had definite and well known boundaries, this worked well but other areas proved more difficult. With these it involved a certain amount of guesswork, though the author having lived in various parts of Bristol did help. Difficulties involved roads such as Stapleton Road, which crossed several different parishes and boundaries which seemed to change regularly.⁶⁰ Therefore when we came to compare the asylum population with areas of Bristol, we only used those whose results we could be fairly sure were accurate.

The pivot table in Fig. 12 shows all the places from which patients were admitted, mostly by parish but a considerable number (679) came from the workhouse, other Bristol institutions such as hospitals or prisons (91), or from outside Bristol (322). The latter category was mainly patients from other asylums who were transferred when their asylum was full.⁶¹ The areas with most patients were Bedminster (656), St Philips (461) and Clifton (449) but all areas were represented, even the very well-to-do Westbury-on Trym had 81 residents. The table includes the results of their stay. The places with significant numbers all have recovery rates in the 40–45 per cent range and so it could be said that those from affluent or poor areas had a fairly equal chance of recovery. The exception to this was those admitted from the workhouse, who had only a 19 per cent chance of recovery. The reasons for this will be examined later in the chapter.

⁶⁰ In order to place the addresses in parishes we consulted the censuses, maps and the Bristol yearbooks, however, these different sources sometimes gave contradictory information.

⁶¹ An example of this was in 1892 when 30 patients were transferred from Denbigh Asylum in Wales and stayed for three years (see database rows 3640–3669). They must have had a particularly hard time as they mostly did not speak English.

Area	Died	Escaped	Improperly admitted	Not improved	Other	Recovered	Relieved	Transferred	Grand Total
Not stated	113	1	0	2	0	109	22	9	256
Bedminster	289	0	1	0	5	277	42	42	656
Clifton	190	4	0	5	1	200	30	19	449
Holy Trinity	62	1	0	0	0	56	14	2	135
Montpelier	21	0	0	0	0	23	2	2	48
Redcliffe	36	0	0	0	0	34	5	4	79
St Andrews	45	1	0	0	0	38	12	5	101
St Augustines	51	0	0	1	0	47	10	6	115
St George	30	0	0	0	0	11	2	2	45
St James	66	2	0	0	0	75	12	7	162
St John	0	0	0	0	0	3	1	1	5
St Judes	16	0	0	0	0	12	2	0	30
St Marks (Easton)	87	0	0	1	0	70	10	4	172
St Michaels	73	0	0	2	2	64	10	7	158
St Nicholas	15	0	0	0	0	9	1	1	26
St Pauls	144	1	0	0	0	166	32	18	361
St Philips	207	0	0	3	1	209	27	14	461
Temple	28	0	0	1	0	29	5	2	65
Westbury	35	1	0	1	2	33	5	4	81
None	211	3	0	3	1	131	45	33	427
Outside Bristol	89	0	0	0	1	61	19	152	322
Wandering	54	0	0	1	1	96	13	21	186
Workhouse	422	0	0	2	2	135	63	55	679
Other institution	27	1	0	1	0	45	8	9	91

Fig. 12 Admissions by area and their results⁶²

We can conclude that the patients came from a wide variety of Bristol areas but that tells us nothing about the relative proportions of population between the asylum and areas of Bristol. This suggests the question of whether the poorer parishes produced proportionally more patients. The pivot table in Fig. 13 shows the three areas considered. Clifton, though not homogeneously affluent, was considered the richest area of Bristol. The city council described it thus:

⁶² Pivot table from database using categories 'result' and 'parish/workhouse'.

By the mid-19th century Clifton was no longer an agricultural community but one characterized by the existence of a large professional and wealthy community of fund holders and landed proprietors, living in large houses. It had become the desirable residential suburb of Bristol.⁶³

Bedminster was a working-class district but without the most severe deprivation (see Chapter 2, Fig. 3) which St James exhibited. The relative proportions between Clifton and Bedminster for the asylum and general population of Bristol are very similar with St James having a slightly higher figure. Thus it would seem that the proportion of asylum patients from areas was similar to the proportion of residents from those areas of Bristol. There are, however, some caveats. There were 56 asylum patients from Clifton who were domestic servants, which was 12.5 per cent of the Clifton asylum patients. These were not part of a wealthy elite and Fig. 14 shows Clifton had a higher proportion of domestic servants than the other areas.⁶⁴ Generally, though, the patients from Clifton wealthier than those of Bedminster. If we take the lowly occupation of labourer, 14.1 per cent of the asylum's Bedminster-based patients were labourers compared with only 3.8 per cent for Clifton. Bedminster produced seven hawkers whilst Clifton had none.⁶⁵ It can also be argued that, in order to afford the higher rents of the Clifton area, residents of a particular occupational category would probably be from the higher paid section of that category. The exception to this would be the live-in servants. The wealthy citizens of Clifton certainly are not represented; they would send their 'mad folks' to an asylum such as Brislington.⁶⁶

⁶³ 'Conservation Area 5 – Clifton & Hotwells: Character Appraisal and Management Proposals,' Bristol City Council, accessed May 23, 2016, <https://www.bristol.gov.uk/documents/20182/33832/clifton-and-hotwells-character-appraisal.pdf>.

⁶⁴ Figure for servants from the database category 'occupation'.

⁶⁵ Figures taken from database category 'occupation'.

⁶⁶ Leonard Smith, 'A Gentleman Mad-Doctor in Georgian England: Edward Long Fox and Brislington House,' *History of Psychiatry* 19 (2008): 163–183.

Area	General population	%	Asylum population	%
Bedminster	44759	54.5	656	51.7
Clifton	28695	35.2	449	35.4
St James	8420	10.3	162	12.8

Fig. 13 Comparison of asylum population with areas of Bristol⁶⁷

Occupation category	Bedminster	Clifton	St James
Agricultural	2.13%	1.34%	1.85%
Commercial	10.98%	9.13%	7.41%
Domestic	11.43%	22.27%	19.14%
Industrial	46.80%	38.08%	53.09%
Non-productive	21.04%	18.49%	13.58%
Professional	4.57%	8.24%	3.09%
Unknown	2.29%	2.23%	1.23%
N/A	0.76%	0.22%	0.62%

Fig. 14 Occupational categories by area⁶⁸

Some patients who came from a particularly rough or affluent district conform to the image of that area but others do not. Ann Holmes came from the notorious Temple district and her story is indicative of how that area is seen, having many very poor and often troubled residents. She had no recorded occupation, there was a strong family history of insanity and both she and other family members drank heavily. Indeed, drink seems to have been a primary factor in her becoming delusional. Once dried out she quickly recovered and only spent one month in the asylum.⁶⁹ Her picture below seems to confirm the picture of someone from a fairly deprived

⁶⁷ Table from database using examples from the category 'parish' and figures from the 1881 census, UK Census Online, accessed May 23, 2016, <http://www.ukcensonline.com/census/1881.php>.

⁶⁸ Pivot table from database using the category 'occupational category' and examples from category 'parish'.

⁶⁹ Admission book BRO 40513/C/3/12, 88. Admitted 1/11/1893, discharged (recovered) 2/12/1893.

background. She is wearing the standard but not obligatory asylum clothing and her rather worn looking face seems to suggest someone who has had a hard life.

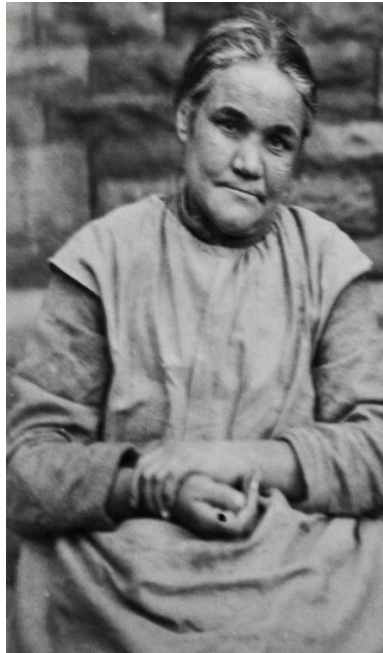


Fig. 15 Ann Holmes⁷⁰

Education

A further question to be answered about the asylum population is, were they educated? The answer to this is yes, up to a point. The asylum noted whether a patient could read or write in the admission book. The results are quite impressive in that the vast majority could read and write. The medical notes show that 75 per cent of women and 79 per cent of men were classed as being able to read and write.⁷¹ We do not know the extent of their literacy beyond this simple assertion. It should be noted, however, that this category, unlike nearly all others, was often written in at a later date, as the writing is often different. This suggests it was not merely a tick-box affair and that someone had taken the time to get this information. These figures are, however, slightly misleading as 132 of the patients were classified as ‘imbeciles’ or ‘idiots’ and

⁷⁰ Ibid.

⁷¹ These figures are produced by excluding all the blank entries.

were largely uneducated, and if we exclude these the figures (as shown in Fig. 17) are even better, with 78 per cent of women and 83 per cent of men able to read and write.⁷² These figures must be set in the context of a country which only introduced compulsory education in 1870 and, as Stephens has shown, compliance was not universal after that date.⁷³ There is a scarcity of research on the literacy levels of asylum patients so it is difficult to assert whether our asylum was typical. However, our figures are very similar to those found by Arieno which were based on the Bethlehem Hospital. She found that 18 per cent of patients could not read and write.⁷⁴ Also, Beveridge in his study of patients' letters did not quantify but asserted that many of the letters he found were from pauper patients.⁷⁵ What is more problematic is comparing our figures with those of the general Bristol population. Literacy figures for this era are usually calculated by the number of people using a mark rather than a signature on their marriage certificate. Bristol was generally thought of as having a fairly high literacy rate, with areas such as St Philips being the exception.⁷⁶ When our figures are examined by area, as seen in Fig. 18, literacy levels in patients from St Philips are less than in Clifton and slightly less than Bedminster and St James but the group with the lowest levels of literacy are those from the workhouse. For Bristol as a whole, the figures for those making a mark are, for 1871, 19 per cent. It is difficult to equate that with our figures as some of our patients who could read but not write may have been able to make a signature. Also, literacy figures rise as the effects of compulsory schooling are felt. It cannot definitely be said that the figures for the asylum were very similar to Bristol's general population, but the difference is not that significant. Lastly, it should be noted that those who could not read or write were less

⁷² It should be noted that the categories of 'imbecile' and 'idiot' include a few people who could read and write, which suggests the categories were not entirely accurate.

⁷³ W.B. Stephens, *Education, Literacy and Society 1830–70* (Manchester: Manchester University Press, 1987), 75.

⁷⁴ Arieno, *Victorian Lunatics*, 82–83.

⁷⁵ A.A. Beveridge, 'Voices of the mad: patients' letters from the Royal Edinburgh Asylum, 1873–1908,' *Psychological Medicine*, 27(4): 899.

⁷⁶ John Campbell, 'Occupation and literacy in Bristol and Gloucestershire, 1755–1870,' in *Studies in the history of literacy: England and North America*. Educational Administration and History Monographs No. 13, ed. W.B. Stephens (Leeds: Museum of the History of Education, University of Leeds, 1983), 20–36.

likely to recover than their more educated inmates. Fig. 19 shows that their recovery rate was only 24 per cent against 42 per cent for those who could read and write. This may be explained by the possibility that the illiteracy of some of the patients was due to a permanent or progressive cognitive impairment. The database shows that the diagnoses which might infer such impairment (imbecility, idiocy, senile dementia and epilepsy) had higher rates for the illiterate group than for those who could read and write, but still only accounted for about 15 per cent of that group.⁷⁷

Literacy ability	Female	Male	Average
Neither read nor write	12.0%	12.2%	12.1%
Read only	13.2%	8.5%	10.7%
Read and write	74.8%	79.3%	77.1%

Fig. 16 Patients' literacy in percentages⁷⁸

Literacy ability	Female	Male	Average
Neither read nor write	8.5%	8.2%	8.4%
Read only	13.7%	8.9%	10.8%
Read and write	77.8%	82.9%	80.8%

Fig. 17 Adjusted patients' literacy in percentages⁷⁹

Literacy ability	Bedminster	Clifton	St James	St Philips	Workhouse
Neither read nor write	10.42%	5.52%	15.20%	14.52%	26.06%
Read only	12.12%	10.76%	7.20%	14.25%	13.81%
Read and write	77.46%	83.72%	77.60%	71.23%	60.13%

Fig. 18 Literacy for patients in selected areas⁸⁰

⁷⁷ Figures obtained from pivot table using the categories 'education' and 'revised diagnosis'.

⁷⁸ Pivot table from database using categories 'sex' and 'education'.

⁷⁹ Pivot table from database using categories 'sex' and 'education' with figures adjusted to exclude those defined as 'idiots' or 'imbeciles'.

⁸⁰ Pivot table from database using the category 'education' and selected areas from the category 'parish'.

Literacy ability	Died	Escaped	Improperly admitted	Not improved	Other	Recovered	Relieved	Transferred
Neither read nor write	57.23%	0.00%	0.00%	0.00%	0.21%	24.26%	8.94%	9.36%
Read only	44.69%	0.97%	0.00%	0.24%	0.00%	40.10%	5.80%	8.21%
Read and write	40.92%	0.33%	0.03%	0.30%	0.37%	42.22%	6.32%	9.50%
(blank)	50.99%	0.08%	0.00%	1.07%	0.33%	31.55%	11.20%	4.78%
Grand Total	45.23%	0.29%	0.02%	0.45%	0.31%	37.81%	7.67%	8.22%

Fig. 19 Results for differing literacy levels⁸¹

Death

The death of a patient in the Bristol Asylum was taken very seriously and most received an autopsy, unless the relatives objected.⁸² The causes of death in asylums and their frequency was a matter of national concern. As Cathy Smith suggests: 'Death from insanity mattered in the nineteenth century. It raised problems within and beyond the medical profession about the implications of dying from madness. If the brain was mortal, was the mind mortal, and if the mind was mortal, what did this say about the soul? Death in numbers posed further questions.'⁸³ In the later stages of our period, a materialist conception of death predominated but in the 1860s death could still be attributed to the Almighty. This is evidenced by some patients having their cause of death recorded as 'visitation by God'. One such patient was Ann Hancock, a 53-year-old widow who died three weeks after admission.⁸⁴ As Smith has suggested, the nascent state of autopsy science in the nineteenth century meant that metaphysical explanations were sometimes still suggested.⁸⁵

About half of all the patients admitted were to die in the asylum. Death rates at asylums were certainly high. Such high rates were in many respects inevitable; many patients were admitted in the process of dying and the asylum acted as a hospice. Fig. 20 shows that 225

⁸¹ Pivot table from database using the categories 'education' and 'results'.

⁸² See death records, BRO 40513/C/16.

⁸³ Cathy Smith, "'Visitation by God': rationalizing death in the Victorian asylum,' *History of Psychiatry* 23(1) (2012): 105.

⁸⁴ Admission book BRO 40513/C/3/4, 187. Admitted 19/11/1863, discharged (died) 29/11/1863.

⁸⁵ Smith, 'Visitation by God,' 19.

patients died within a month of their admission. Within one year of admission 783 had died, or 38 per cent of the total deaths.

Result	0 to 1	1 to 3	3 to 12	12 to 36	36 to 120	over 120	Grand Total
Died	225	180	378	436	451	643	2313
Escaped	0	2	7	2	4	0	15
Improperly admitted	1	0	0	0	0	0	1
Not improved	4	4	8	5	0	2	23
Other	3	2	5	0	1	3	16
Recovered	94	542	950	246	88	13	1933
Relieved	26	41	91	58	83	92	391
Transferred	26	59	144	112	63	16	420
Grand Total	379	830	1583	859	690	769	5112

Fig. 20 Results of admissions at various intervals (in months)⁸⁶

In many of the Superintendents' yearly reports, they complain of the terrible physical state of many admissions who, in their opinion, should never have come to the asylum.⁸⁷ A question asked, but perhaps not sufficiently answered by several authors, is whether the high death was more due to the effects of different types of insanity or to the adverse effects of living in an institutional environment.⁸⁸ Certainly some deaths resulted from the asylum's deficiencies; there were problems with the water supply for many years and the overcrowding of later years would have encouraged infection.⁸⁹ However, as Fig. 21 shows, few of the deaths were from infectious diseases. In the later years, this picture changed and by the 1890s quite a large proportion (41 per cent) of the deaths were from thoracic diseases, for which infection and air quality may have been factors. Some deaths may have been caused by a gradual decline brought

⁸⁶ Pivot table from database using categories 'results' and 'duration category'.

⁸⁷ Medical Superintendents' Reports, Wellcome Library: WLM28.BE5B86, 1861–1869, 1870–1880 and 1881–1898.

⁸⁸ Leonard Smith, 'Welcome release: perspectives on death in the early county lunatic asylums, 1810–50,' *History of Psychiatry* 23 (2012): 117.

⁸⁹ Donal Early, *'The Lunatic Pauper Palace' Glenside Hospital Bristol 1861 – 1994* (Bristol: Friends of Glenside Hospital Museum, 2003), 12-13.

about by the patient neglecting themselves, despite the sometimes heroic and sometimes brutal attempts by staff to get patients to eat.

A typical such case was Sarah Anne Richards, who was admitted on 15 November 1888. She was described as being very talkative and excited. She said Queen Victoria was her friend and that people had been trying to poison her. This last delusion seems to have been maintained for the rest of her life. It caused her to often refuse food and the staff had a fairly constant battle to get her to eat. Her diagnosis was 'mania with delusions'.⁹⁰ She initially did not sleep but then began to sleep for long periods during the day. Sometimes she spent all day awake, but with her eyes closed, refusing to speak or eat. It was reported on 22 January 1889 that she 'has a delusion that dynamite has exploded over her head every night' and on 15 May she was said to be still full of delusions, including saying that 'I am constantly injuring the royal family'.⁹¹ There were periods of improvement when she would eat and attended church but generally she was wasting away. In December 1891 it was reported, 'she sits on the settee all day with her eyes closed and refusing to speak to anyone' and on 6 December of the same year she was still 'absolutely apathetic, sits in an armchair all day'.⁹² She was obviously taking no part in the life of the institution and thus there was usually only one entry per month, which often stated there was no change, the exception being on 20 July 1892 when she was struck by another patient. Significantly she did not retaliate.⁹³

On 16 June 1893 she weighed 5 st 6 lb. There are many entries in her notes around this period which mostly concern efforts to get her to eat and the physical monitoring of her condition. On some days she ate well but was described on 18 June as 'emaciated and feeble'.⁹⁴ She was given a stimulant to help her to eat and she rallied slightly; her weight increased to 5 st 7½ lb. However, her physical condition was by now very feeble, her pulse was 120 and her

⁹⁰ Admission book BRO 40513/C/3/11, 167. Admitted 7/11/1888, discharged (died) 8/7/1893.

⁹¹ Ibid.

⁹² Ibid.

⁹³ Admission book BRO 40513/C/3/11, 168.

⁹⁴ Ibid.

temperature raised at 101 degrees. Her abdomen was described as ‘distended’ (28 June).⁹⁵ She developed oedema in her ankles, her lungs became congested and she spent most of the day dozing in her bed (2 July).⁹⁶ Then on 8 July 1893 ‘she sank and died at 10.50pm’ and the cause of death was given as oedema of the lungs.⁹⁷

For most years, the most common attributed causes of death were related to brain disease or dysfunction, with General Paralysis of the Insane (GPI) the most common, followed by epilepsy.⁹⁸ These will be discussed in the next chapter. These diseases had terrible symptoms and Weston’s account of the infirmary ward at the asylum shows that their devastating effects were not helped by the attitudes and actions of some of the attendants (see Chapter 4).⁹⁹

Causes of death	Males	Females	Grand Total
Cerebral or Spinal diseases			
Apoplexy and Paralysis	0	0	0
Epilepsy and Convulsions	5	3	8
General Paralysis	3	0	3
Maniacal and Melancholic Exhaustion and Decay	2	0	2
Inflammation and other Diseases of the Brain	3	0	3
Thoracic Diseases			
Inflammation of the Lungs	0	0	0
Pulmonary Consumption	2	1	3
Diseases of the Heart	1	0	1
Abdominal diseases			
Inflammation of the Stomach, Intestines or Peritoneum	0	0	0
Dysentery or Diarrhoea	0	0	0
Fever	0	0	0
Smallpox	0	0	0
Erysipelas	0	0	0
Cancer	0	0	0
General Debility and Old Age	2	3	5
Strumous cachexia	1	0	1
Suicide and Accidents	0	0	0
Grand Total	19	7	26

⁹⁵ Ibid.

⁹⁶ Ibid.

⁹⁷ Ibid.

⁹⁸ Exact figures are difficult to calculate as most patients with GPI were not diagnosed as such on admission so the admission figures under-represent the prevalence of GPI.

⁹⁹ John Weston, *Life in a Lunatic Asylum* (London: Houlston and Wright, 1867), 50-59.

Fig. 21 Causes of death, 1870¹⁰⁰

We have now examined various aspects of the patients at the asylum and how, in a number of respects, their composition is not that dissimilar from Bristol's general population, apart from the wealthy. There are two groups which seem to be at either end of the asylum's demographic spectrum. These are those from the workhouse and the private patients. An examination of these groups and individuals from them, should show how they differed from the general asylum population.

The Patients from the Workhouse

In Chapter 2 we saw how admission to the workhouse was one of the options when a person who was considered to be insane was presented to the Poor Law officials. Authors such as Bartlett have shown how this practice continued throughout our period. Thus, the workhouse contained some people who were not admitted for reasons of poverty but because they were considered to be insane. A number became unmanageable at the workhouse and were sent to the asylum.¹⁰¹ Thus if someone was admitted from the workhouse, they were not necessarily from a very poor background. It is, however, likely that they were more mentally and physically unwell than most of the other patients because of the conditions at the workhouse.

In the first half of the nineteenth century workhouses were heavily criticised for their care of the poor in general and the insane in particular. Scandals, such as that concerning the Bridgwater workhouse, sullied their already unsavoury reputation. At Bridgwater, a third of the inmates died during the winter of 1837. This was found to be due to a combination of overcrowding, insanitary conditions and a very poor diet.¹⁰² In Bristol a number of reports were

¹⁰⁰ Figures for causes of death from Medical Superintendent's Report 1870, Wellcome Library WLM28.BE5B86.

¹⁰¹ Peter Bartlett, 'The Asylum, the Workhouse, and the Voice of the Insane Poor in 19th-Century England,' *International Journal of Law and Psychiatry* 21(4) (1998): 421–432.

¹⁰² Samantha Shave, 'Immediate Death or a Life of Torture Are the Consequences of the System': The Bridgwater Union Scandal and Policy Change,' in *Medicine and the Workhouse*, eds. Jonathan Reinarz and Leonard Schwarz (Rochester: University of Rochester Press, 2013), 164–191.

quite scathing in their assessment of the workhouses.¹⁰³ In 1835 a report on the workhouse at Easton concluded:

I was ill prepared to find a parish of nearly 17,000 inhabitants, expending nearly £6,000 for the support of the poor, such a disgraceful instance of neglect and mismanagement. The state of the workhouse was filthy in the extreme; the appearance of the inmates dirty and wretched. There was no classification: men, women and children being indiscriminately huddled together. A dismal, filthy room as dirty as a coal cellar, contained a poor distressed lunatic as dirty as the floor, clothed in rags, and with feet protruding from his shoes. The poor creature had never quitted the den for years. Another room contained a young lunatic, almost in a state of nudity, who had been detained there for four years.¹⁰⁴

Although the newly created asylums of the second half of the nineteenth century were meant to replace the housing of lunatics in the very unsuitable workhouses, this often did not happen in practice. As Myers has shown, workhouses continued to care for lunatics and the number of lunatics resident in workhouses increased through the century.¹⁰⁵ Towards the end of the century the Lunacy Commissioners began to argue that lunatics who had no chance of recovery could be housed in workhouses.¹⁰⁶ The workhouse had a worse environment, poorer food and the balance between care and control was much more on the side of control in the workhouse. As it cost more to house someone in an asylum, this decision seems to be a case of finance triumphing over care.

¹⁰³ Ibid.

¹⁰⁴ Quoted in 'The Easton Workhouse,' Living Easton, accessed May 8, 2013, http://www.cems.uwe.ac.uk/~rstephen/livingeaston/local_history/eastvilleworkhouse.html.

¹⁰⁵ E.D. Myers, 'Workhouse or asylum: the nineteenth century battle for the care of the pauper insane,' *Psychiatric Bulletin* 22(9) (1998): 575–577.

¹⁰⁶ Charlotte Newman, 'To Punish or Protect: The New Poor Law and the English Workhouse,' *International Journal of Historical Archaeology* 18(1) (2014): 122–145.

Using our pivot tables to compare the patients from the workhouse with the general asylum population, we can see that, though by no means a homogenous group, the workhouse patients did differ in a number of ways. Fig. 23 below shows that they were more likely to be illiterate, more likely to be single and less likely to come from a professional background. They were also more likely to suffer from epilepsy and have a diagnosis of imbecility. Once admitted they generally fared less well, having half the chance of making a full recovery (Fig. 22).

Patient origin	Died	Escaped	Improperly admitted	Not improved	Other	Recovered	Relieved	Transferred
Non-workhouse	42.63%	0.34%	0.02%	0.47%	0.32%	40.56%	7.42%	8.23%
Workhouse	62.15%	0.00%	0.00%	0.29%	0.29%	19.88%	9.28%	8.10%
Grand Total	45.23%	0.29%	0.02%	0.45%	0.31%	37.81%	7.67%	8.22%

Fig. 22 Results of admission of patients from workhouse compared to non-workhouse¹⁰⁷

	Patients from workhouse	Rest of asylum population
Education		
cannot read or write	17.23%	7.96%
Marital Status		
married	29.01%	48.68%
Occupation		
professional	2.50%	5.50%
Physical problems		
epilepsy	22.83%	9.18%
Diagnosis		
imbecility	6.33%	2.33%

Fig. 23 Comparisons of workhouse patients with general asylum population¹⁰⁸

There are many tragic stories of patients from the workhouse, including the 16-year-old Florence Amy Benger. She was admitted from the Imbecile ward at the Bristol Union Workhouse. She suffered from a severe form of epilepsy which was probably the cause of her mental incapacity. The workhouse stated she had been with them for four years since she was 12 but had

¹⁰⁷ Figures from database using categories 'results of admission' and 'workhouse'.

¹⁰⁸ Figures from database using categories 'workhouse', 'education', 'marital status', 'diagnosis' and 'physical problems'.

recently become unmanageable, especially at night. Her epilepsy eventually caused her death at the age of only 20.¹⁰⁹

The Reardons and the Workhouse

The Reardons were a Bristol family whose lives were blighted by a combination of poverty and mental health problems. However, without their mental health problems it is doubtful if they would ever have needed the workhouse. They came from a respectable but poor family, their father Timothy was a ship's stoker and they lived in St Augustines in central Bristol.¹¹⁰ Three of the Reardon offspring had mental health problems; the two daughters were admitted to the asylum and the son to the workhouse. By 1891 all three resided in the workhouse. According to the workhouse records, they were on the Imbecile ward.¹¹¹ This may be misleading as to their mental capacity, as both Elizabeth and Margaret could read and write and they were all involved in the clothing trade as tailors or seamstresses.¹¹²

Both Elizabeth and Margaret spent considerable periods in the asylum; Elizabeth was there from 1867 until 1879 and Margaret from 1875 until 1884. Both were discharged back to the workhouse and were not classed as 'recovered' but rather 'relieved'. What is unclear is whether this was due to their mental health or because they had nowhere else to go. Also, when Margaret was discharged in 1884, both her sister and brother were in the workhouse, so it may have seemed natural for her to go there.¹¹³ We do not know what she felt.

What is apparent from the medical notes is that although poverty may have played a part in the causes of their admissions (the other obvious cause being the death of their mother) they

¹⁰⁹ Admission book BRO 40513/C/3/13, 65. Admitted 29/9/1896, discharged (died) 28/11/1900.

¹¹⁰ '1871 England Census,' Ancestry, accessed May 23, 2016, <http://search.ancestry.co.uk/search/db.aspx?dbid=7619>.

¹¹¹ See the excellent website on workhouses, The Workhouse; '1881 Census: Residents of Bristol City Workhouse, Stapleton, Gloucester, England,' The Workhouse, accessed March 17, 2014, <http://www.workhouses.org.uk/Bristol/Bristol1881.shtml>.

¹¹² Admission book BRO 40513/C/3/8, 6 for Margaret. Admitted 15/6/1875, discharged (relieved) 15/5/1884. and Admission book BRO 40513/C/3/6, 97 for Elizabeth. Admitted 25/4/1867, discharged (relieved) 17/9/1879.

¹¹³ *Ibid.*

were not admitted for social reasons. They were admitted because they were mentally unwell. The causes of their mental conditions are unknown but social causes, family tensions and genetic disposition may have all played a part. It was, however, their mental symptoms that caused them to be admitted. Elizabeth suffered from melancholic delusions and thought there was a coffin in her room. She also heard voices. Margaret had delusions of a more elevated kind: she told the doctors she was the Queen and had a palace in London. In 1877 she announced she had abdicated and was now Margaret Reardon.

The two sisters' mental states were probably little different when they were in the asylum than in the workhouse. They caused few problems in the asylum except on 1 October 1875, when they had a fight. For most of the time there are few entries, but they both helped out on the wards.¹¹⁴ Their stories show how the asylum and workhouses both cared for those with mental health problems. The asylum took people from the workhouse when they became acutely unwell and they returned to the workhouse when they were stable or perhaps because the asylum was becoming overcrowded and beds were needed.

The Private Patient

The distinction between the private and pauper patient has been seen by Scull as, 'reflecting accurately the basic class divisions of Victorian society'.¹¹⁵ Others, such as Lorraine Walsh, have refuted this idea and suggested the basic division was between the 'respectable' and 'non-respectable'.¹¹⁶ This division may have some uses but who decides who is respectable? In the Bristol area, the division between the pauper asylum and the private asylums was clearly viewed as based on very distinct class divisions. The private Northwoods Asylum in north Bristol advertised itself as 'An establishment for the Reception and Cure of a limited number of insane

¹¹⁴ Ibid.

¹¹⁵ Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London: Allen Lane, 1979), 355.

¹¹⁶ Lorraine Walsh, 'A Class Apart? Admissions to the Dundee Royal Lunatic Asylum,' in, *Sex and Seclusion, Class and Custody*, eds. Andrews and Digby, 249–271.

patients from the Higher Classes of Society'.¹¹⁷ Indeed, at the private Brislington House, founded by the esteemed Edward Long Fox, they divided their private patients into three classes, which were strictly separated.¹¹⁸ The Bristol Asylum was termed a 'pauper asylum', but it had some private patients who provided a useful addition to the financial support from the local council. Our database identifies 130 patients as private, however this is an underestimate of their numbers as for some years they were not identified as private, so the actual number was probably between 160 and 200 or between 3–4 per cent of the population.¹¹⁹ How then did these people compare to the general asylum patients? Perhaps surprisingly, the differences are not as great as might be imagined. Fig. 24 shows that in terms of occupation there were differences between the private patients and the rest of the patients but they were not that dramatic. Those private patients with professional occupations amounted to only 8.5 per cent, compared to 5.4 per cent of the rest. A number of the private patients had occupations of fairly low status. There were three servants, three labourers and many with occupations such as shoemakers, clerks and tailors, who might be seen as 'respectable' working class. Only 11 had occupations considered 'professional' and only three identified themselves as 'gentlemen'.¹²⁰ This group, though undoubtedly on average wealthier than those identified as 'paupers', could not be considered as representative of the 'higher classes' who populated Northwoods. In terms of where they lived there were more from Clifton than Bedminster but Fig. 25 shows that still nearly 10 per cent lived in working class Bedminster. They seem a disparate group and can perhaps be better understood when we look at individual cases, as there were many differing reasons why these people ended

¹¹⁷ 'Northwoods Asylum BS36,' Paul Townsend, accessed February 25, 2014, <http://www.flickr.com/photos/brizzlebornandbred/10097423535/>.

¹¹⁸ Leonard Smith, 'A Gentleman Mad-Doctor in Georgian England: Edward Long Fox and Brislington House,' *History of Psychiatry* 19 (2008): 163–183.

¹¹⁹ Figures from database category 'private'.

¹²⁰ Figures from database category 'occupation' and the private patients being identified after their name with (p).

up at our asylum. Some were too violent for the private asylums to cope with and some may have had enough money for the asylum's private fees but not for Northwoods or Brislington.

Patient type	Agricultural	Commercial	Domestic	Industrial	Non-productive	Professional	Unknown	N/A
Private	3.10%	11.63%	7.75%	20.93%	43.41%	8.53%	2.33%	2.33%
General population	1.93%	9.85%	12.96%	39.66%	26.56%	5.41%	2.44%	1.18%
Workhouse	1.18%	6.20%	17.43%	38.55%	30.28%	2.51%	2.36%	1.48%

Fig. 24 Occupational categories of private patients, the general asylum population and those from the workhouse¹²¹

Patient type	Bedminster	Clifton
Private	9.16%	12.98%
General population	12.93%	8.67%
Total of the asylum	12.83%	8.78%

Fig. 25 Residence of private patients and general population, selected areas¹²²

Frederick William Pullin

Frederick William Pullin was a private patient, a clerk from St Andrews. According to his father he had been quite normal until he was told of the death of a cousin of his. He became very agitated, delusional and violent. On admission to the asylum it took four men to hold him down. Shortly after, he broke all the furniture in the room. Someone with that degree of agitation would probably not have been accepted by the genteel Brislington or Northwoods asylums. His family were obviously not that wealthy and four months after his admission he was transferred to the pauper list.¹²³ A few months later he developed very bad swellings on his face and died shortly after, with the cause being given as Erysipelas Septicaemia (an acute streptococcal infectious disease of the skin).¹²⁴

Some of the private patients were placed there by the courts and others were basically not that wealthy but found enough money to pay the fees. These latter cases did not want to be

¹²¹ Pivot table from database using the categories 'workhouse', 'private' and 'occupational category'.

¹²² Pivot table from database using examples from the category 'parish' and the category 'private'.

¹²³ Admission book BRO 40513/C/1/5, 53–56.

¹²⁴ Admission book BRO 40513/C/2/7, 114. Admission 13/6/1885, discharge (died) 28/2/1886.

considered 'paupers'; they wanted to be 'respectable'. It is significant that Walsh's study looked at an asylum that took both pauper and private patients and in such an establishment the desire for 'respectability' seems a useful division, but when comparing our asylum with Northwoods or Brislington class divisions seem very considerable.¹²⁵ According to the Visitors Committee, the private patients were charged £1 per week (in 1863) and 'the only advantage over the general body of the paupers is that they sleep in single rooms furnished in a somewhat superior manner, having a carpet and a chest of drawers'.¹²⁶

In the early years of the asylum several private patients were admitted who must have come from a reasonably wealthy family but had no occupation and were classed as 'idiots' or 'imbeciles'.¹²⁷ This may have been because the private asylums would not take them. In later years there are no such cases, perhaps because a private institution had started to specialise in such people. In general we can conclude that Scull's assertion about the difference between private and pauper patients was correct for those patients in private institutions but problematic for the private patients in the Bristol Asylum.

Ann Luton

Ann Luton was a 60-year-old widow who had two admissions to the asylum between 1879 and 1882. She was a private patient but was convinced she was about to be sent to the workhouse, although in reality she had over a thousand pounds. This conviction so alarmed her she tried to commit suicide by cutting her throat. She also believed she was being robbed and her house was on fire. Her admissions were quite brief and she soon was discharged. Her case shows, firstly, the fear of the workhouse and, secondly, that although her background was very different to most of the other patients, she still suffered from psychiatric symptoms similar to those of the general asylum population (see Chapter 5).¹²⁸

¹²⁵ Walsh, 'A Class Apart?' 250–251.

¹²⁶ Bristol City Council meetings minutes, February 21, 1863, BRO M/BCC/MEH/3/1.

¹²⁷ See database categories 'private' and 'diagnosis'.

¹²⁸ Admission book BRO 40513/R/2/4. Admitted 25/8/1880, discharged 2 (recovered) 2/3/1881.

Alcibiades Adalbert Kenrick

The case of the exotically named Alcibiades Adalbert Kenrick perhaps illustrates the diversity of the private patients, that their class was often difficult to determine and perhaps their main connection being a determination to avoid the term 'pauper'. Alcibiades was admitted to the Bristol Lunatic Asylum on 21 December 1879 and transferred to another asylum in May of the following year. His time in Bristol was a short, but by no means minor, episode in a chaotic and colourful life, which was dramatised in a court case brought about whilst he was in the Bristol Asylum. The case sought to determine his sanity and whether he was capable of managing his own affairs. It was instigated by his long-suffering wife who had suffered financially from his various escapades, often being left with the children and no means of support.¹²⁹

He was born in about 1842, the illegitimate son of a well-to-do woman with whom he lived in Twickenham. He met and married his wife Agnes Huggins in 1865 and this was the start of a tempestuous relationship during which he seems to have treated his wife appallingly, leaving her several times to go wandering. On one occasion he took her small inheritance with him. Whether his treatment was due to a feckless nature or a paranoid illness is unclear. By the time of his admission he had left her several times and had fathered six children, four of whom died very young. He had received two convictions for theft, served a spell in the army and between 1870 and 1871 was resident in the Hanwell Lunatic Asylum. His wife, minus her small inheritance taken by her husband, became destitute and entered a workhouse.¹³⁰ She must have recovered financially somewhat by the time of the court case, as she hired a private investigator to look into her husband's affairs.¹³¹

In the Bristol Asylum he was clearly thought of as suffering from some form of paranoid illness. On admission he was described as having 'a very suspicious air and all the voluble

¹²⁹ Admission book BRO 40513/C/1/9, 65. Admitted 21/12/1879, discharged (transferred) 14/5/1880.

¹³⁰ 'Lunacy Inquiry at Stapleton: Extraordinary Conduct,' *Bristol Mercury and Daily Post*, March 18, 1880, 3.

¹³¹ *Ibid.*

incoherence of delusional insanity'.¹³² In the court case (well publicised by the newspapers) the testimony of Dr Thompson, the Medical Superintendent, was vital. He described how Alcibiades wrote numerous letters daily (sadly unavailable to us) and read out a couple in court. One described how he had sent considerable sums of money to 'the Horse Guards, the Life Guards and institutions' in order to obtain his release. This could not have been true as he had no money at the time and much of the evidence in court and the ward notes suggest delusional thinking. However, Alcibiades produced two other doctors who claimed that 'they did not discover any unsoundness of mind' and that his behaviour was due to the pressures put upon him. In court he seems to have made a fairly good impression and although the verdict went against him and he was declared insane, it was only by a majority of 12 to 8.¹³³

He must have been devastated by the verdict but on the ward he continued to affirm his sanity and he alternated between stressing his wife's infidelity (with a Mr Fitzgerald of the Civil Service) and trying to win her back. This seems to have been unsuccessful and the 1911 census shows her living with her grandchildren.¹³⁴ During his stay most of the case note entries, apart from the odd mention of the state of his bowels, refer to his obsessive letter-writing. These were sent to numerous different people, mostly of very high rank, such as the Prince of Wales. He claimed to know these people but that seems unlikely. He seems to have played little part in the daily running of the ward, did no work and did not seem to attend any of the entertainments.¹³⁵ He may have thought himself above all that. After being transferred to another asylum (name unreadable) his story is unclear but he lived until 1923 and left the considerable sum of £4981 8s 10d to his son Sidney who was a confectioner.¹³⁶

¹³² Admission book BRO 40513/C/2/6, 65.

¹³³ 'Lunacy Inquiry at Stapleton: Extraordinary Conduct,' *Bristol Mercury and Daily Post*, March 18, 1880, 3.

¹³⁴ '1911 England Census,' Ancestry, accessed May 23, 2016, <http://search.ancestry.co.uk/search/group/1911uki>.

¹³⁵ Admission book BRO 40513/C/2/6, 66–68.

¹³⁶ *Ibid.*

Alcibiades was by no means a typical patient and is very difficult to classify. His notes suggest why the Bristol psychiatrists thought him insane but it is also easy to sympathise with the members of the jury who dissented from that opinion.¹³⁷ He thought of himself as upper class but he had no money at that time and his wife had been in the workhouse. The fact that he left nearly £5000 in his will shows he must eventually have acquired wealth but his case shows how criteria for measuring class are often misleading and a description of his background seems to be more instructive than categorising his condition. Did the asylum treat him differently because of his background? The attendants may have resented his airs and graces and the medical staff may have been more deferential, but the evidence is scarce.

Conclusions

This chapter has mainly been concerned with the background of those committed to the asylum. Historians such as Scull have argued that the asylums were a dumping ground for the inconvenient poor.¹³⁸ In some ways this seems self-evident: these were 'pauper asylums', however, authors such as Bartlett show that in some ways the term pauper was an administrative convenience.¹³⁹ Laurence Ray and John Walton have questioned the idea that these patients were part of an underclass and argued that the patients came from a fairly wide set of backgrounds.¹⁴⁰

The results of this work are broadly in line with the work of Ray and Walton. The advantage of our methodology is that we have been able to look at the composition of the asylum population from several perspectives. Most authors, such as Pamela Michael, have just looked at occupation when examining the background of patients and it is often unclear as to the

¹³⁷ G.E. Berrios, 'Historical aspects of psychoses: nineteenth century Issues,' *British Medical Bulletin* 43(3) (1987): 484–494.

¹³⁸ Scull, *Museums of Madness*, 240.

¹³⁹ Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England* (London: Leicester University Press, 1999), 1–32.

¹⁴⁰ Laurence Ray, 'Models of madness in Victorian Asylum Practice,' *Archives of European Sociology* 22 (1981): 229–264; John Walton, 'Casting out and bringing back in Victorian England: pauper lunatics, 1840–1870,' in *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. II*, eds. W.F. Bynum, R. Porter and M. Shepherd (London: Tavistock, 1985), 132–146.

methodology and sample size which have been used.¹⁴¹ With our methodology we can assess all 5,000 patients in terms of their occupation and also look at where they lived, their education, age and gender.

The results for employment produced a huge diversity of occupations which were not dissimilar to those found in the census for Bristol. Although there were not people from the upper echelons of society, those who might be termed as from the lower status professions, mostly teachers and nurses, were well represented. The results for education were difficult to compare with those of Bristol, as the methodologies differed, but the vast majority of patients were classified as being able to read and write. The patients came from all areas of Bristol, although some of the very poor central areas seemed to be over-represented. These, however, were only a small percentage of the admissions. Towards the end of our period more elderly patients were admitted, but there was generally a wide range of ages. Lastly, in terms of gender, the numbers of admissions were almost exactly equal, but the higher death rate for men resulted in a preponderance of female long-term patients. To summarise, it could be said that the patients were ordinary, they did not include the wealthy but they did include a fairly wide range of Bristol's population in terms of class, age and gender. What made them less than ordinary was their mental suffering, which will be examined in Chapter 5.

There are, however, two groups of patients who, although not homogenous entities, did differ statistically from the general asylum population. These were the private patients and those admitted from the workhouse, groups who could be considered to be at the opposite ends of the social scale. The private patients were generally from more privileged backgrounds and many from the workhouse were poor but the differences were perhaps not as marked as might be expected. The private patients were a fairly diverse group and many patients from the workhouse

¹⁴¹ Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800–2000* (Cardiff: University of Wales Press, 2003), 89.

had been admitted there purely for reasons of insanity. The stereotype of the impoverished pauper admitted to the asylum did exist but these patients were certainly in a minority.

What do these results tell us in terms of how typical Bristol's asylum was? Comparing our results with other studies presents some problems. Many studies offer little in the way of statistical analysis and although this study's ability to compare several categories simultaneously is significant in terms of originality it does make comparisons more difficult. Also as Walton points out the nature and number of admissions was dependent on a several local factors. Some county asylums had no private patients whilst others like Bristol did.¹⁴² The number of lunatics placed in workhouses varied with rural areas less likely to have an available workhouse.¹⁴³ Some albeit tentative comparisons can nonetheless be made. Our table of the ages of those admitted (Fig. 1) is remarkably similar to that produced by Walton with the ages 30 to 40 being the most numerous in both cases. The work of Melling and Forsythe on the Devon Asylums offers a number of useful comparisons, as their use of statistics is fairly sophisticated and quite similar to that of this study. The occupational statistics they produce are different from our own as Devon was a much more rural area than Bristol and thus there were more agricultural labourers there. What is similar is that both studies conclude that, apart from a few occupational groups such as servants, the asylum population was not that different from their local area.¹⁴⁴ In terms of gender and marital status, Melling and Forsythe's results are very similar to our own. The Devon results do show a higher proportion of single women but both studies show that a patient was most likely to recover if she was a married woman and least likely if he were a single man.¹⁴⁵ In terms of a statistical analysis of the composition of the Asylum population our results do show a high degree

¹⁴² Ibid. 12.

¹⁴³ Walton, 'Lunacy in the Industrial Revolution', 11-13.

¹⁴⁴ Melling and Forsythe, *The Politics of Madness*, 152-157.

¹⁴⁵ Ibid. 105, our results from a pivot table from database using categories 'sex', 'marital status' and 'result'.

of typicality at least from the studies from which a meaningful comparison can be made. Other areas such as diagnoses need to be compared to further test typicality.

Chapter 4: The Patients' Experiences of the Asylum

Among the many signs of progress and improvement...perhaps there is none more striking or more creditable to our humanity, than the change which has taken place in the manner in which the poor lunatics of our country are treated. Up to a few years ago the law of treatment adopted...was one more of cruelty than kindness and the best means of cure were thought to be found in dark cells, handcuffs, solitary confinement, and frequent punishment...

But all that is changed now the lot of the lunatic, though still a pitiable one, is being alleviated in every possible way. Instead of being cursed or scolded, lunatics now hear kindly coaxing words and are spoken to with a remembrance that, though their minds have gone or are clouded, they are still human beings. The clunk of fetters has been superseded by the sound of the piano, and instead of the clunk of handcuffs they hear the merry strains of the violin.

Flowers and flags and gay hued bright lighted rooms have taken the place of the dark cells and the prison stocks. The dietary fare is good and abundant and were it not for the fact of their loss of reason many a man might be tempted to exclaim, **'Who would not be a lunatic?'**

– Bristol Mercury, 1864¹

Thus the readers of the *Bristol Mercury* were presented with the life of a lunatic in the recently opened Bristol Lunatic Asylum. The piece is probably factually correct; it's certainly smug and patronising but it is also an antidote to the sometimes jaundiced views of later commentators.² It also shows some of the ways by which the asylum tried to help, manage and

¹ *Bristol Mercury*, January 28, 1864.

² By the end of the century newspaper reports did not seem to cover patients' entertainment but rather concentrated on less savoury stories, such as the story of the Bristol Asylum patient who threatened to kill the Prince of Wales: *Morning Post* (London, England), March 24, 1884: 6.

control their patients, which will be the subject of this chapter. Alternative voices such as that provided by the memoir of John Weston, which present a much harsher view, will also be examined. Although the chapter's title is the patients' experiences, it is about their experience of the *asylum*; their experiences which resulted from their *illnesses* will be examined in the next chapter.

Work and the Asylum

'My doing something was spoken of: "Would I like to try?" "Oh yes," I replied, "Anything. I could pick up stones or paint something".'³ Thus John Weston in his vivid account of life in the Bristol Asylum begins his account of occupation in the asylum. He found work in the asylum as a blessed distraction from the infirmary ward where he had been placed. He wrote, 'I could only sweep, sweep, sweep and dust, dust, dust as a safety valve to my distracted thoughts' and 'with my outdoor work I was now fully occupied from six in the morning till seven at night'.⁴ Thus work or occupation formed a major part of John's experiences of the asylum. John was not typical; he was a skilled sign painter, an ability the asylum put to good use and his energy, which may or may not have been related to his diagnosis of mania, enabled him to pursue an onerous workload. Most patients did less and many did nothing, either because of illness, psychological problems or lack of opportunity.

The idea that work is beneficial to those with mental health problems has a long and contentious history. This idea was one of the cornerstones of the Moral Treatment movement. Samuel Tuke, the son of the York Retreat's founder, William Tuke, claimed in 1813 that 'regular employment was proclaimed the 'most efficacious intervention in inducing recovery'.⁵ W.A.F. Browne, a leading advocate of Moral Treatment shared this view and suggested rather

³ John Weston, *Life in a Lunatic Asylum* (London: Houlston and Wright, 1867), 33. He was admitted to the asylum 17/6/1864 and discharged (recovered) 1/6/1866, BRO 40513/R/1/2.

⁴ *Ibid.* 79.

⁵ Samuel Tuke, *Description of the Retreat, an Institution near York, for Insane Persons of the Society of Friends* (York: W. Alexander, 1813), 156.

optimistically that 'they (the patients) literally work to please themselves and having once experienced the possibility of doing this and of earning peace, self-applause and the approbation of all around, a difficulty is found in restraining their eagerness and moderating their exertions'.⁶ These ideas were based on a combination of a belief in self-reliance and capitalist self-interest. The proponents of Moral Treatment thought self-discipline was the cornerstone of recovery from madness and that a combination of work, leisure and worship should form the patient's therapeutic programme.⁷ This was unlike the workhouse where the inmates had to work at tasks that were deliberately unpleasant and demeaning.⁸ Foucault, writing in the 1970s, had a very harsh view of the place of work in the York Retreat, claiming that in a capitalist system 'work possesses a constraining power superior to all forms of physical coercion, in the regularity of the hours, the requirements of attention, the obligation to produce a result, detach the sufferer from a liberty of mind that would be fatal and engage him in a system of responsibilities'.⁹ Undoubtedly the Retreat fostered the idea that idleness was 'incompatible with a meaningful life',¹⁰ but Foucault's criticism applies to any worker in a capitalist system. It also begs the question as to what Foucault would put in its place. In the 1950s and 1960s many mental hospitals, including Barrow in Bristol, closed down their farms and workshops because they were considered exploitative. The personal experience of the author suggests this led to many and probably most patients doing very little all day with many finding the occupational therapy that was offered demeaning or childish.¹¹

⁶ W.A.F. Browne, 'What asylums were, are, and ought to be', being the substance of five lectures delivered before the managers of the Montrose Royal Lunatic Asylum 1837,' Internet Archive, accessed January 23, 2016, https://archive.org/stream/whatasylumswarea02brow/whatasylumswarea02brow_djvu.txt.

⁷ Louis C. Charland, 'Benevolent theory: moral treatment at the York Retreat,' *History of Psychiatry* 18(61) (2007): 66.

⁸ Jennifer Laws, 'Crackpots and basket-cases: a history of therapeutic work and occupation,' *History of the Human Sciences* 24(65) (2011), 68.

⁹ Michel Foucault, *Madness and Civilization* (London: Random House, 1965), 247.

¹⁰ Charland, 'Benevolent theory,' 67.

¹¹ See note on author's personal experiences in the Introduction.

Historians' views on the motives behind the provision of work programmes in asylums vary. Jonathan Andrews has suggested that at the Bethlem Asylum, the motives were mostly financial in that they reduced the need for staff, whilst David Mellett emphasises the control which the discipline of work produced.¹² James Gardner, in his study of the Sussex Lunatic Asylum, has researched the financial aspects in some detail and concluded that the financial gain was considerable, adding about £1500 a year to their income. He does point out that much of this work went towards improving the asylum environment.¹³ Leonard Smith takes a different view suggesting that 'if there was a significant advance in treatment in the early county asylums it came with the introduction of work as a therapeutic agent'.¹⁴ My research on Bristol suggests that Smith's view is probably correct but that this does not contradict the other writers' views. The motives of those in charge of the asylum might have been mercenary; the results were not.

We also have to consider what constituted work in the asylum, how therapeutic the activity was for the patients and how beneficial it was for the institution in both financial terms and in pleasing its regulators. The Bristol Asylum was heavily influenced by the Moral Treatment philosophy that work was therapeutic, and though this idea was never entirely discarded, the financial merits of patients' work probably played a more significant role in the later years. The yearly reports always consider how much work the patients were doing.¹⁵

At the asylum the majority of patients did some sort of work: the 1894 Superintendent's Report shows that out of the 652 patients about 448 worked on most days.¹⁶ The financial gain from this work would have been greater than the £1,500 identified at the Sussex Asylum as there

¹² Jonathan Andrews, 'Hardly a Hospital but a Charity for Pauper Lunatics,' in *Medicine and Charity before the Welfare State*, eds. J. Barry and C. Jones (London: Routledge, 1991), 75; David Mellett, *The Prerogative of Asylumdom: Social, Cultural and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth Century Britain* (London: Taylor and Francis, 1982), 26–27.

¹³ James Gardner, *Sweet Bells Jangled Out of Tune: A History of the Sussex Lunatic Asylum (St Francis Hospital) Haywards Heath* (Brighton: Gardner, 1999), 115.

¹⁴ Leonard Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* (London: Leicester University Press, 1999), 227.

¹⁵ Wellcome Library: WLM28.BE5B86, 1862–1868, 1870–1889 and 1890–1898.

¹⁶ Medical Superintendent's Report 1894, BRO 35510.

were more patients doing work in Bristol and wages had risen since the Sussex calculation. This equates to approximately £3,300, which is about 11 per cent of their total budget for 1894.¹⁷ This work varied enormously. Over two hundred were employed as ward helpers which involved sweeping and tidying the ward and probably bed-making. This would not take that long and would have mostly been done by those who were not physically or mentally able to undertake the more demanding work. Those who worked on the ward but could do the more demanding jobs, such as scrubbing the floors, were, according to John Weston, favoured by the attendants who sometimes turned a blind eye to their bullying of other patients.¹⁸ The work was strictly segregated along gender lines, the only exception being the two men who worked in the kitchen and three in the laundry. Men did all the farm and garden work, whilst 85 women were employed doing needlework.¹⁹ Some of the work, such as in the tailor's, would have required specialist skills. Hubert Stagg, whose story is told in Chapter 6, was a patient and a tailor by trade. During each of his four admissions he worked in the tailor's shop as soon as he was well enough. Anne Shepherd, in her study of different types of asylum, shows how work was segregated by class as well as gender with the more genteel female patients being given work that befitted their class and thus did not include hard physical work.²⁰

John Weston was a sign painter and as such had access to prohibited areas, such as the women's wards where his wife was based. When he was first allowed into these wards he met the matron who greatly impressed him and he described the kindness shown to him by her as 'a sweet smelling bouquet refreshing my thoughts'.²¹

¹⁷ The budget was £25,581, *ibid.* These figures are based on a 30 per cent rise in wages which are obtained from the 1862 and 1894 reports, Wellcome Library: WLM28.BE5B86, 1862–1868 and Medical Superintendent's Report 1894, BRO 35510.

¹⁸ Weston, *Life in a Lunatic Asylum*, 33–34.

¹⁹ Medical Superintendent's Report 1894, BRO 35510.

²⁰ Anne Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums,' in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (Amsterdam: Rodopi, 2004), 241.

²¹ Weston, *Life in a Lunatic Asylum*, 91.

Many patients who recovered after a fairly short admission did work in the period prior to discharge and this seems to have been one of the criteria by which their suitability for discharge was judged.²² Edward John Seymour was a 22-year-old draper's assistant who had been suicidal on admission, but improved quickly and began working in the asylum shop. Shortly after, the Visitors recommended his discharge.²³ For other long-term patients, they would work when well enough and this work seems to have been less a means of proving your sanity than a way of passing the time and feeling more useful. John Longman, whose story is told later in this chapter, was for much of his admission too disturbed to be able to work but in his later years this changed and he worked in the tailor's and then the shoemaker's.²⁴ From Foucault's perspective this could be seen as the institution finally exerting control over him, however, his quality of life probably improved and work gave his existence some meaning. For patients such as John Longman, it is difficult to assess whether the work helped them or was merely an indication that their mental state had improved.

Males		Females	
Employed in:		Employed in:	
Garden or Farm	40	Laundry	24
Stores and Cellar	8	Kitchen	23
Kitchen	2	Dwelling Houses	1
Bake house	1	Dressmaking	10
Laundry	3	Needlework	85
Tailor's	3	Stoking mending	0
Shoemaker's	4	Ward Helpers	103
Upholsterer's	17		
Ward Helpers	123		
Total Employed	201	Total Employed	246

²² Interestingly, currently in the NHS, psychiatric treatment is usually only provided for people who cannot work. This evidence is only anecdotal, not official policy, but comes from a variety of reliable sources, including the author's GP.

²³ Admission book BRO 40513/C/2/4, 93. Admitted 13/4/187 discharged (recovered) 11/7/1871.

²⁴ Admission book BRO 40513/C/2/5, 110. Admitted 9/2/1877, discharged (recovered) 28/3/1877.

Fig. 1 Number of patients employed on 31 December 1894²⁵

Leisure in the Asylum

‘Last night a handsome girl played a long and difficult fantasia in the ballroom in a brilliant style. Then the young Indian soldier volunteered a song accompanied by me.’²⁶ This excerpt from a letter from the patient Arthur Nichols to his mother illustrates a facet of the leisure activities which the asylum provided. For those like Arthur these activities would have been appreciated. However, it illustrates the type of entertainment those in charge felt would be good for the patients. The unsophisticated patients needed to be uplifted by a middle-class version of culture. Perhaps some were uplifted whilst others felt patronised.

In the nineteenth century, the concept of leisure as an essential facet of a modern community became an idea that was fostered amongst the elite in cities such as Bristol.²⁷ This was welded to ideas of citizenship and community. Thus the advocates of Moral Treatment saw the provision of leisure activities as an adjunct to the provision of work and therefore would attempt to turn their communities into facsimiles of a modern city where good bourgeois values could be fostered. Although it cannot be denied that many patients through choice or illness did not partake in any of these activities and did very little all day, the asylums did make strenuous efforts to provide several types of activity. Susan Marshall’s study of Mendip Hospital, though uncritical to the point of naivety, describes the numerous balls, concerts, games and sports which, in her description, makes the place seem like a holiday camp.²⁸ Although such an emphasis ignores both the rigid control imposed on the patients and their suffering from their illnesses, these activities did occur and were probably well appreciated.

²⁵ Figures from 1894 Superintendent’s report BRO 35510.

²⁶ Admission book BRO 40513/C/2/7, 33, undated letter probably 1884–5. The patient was Arthur Nichols, an artist.

²⁷ Helen Meller, *Leisure and the Changing City, 1870–1914* (Boston: Routledge & Kegan Paul, 1974), 5–7.

²⁸ Susan Marshall, *Mendip Hospital: An Appreciation* (Ely: Melrose Press, 2006), 129–139.

At the Bristol Asylum similar pursuits were provided and the report for the year 1894 shows that the vast majority had some kind of outdoor exercise and about half attended the weekly concert.²⁹ The activities provided increased over time: in 1864 bagatelle and a skittle alley was provided, billiards were introduced in 1884, croquet in 1892 and bowls in 1896.³⁰ They had a small library and a number of sports activities, including cricket, were encouraged. The aforementioned Hubert Stagg is noted as attending cricket practice in 1899.³¹ The asylum had a cricket team made up of staff and patients and in 1888 managed to easily defeat a team led by W.G. Grace, the foremost cricketer of this or any other age, despite Grace taking 8 wickets for 29 runs.³²

Not all the activities were physical and the asylum had a library with 500 books which was overseen by the hospital chaplain. Patients were also provided with copies of magazines, including *Punch*, *Temple Bar* and *Harper's*, which were provided by philanthropic women.³³ This can be interpreted as providing a middle-class culture and most may have preferred a copy of *The Sporting Life* but many patients were quite well educated so they could have been responding to requests.³⁴ Also, anything that distracted and interested a patient was usually considered beneficial.

The patients were mostly confined to the asylum but there were some visits to places outside, presumably for those who did not present a risk of absconding. The report of the Visitors for 1865 notes that the chaplain took a large party of female residents to his house in Clifton and afterwards they visited the Bristol Zoological Gardens, and that year there were also visits to the Suspension Bridge, the Industrial Museum and the Rifle Drill Hall. These visits were in part the

²⁹ Medical Superintendent's Report 1894, BRO 35510.

³⁰ Donal Early, *'The Lunatic Pauper Palace' Glenside Hospital Bristol 1861 – 1994* (Bristol: Friends of Glenside Hospital Museum, 2003), 29.

³¹ Admission book BRO 40513/C/2/12, 186, September 16, 1899.

³² 'Bristol Lunatic Asylum v Mr W.G. Grace Juniors XI,' *Bristol Mercury and Daily Post*, September 18, 1888, 3.

³³ Chaplain's report, Wellcome Library: WLM28.BE5B86, 1881–1898.

³⁴ James Lambie, *The Story of Your Life: A History of "The Sporting Life" Newspaper (1859–1998)* (Leicester: Matador, 2010).

asylum trying to show that patients were not merely locked away and this is evidenced by the fact that visits were reported in the chaplain's report to the Commissioners.³⁵ It is probably also true that the chaplain thought it would do them good.

Of all the asylum activities the one which has gathered the most press was their annual ball. This was always covered in the local press who tended to be very congratulatory, suggesting that the asylum was doing a wonderful job and what an amusing bunch of eccentrics the patients were. The *Bristol Times* gave a glowing report of a Ball in 1862 and commended the patients' behaviour as 'orderly and decorous'.³⁶ This extract from the *Bristol Mercury's* report on the ball of 1871 is even more complimentary:

The annual ball given for the delectation of the unfortunate inmates of the Bristol Lunatic Asylum took place on Thursday. The male inmates have formed a brass band and their performance excited and astonished the visitors including many members of the Visiting Committee. Of the 243 inmates 170 took part in the activities and there was not a single instance in which it was found necessary to withdraw a patient... Amongst the inmates we have often noticed were Green, the scripture reader, who wishes to advertise for a solicitor to recover for him a bequest of £1000, Tustin the inventor who, after patenting inventions which brought him too much money for his brain to stand, was obliged to seek the aid of the asylum, Bibby the jester, Lingard the graceful dancer and the lady with the dolls... The singing, the music and the dancing were entered into with the greatest spirit and the festival was never more thoroughly enjoyed.³⁷

This quote illustrates a number of facets of asylum life and the patronising tone of the local press. The fact that several patients formed a brass band shows commendable enterprise on their part, but also a suggestion that, by that time, they cannot have been that unwell, as it takes

³⁵ Chaplain's Report, Wellcome Library: WLM28.BE5B86, 1860–1869.

³⁶ The *Bristol Times* and Felix Farley's *Bristol Journal* June 18 1862, 8.

³⁷ 'Ball at the Lunatic Asylum Stapleton,' *Bristol Mercury*, February 4, 1871, 3.

much concentration and application to learn and play an instrument. Also, it shows they were committed to asylum life; the act of joining a brass band shows you want to fit in and that you expect to be there for some time. As the testimony of John Weston shows, it could take considerable time for someone who was fairly well to be discharged. He details his lengthy efforts to be discharged; however, we unfortunately do not possess the doctor's view on this.³⁸ The cast of colourful characters from the newspaper article can mostly be traced in the database and Lingard's profession is listed as 'comedian' but, sadly, Tustin was not an inventor; he was a tailor.³⁹ The quote also shows a voyeuristic fascination with the more colourful characters and though, as writers such as Porter have shown, this fascination can be seen as exploitative and unpleasant, however it is, in some ways understandable.⁴⁰ They were people whose illness or different sense of reality made them interesting. Whether they thought themselves to be the Prince of Wales or heard voices telling them to kill the Prince of Wales, these experiences are very different to what most of us perceive. The case of William John Donne excited the press greatly, with reports in the *Times*.⁴¹ Donne was sent to the Bristol Asylum in 1884 after threatening to kill the Prince of Wales. Donne thought that the Prince had mesmerised him and had power over his actions.⁴² The laudatory press reports are, as Gardner has shown, replicated in press reports of other asylums, such as Sussex. Such reports follow visits that were highly regulated.⁴³ Weston stated that the medics did not see the abuses that occurred and similarly the reporters would not have seen any ill-treatment.⁴⁴

For Showalter the patients' ball was 'a demonstration of the Victorian asylum's exercise of disguised control, a rigidly programmed demonstration to the world of their humanitarian regime'. In evidence she quotes a contemporary, M. Paul Janot, who noted an underlying

³⁸ John Weston, *Life in a Lunatic Asylum*, 78–85.

³⁹ For Lingard, admission book BRO 40513/C/2/3, 116; for Tustin, admission book BRO 40513/C/2/4, 73.

⁴⁰ Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2003), 62–76.

⁴¹ *The Times*, January 31, 1884, 9.

⁴² Early, *Pauper Palace*, 21.

⁴³ James Gardner, *Sweet Bells*, 162.

⁴⁴ Weston, *Life in a Lunatic Asylum*, 48.

'melancholy of the amusement'⁴⁵. Although the balls and other amusements were controlled, this is somewhat inevitable in any institution. If you are admitted to a modern hospital for a physical ailment your time there is very tightly controlled. Also, the Bristol observer did not notice an underlying sadness which may have been due to an inability to distinguish between happiness and mania. If there were, it would not be surprising; the balls were full of people with very severe mental health problems and a depressed person might make the effort to attend such a ball but might still exhibit an underlying sadness. Also, a person with mania might seem to be enjoying themselves hugely but an observer might detect that something was not quite right. It is thus probable that a perception of the patient's underlying mood would be more a reflection of their mental state, than the good or ill actions of the asylum. Janot's 'underlying melancholy' was unsurprising in a place full of people suffering from melancholia. Our two illustrations of balls at asylums show differing perspectives. Fig. 2 shows a ball at a Somerset asylum (perhaps Mendip) and is a fairly small affair. It shows a number of the patients at least trying to enjoy themselves but others looking morose, whilst the ball at Colney Hatch, which was a very large asylum, shows a large crowd of people who all seem to be having a good time. Both are presenting a viewpoint about asylums and the actual balls were probably somewhere between the two, with most people at least looking as if they were having a good time and, compared to the rest of their existence, it probably was a highlight. These pictures were produced because it was thought they would be popular. Asylums were controversial in the late nineteenth century and madness has often held a voyeuristic fascination for the general public.⁴⁶ These pictures are both a depiction of 'otherness': in the Colney Hatch picture the 'otherness' was to be patronised; in the Somerset one it was to be feared (see Chapter 6).⁴⁷

⁴⁵ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture 1830–1980* (London: Virago, 1987), 49.

⁴⁶ David Semple, *The Oxford Handbook of Psychiatry* (Oxford: Oxford University Press, 2005), 14.

⁴⁷ Sander L. Gilman, *Seeing the Insane* (Lincoln: University of Nebraska Press, 1982).

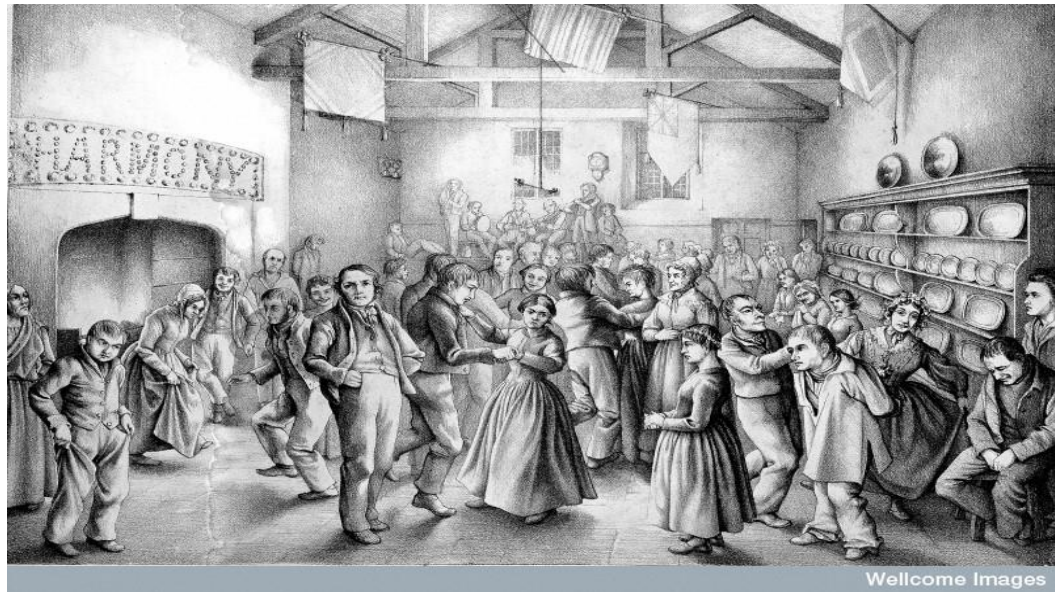


Fig. 2 Mentally ill patients dancing at a ball at Somerset County Asylum⁴⁸



Fig. 3 A ball at Colney Hatch Asylum⁴⁹

⁴⁸ Process print after a lithograph by K. Drake, Wellcome Images, accessed January 29, 2015, https://commons.wikimedia.org/wiki/File:Mentally_ill_patients_dancing_at_a_ball_at_Somerset_County_A_Wellcome_L0000508.jpg.

⁴⁹ 'Entertainment for the patients at the Middlesex County Lunatic Asylum, Colney Hatch, 1853,' Wellcome Images, accessed May 26, 2015, <http://blog.wellcome.ac.uk/2011/11/29/feature-tax-and-quacks-the-role-of-tax-in-the-development-of-modern-medicine/l0000641-colney-hatch-lunatic-asylum/>.

Certainly it could be reasonably argued that such balls were essentially an advertisement for the asylum, however, most of the leisure activities were not observed. At Bristol there was a weekly concert that was well attended. This, like a number of the activities, had an element of patronage with the middle-class doctors and administrators providing a cultural diet largely attuned to middle-class sensibilities, rather than based on their patients' mostly working-class culture. The controllers were, in part, humanitarians but they were products of their class and provided what they felt was best for the patients. This seems inevitable in a class-based system operating in an institution and was in no way peculiar to lunatic asylums or the Victorian age. Because they were humanitarian they wanted what they thought was the best for the patients. However, it seems they could only reproduce leisure activities that were a reflection of their own experiences.

Leisure activities were in part provided in order to increase a patient's social interactions. These interactions involved the patient's friends and family, the staff and other patients. Visits were allowed and Fig. 4 below shows the number of visits for 1864. This equates to about a quarter of the patients receiving visitors. Other studies do not quantify visits but Gardner's study of the Sussex Asylum, shows how Robertson, the Superintendent, restricted the number of visitors because he felt they were an encumbrance that he barely tolerated.⁵⁰

⁵⁰ Gardner, *Sweet Bells*, 120.

Month	Males	Females	Total
January	30	25	55
February	28	25	53
March	26	28	54
April	32	20	52
May	30	29	59
June	24	31	55
July	30	31	61
August	29	27	54
September	33	30	63
October	29	35	64
November	25	33	58
December	26	30	56
Total	342	344	686

Fig. 4 Number of patients visited each month, 1864⁵¹

The evidence on leisure in the asylum is perhaps misleading, as it suggests a vibrancy which was probably only a small part of asylum life. Many patients did not partake in the leisure activities and mostly did very little. A few like Arthur Nichols spent their time on self-directed activities. Arthur was an artist and spent most of his time painting and one of his works is reproduced below. This was painted for the Superintendent in 1885.⁵²

⁵¹ Figures from Wellcome Library: WLM28.BE5B86, 1862–1868.

⁵² Admission book BRO 40513/C/2/7, 33. Admitted 22/4/84. Discharged (transferred) 30/11/1889.

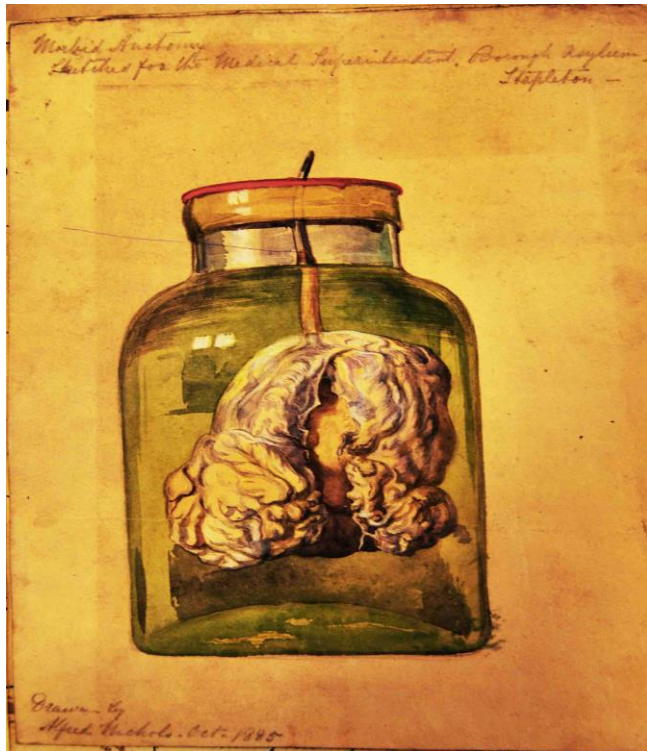


Fig. 5 Painting of unknown body part by Arthur Nichols⁵³

Certainly for those who were able and willing to join in with the patients' leisure activities life was very controlled but probably not as desperate as if they were fending for themselves.

Leisure activities can, like religion, be seen as a method of controlling a population, but there seems to have been several motives for the asylum in providing these activities. As Barbara Taylor notes, the balls were a form of advertisement for the asylums where they could bask in a public demonstration of what they were providing.⁵⁴ Many of the activities, from the balls to the provision of a library, can be seen as offering a bourgeois culture which, in line with the precepts of Moral Treatment, would be uplifting for the patients. Some leisure provisions were provided after pressure from patients. Literature was provided in Welsh after complaints from the Welsh-speaking patients who had been transferred from Denbigh.⁵⁵ Of course, many things they might have enjoyed were not provided: there were no brothels or public houses or gambling dens,

⁵³ Source: *Ibid.*

⁵⁴ Barbara Taylor, 'The Demise of the Asylum in Late Twentieth Century Britain: A Personal History,' *Transactions of the Royal Historical Society* 21 (December 2011): 213–215.

⁵⁵ Medical Superintendent's Report 1894, BRO 35510.

though it might seem absurd to suggest this. It shows that what was provided was what the authorities thought was good for them. It was a prime example of Victorian paternalism.

Gender: Seclusion, Separation and the Doctors' Attitudes

The medical journals of the asylum show which patients were placed in the seclusion room. Seclusion involved using a padded locked room.⁵⁶ These journals show that those placed in these rooms were mostly female (see Fig. 6 below). The name which occurs most often is Hannah Llewellyn. Over a number of years starting in 1873 she was regularly placed there; usually the reason given was 'excitement' or 'fighting'.⁵⁷ Hannah Llewellyn was admitted to the asylum on 13 February 1871, the admitting doctor stating, 'her mind seems given up to fear and anticipation of evil'. Her character was said to be good and her physical state was described as 'feeble and in an exhausted condition'.⁵⁸ She had injuries to her spine and head after jumping out of a window and the following day she had tried to hang herself.⁵⁹ She had been epileptic for four years and had several fits shortly after admission. She was obviously in a terrible state and continued to be suicidal, trying to strangle herself and tearing up all her clothes.⁶⁰

From 1873 her behaviour changed; her fits continued and some sort of brain damage may have been the cause of her subsequent violence. There are several pages of reports which mostly document her violence and her fits. A typical entry stated on 11 October 1881, 'excited, struck fellow patient on cheek causing it to swell, injected with morphine'.⁶¹ She also often broke things, mostly windows, and often refused food. Another entry stated, 'sinister, not destructive', which perhaps shows how the doctors and attendants could not understand her, believing if she was not being destructive there was something wrong. Her behaviour was completely the antithesis of

⁵⁶ A mock-up of a padded cell can be seen at the asylum museum; see Glenside Hospital Museum website, accessed June 2, 2014, www.glensidemuseum.org.uk. The seclusion figures are compiled from the various reports of the Commissioners: Wellcome Library: WLM28.BE5B86, 1881–1889, 1862–1869 & 1877–1880.

⁵⁷ Medical journals BRO 40513/J/7 and 40513/J/8.

⁵⁸ Admission book BRO 40513/C/3/7, 17. Admitted 13/2/1871, discharged (died) 1/11/1893.

⁵⁹ *Ibid.*

⁶⁰ *Ibid.* February 26, 1873.

⁶¹ Admission book BRO 40513/C/3/7, 26.

what they expected from women. She was often placed in seclusion, given sedation and nursed in a single room but nothing seemed to help. She does, however, seem to know what she was doing; on one occasion the doors were slightly open and her and Tripp (another regular in the seclusion room) dashed into the laundry overturning all the clothes baskets.⁶² This perhaps shows her trying to get at the institution which had imprisoned her.

In the 1890s her health deteriorated and it was reported that she 'is getting very thin, her maniacal attacks seem to be weakening her'. She died on 1 November 1893, when she was 46 years old.⁶³ The cause of death was listed as marasmus, which is a form of malnutrition. With this condition prolonged hospitalisation is listed as a risk factor and thus 'the challenging nutritional management is often overlooked and underestimated, resulting in an impairment of the chances for recovery and the worsening of an already precarious neurodevelopmental situation'.⁶⁴ Thus the asylum failed to even keep her well-nourished. Her illness and behaviour were very challenging but the institution failed to help her in any respect.

Hannah's case illustrates how gender differences were apparent in attitudes and responses to patient violence. The asylum only used mechanical restraint on very rare occasions, perhaps once or twice a year.⁶⁵ This meant that if a patient was violent or uncontrollable, their choices were to use a sedative or to place the patient in seclusion. These options are found in similar establishments; Melling and Forsythe documented that the Exminster Asylum used only opiates or seclusion for violent patients.⁶⁶ Perhaps surprisingly, this at Bristol it was used much more often on women than men, as Fig. 6 below demonstrates. Why this was so is difficult to determine; perhaps the female staff were less tolerant of violence or perhaps the male doctors viewed female violence as more alarming than male violence. From John Weston's account it

⁶² Ibid. June 12, 1880.

⁶³ Admission book BRO 40513/C/3/10, 27.

⁶⁴ 'Marasmus,' Medscape, accessed July 15, 2014, <http://emedicine.medscape.com/article/984496-overview>.

⁶⁵ Mechanical restraint book BRO 40513/C/14/1.

⁶⁶ Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845–1914* (London: Routledge, 2006), 65.

does seem that there was violence on the men’s wards, which did not lead to seclusion and which the attendants tolerated. They often used bullying and sometimes violence against the patients who were difficult. He describes the female wards and attendants in much more favourable terms and described the help the female head attendant gave him in glowing terms.⁶⁷ Later the doctor remarked what ‘a great favourite I was in the women’s wards and the Mistress reiterated the compliment’.⁶⁸ The male attendants may have physically suppressed the violence on their wards or they may have ignored it. Louise Hide also found that at the Claybury Asylum, seclusion was more often used on women. She suggests that male attendants were more likely to use violence and that ‘they may have regarded ‘seclusion’ as an ‘unmanly way of dealing with a situation’’.⁶⁹

Year	Male	Female
1868	9	3
1869	9	2
1870	12	6
1871	11	13
1873	10	28
1874	7	24
1876	3	8
1877	27	23
1878	25	32
1879	20	43
1880	11	22
1881	8	51
1882	9	27
1884	22	22
1886	10	15
1887	10	17
1891	1	6
Total	204	342

Fig. 6 Numbers of patients placed in seclusion⁷⁰

⁶⁷ Weston, *Life in a Lunatic Asylum*, 51–77.

⁶⁸ *Ibid.* 91.

⁶⁹ Louise Hide, *Gender and Class in English Asylums, 1890–1914* (New York: Palgrave Macmillan, 2014), 162.

⁷⁰ Source figures taken from medical journals BRO 40513/J/1–8. Figures for some years are missing.

Another example of the women who were placed in seclusion was Mary Anne Mawditt. She had first been admitted in 1869 after trying to drown herself.⁷¹ Her husband was also admitted a few months later but escaped from the asylum soon after.⁷² She was discharged in 1878 but readmitted about six months later and this time she seems to have been much more disturbed. She was reported as having attacked the head attendant (not a wise thing to do) and then on 14 November she pushed another patient, cutting her head, and was then placed in seclusion.⁷³ A few months later she became physically unwell and died of bronchitis and heart failure, at 67 years of age. Thus it was an elderly woman who was considered to need seclusion. If Weston's account of the differences between the attendants on the male and female wards is to be trusted, and there seems little reason for him to lie, then if Mary Anne had been male her attendants would probably have delivered a physical response which might have cowed her into behaving better. This is not to suggest that the use of violence or its threat is therapeutic. The fact that more women than men recovered (see Chapter 2) suggests it was not.

The previous chapter showed that in terms of the number of admissions men and women were very similar but women were more likely to recover. They were also more likely to remain in the asylum largely because men had a much higher death rate. This section looks at how their experiences in the asylum differed. A fundamental problem with examining this is that the evidence is largely from the exclusively male doctors who exhibited patriarchal attitudes typical of their sex and class during this period. This is shown by Fig. 7 below, which shows the doctors' views of what they termed as the moral causes of patients' admissions. It shows that female causes were mostly thought to be of a domestic or family nature, whilst the men were statistically dominant only in their drinking habits. The doctors attributed love affairs as a causal factor of their admission, mostly to females, a finding in line with Melling and Forsythe's work.⁷⁴ Of the

⁷¹ Admission book BRO 40513/C/3/6, 167. Admitted 4/1/1869, discharged (recovered) 17/12/1878.

⁷² Admission book BRO 40513/C/2/4, 19. Admitted 30/9/1869, discharged (escaped) 3/6/1871.

⁷³ Admission book BRO 40513/C/3/9, 32. Readmitted 26/9/1879, discharged (died) 30.12.1894.

⁷⁴ Melling and Forsythe, *The Politics of Madness*, 133.

other given causes all were attributed mostly to females except for drink and masturbation. Men seem to have got off lightly in that their supposed causes were at least enjoyable. If domestic problems were a common cause of female admissions, then their withdrawal from the domestic sphere could have contributed to their recovery.

Intemperance was the predominant given cause, even for women. If this figure is broken down by marital status then only 17, or 15 per cent, of women with alcohol problems were single and 76, or 30 per cent, of men were single. This could suggest that women turned to drink because of their marriage, whilst for men marriage may have curbed their drinking.⁷⁵ This finding needs further research.

Cause of admission	Female	Male	Total
Trouble	11	7	18
Religion	44	37	81
Privation	19	11	30
Overwork	14	10	24
Masturbation	0	10	10
Love affairs	15	5	20
Intemperance	111	235	346
Grief	35	17	52
Fright	19	9	28
Family troubles	11	4	15
Domestic troubles	27	13	40
Anxiety	20	20	40

Fig. 7 Moral causes of admission⁷⁶

The asylum was segregated along gender lines, with the single sex wards supposedly barred to members of the opposite sex. The impression of strict segregation is slightly repudiated by the letters of the patient Arthur Nichols, where he describes a number of meetings with females, including a 'visit to ward 4'. He also mentions 'two handsome blond females in the choir',

⁷⁵ Figures obtained from pivot table using categories 'marital status' and 'moral causes'.

⁷⁶ Ibid.

though it is not clear how much he communicated with them or was merely a lustful observer.⁷⁷ Bristol was unusual amongst asylums at the time for allowing men and women to eat in the dining hall at the same time. This study has not found any instances of women giving birth more than nine months after admission so the segregation must have been fairly successful. Gardner has noted that at the Sussex Asylum segregation actually increased during the Victorian era and Michael states that in Wales even the attendants were forbidden to mix.⁷⁸

The work done by the patients was also segregated, with women being confined to 'domestic' occupations, such as working in the laundry or kitchen, doing needlework or dressmaking. The only exceptions to this were two men who worked in the kitchen and three who worked in the laundry (see Fig. 1). Women were certainly confined to their traditional roles at a time when women were starting to work in factories, far removed from the domestic sphere. However, women such as Eliza Jane Brock, a 21-year-old factory worker, admitted to the asylum from Bedminster, were still a small minority and the conservative division of labour was not surprising as there were no females in any influential position, either in the asylum or amongst the Visitors or Commissioners.⁷⁹

From reading the case notes it is clear that the medical staff were very preoccupied with women's bodies, which they perhaps viewed with a mixture of interest and fear of the unknown. This study along with that of Melling and Forsythe did not find evidence of what Showalter suggested was the psychiatrist's preoccupation with 'sexual allure of young women', but they may have been careful to keep such desires out of the notes.⁸⁰ The doctors did, however, seem fairly obsessed with women's reproductive systems and menstrual cycles, which was then termed 'catamenia'. In some respects this preoccupation was understandable as a number of women were admitted with puerperal conditions. Harriet Paske was admitted with puerperal mania one

⁷⁷ Admission book BRO 40513/2/7, 33.

⁷⁸ Gardner, *Sweet Bells*, 78; Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800–2000* (Cardiff: University of Wales Press, 2003), 58–59.

⁷⁹ Admission book BRO 40513/C/3/12, 67. Admitted 10/8/1893, discharged (recovered) 16/4/1894.

⁸⁰ Melling and Forsythe, *The Politics of Madness*, 130.

month after giving birth and a few days later it was noted 'catamenia has resumed', which they seemed to view as a sign she was improving and she was discharged five months later.⁸¹ It was, however, the only entry and the impression is that the doctors found women's reproductive systems a thing of mystery and the cause of many of their conditions. The Bristol doctors' attitudes to female insanity seems typical of the period. One doctor named Robert Ritto advocated in 1891 the removal of ovaries as not only a cure, but also as a prophylactic treatment for certain types of insanity.⁸²

Diet and health

Charlotte Long was a 19-year-old married woman who was admitted three weeks after giving birth. She had become depressed and was refusing food. On admission, she weighed 113 pounds and as can be seen from her picture below looked very gaunt and frail. Like most patients with puerperal conditions she recovered, and was discharged six months later weighing 143 pounds and thus had put on 30 pounds of weight during her admission.⁸³

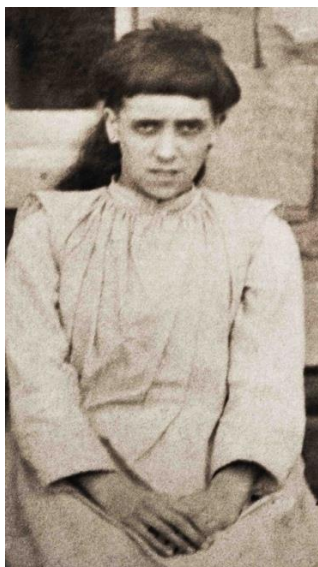


Fig. 8 Charlotte Long on admission⁸⁴

⁸¹ Admission book BRO 40513/C/3/12,49. Admitted 3/6/1893, discharged (recovered) 7/11/1893.

⁸² Robert Ritto, 'Ovariectomy as a Prophylaxis and a Cure for insanity', *Journal of the American Medical Association* XVI(15) (April 11, 1891).

⁸³ Admission book BRO 40513/C/3/12, 62. Admitted 18/7/1893, discharged (recovered) 29/12/1893.

⁸⁴ *Ibid.*

Two factors which would have been very important for any patient were the food they were given and their health. Firstly, we have to ascertain a baseline of what their pre-admission diet would have been and their physical condition. At the end of our period, influential studies of working-class poverty by Booth and Rowntree and the poor condition of recruits for the Boer War had led many contemporaries to the conclusion that the working class suffered from a very poor diet and were generally in poor health.⁸⁵ At the turn of the nineteenth century 40 per cent of recruits for the Boer War were considered unfit for enlistment. Recent work by Paul Clayton and Judith Rowbotham has, however, suggested that during the early Victorian period, working-class diets were actually quite nutritious with a large amount of fresh vegetables. They point out that mortality figures for the period are misleading, because if you omit child mortality, which was indeed high, the figures for adults are not that different from those of the second half of the twentieth century. It was only from the 1880s, with the introduction of processed food and a reduction in the price of sugar, causing increased consumption of sweet foods, that the working-class diet deteriorated.⁸⁶ The asylum's residents came from a range of backgrounds and would have been used to diets of varying quality.

The asylum assessed the health of all the patients on admission, these were categorised and tables were produced for each year's annual reports. From these we have taken the reports for the years 1862, 1880, 1894 and 1898 to evaluate the patients' health on admission and these are produced in Fig. 9 below.⁸⁷ The findings would seem to be in complete contradiction to the assertions of Clayton and Rowbotham, with the admissions for the year 1880 being in very poor

⁸⁵ Charles Booth, *Life and Labour of the People in London* (London: Macmillan, 1902) and B.S. Rowntree, *Poverty: A Study of Town Life* (London: Macmillan, 1901).

⁸⁶ Paul Clayton and Judith Rowbotham, 'An unsuitable and degraded diet? Part one: public health lessons from the mid-Victorian working class diet', *Journal of the Royal Society of Medicine* 101(6) (2008): 282. See also 'Part two: realities of the mid-Victorian diet', and Judith Rowbotham and Paul Clayton): 'Part three: Victorian consumption patterns and their health benefits' in the same journal volume, issues 7, 350-357 and 9, 454-462, respectively.

⁸⁷ 'Report of the Committee of Visitors of the Lunatic Asylum for the City and County of Bristol, together with the reports of the medical superintendent & chaplain,' Wellcome Library: WLM28.BE5B86, 1869-1880 and 1881-1898.

health, a situation which improved and by 1898 the vast majority were in fair health. There may, however, be another explanation. As we shall see in Chapter 4, the Medical Superintendents had almost complete control over the assessment of patients and they alone would have assessed the health of the admitted patients. It does seem inconceivable that the percentage of patients in fair health rose from 2 per cent in 1880 to 65 per cent in 1898 and thus it is probable that the different doctors had very different ideas as to what constituted the rather nebulous term 'fair health'. In 1880 Dr Thompson was in charge and he seems to have been a therapeutic pessimist and was considered pompous and mean.⁸⁸ This suggestion seems to be reinforced if we look at the admissions of private patients during the term of Dr Thompson. Some of the figures are not available but if we take the years 1878–1883 there were 34 private patients admitted and of these a remarkable 26 were reported as being in 'a very feeble condition'. These were people who could pay for their care and thus poverty would not have been a factor in their poor health. Some may have had very serious physical ailments but only three died within four months of admission and 59 per cent did not die in the asylum.⁸⁹ Susannah Foley Turner was a married private patient who was admitted in 1882 and described as being in a 'very feeble bodily condition'. She was suffering from mania but after four months was discharged as recovered.⁹⁰ With many of the patients' poor physical health, their condition may have been due to their mental condition rather than poverty. The Medical Superintendent's report for 1862 illustrates this and states that:

Many of the patients have been received into the asylum in a very unfavourable bodily condition; acute melancholia with suicidal impulses and obstinate refusal of food has been the predominate form of mania in a large number of recent cases. Several of these

⁸⁸ Early, *Pauper Palace*, 17–25.

⁸⁹ Figures from database for the years 1878–1883, private patients are marked with a (p) after their name.

⁹⁰ Admission forms BRO 40513/R/2/4.

melancholic patients were kept alive by artificial sustentation delivered by oesophageal tube.⁹¹

We can perhaps make few conclusions about the pre-admission health of the patients. The evidence from the Superintendents both in their reports and statistics have to be seen in the context of the differing subjective judgements as to what constituted 'fair health' and the need for them to justify themselves to the Visitors and Commissioners. Many patients were in poor health on arrival at the asylum, 225 died within a month (see Fig. 20, Chapter 3) but further reliable quantification remains elusive.

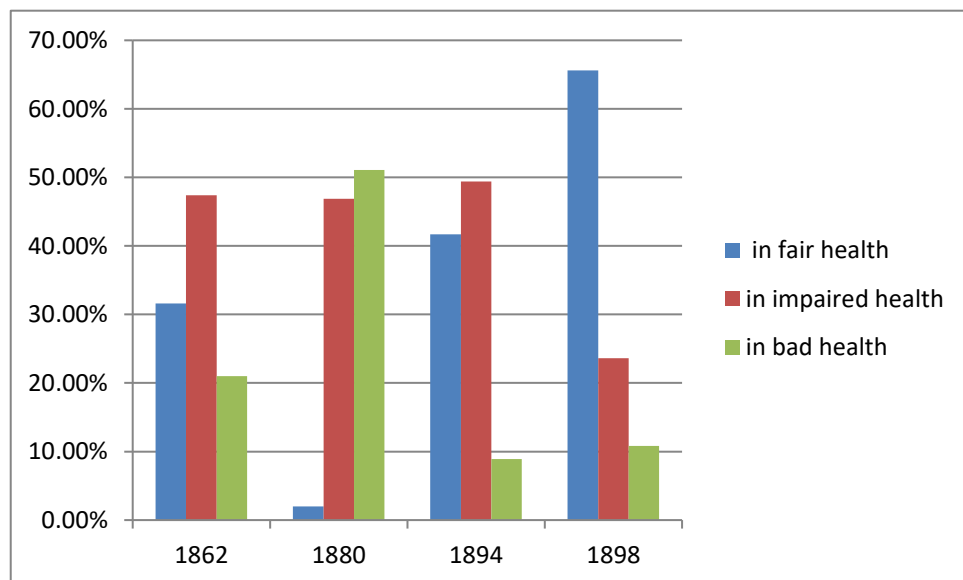


Fig. 9 Assessment of bodily health of admissions⁹²

The notes on patients generally reveal a profound concern with ensuring the patients had an adequate diet and they regularly resorted to tube feeding those who would not or could not eat. This shows the two facets of the asylum: they did care for their patients, but they were also

⁹¹ Medical Superintendent's Report 1862, 8-9 Wellcome Library: WLM28.BE5B86, 1862-1868.

⁹² 'Report of the Committee of Visitors of the Lunatic Asylum for the City and County of Bristol, together with the reports of the medical superintendent & chaplain,' Wellcome Library: WLM28.BE5B86, 1862-68, 1869-1880 and 1881-1898.

controlling. John Weston notes, 'next to striking an attendant the non-eaters seemed to be accounted the greatest sinners'.⁹³

Whatever the condition of the patients on admission, there is ample evidence of the diet of the patients during their stay. Fig. 10 below shows the diet of the patients in 1894, which seems by today's standards to be well balanced with a very good proportion of vegetables.⁹⁴ Although we cannot guarantee the quality of the cooking, the ingredients were nearly all grown at the asylum, which included a piggery, and thus would have been very fresh. The Visiting Committee and the Commissioners regularly inspected and tasted the food. Their comments were invariably favourable though as members of the Bristol elite they would generally have had much finer fare. The comments of the Visiting Committee sometimes indicated that they felt the patients were being too well fed. They noted on 7 June 1862 that the diet was so good that 'it was more than was allowed in many asylums and may partially explain the high charge... And everything should be done to economise expenditure at the asylum.'⁹⁵ The nearest to criticism of the food was in the Commissioners' report for 1870 which stated, 'judging from the untouched portion of the stew which we tasted and did not object to, it is unpopular especially with the men'.⁹⁶ These two comments show perhaps that, although both the Visiting Committee and the Commissioners were supposed to look after the welfare of the patients, the Visiting Committee also had a responsibility to the corporation and thus a financial incentive to keep costs down. Current staff of the National Health Service would recognise this parsimony disguised as efficiency.⁹⁷

⁹³ Weston, *Life in a Lunatic Asylum*, 24.

⁹⁴ Medical Superintendent's Report 1894, BRO 35510.

⁹⁵ Bristol City Council meeting minutes, June 7, 1862, M/BCC/MEH/3/1.

⁹⁶ Visiting Commissioners Report 1870, 6Wellcome Library: WLM28.BE5B86, 1869–1880.

⁹⁷ The author had numerous personal experiences of this and cannot remember an 'efficiency saving' that was anything other than a reduction of service.

Meal	Days	Gender	Diet
Breakfast	All days	Males	1 pint coffee, 7 oz. bread ½ oz. butter
		Females	1 pint coffee, 5 oz. bread, ½ oz. butter
Dinner	Sunday, Monday Wednesday & Friday	Males	5 oz. cooked meat free from bone, 16 oz. vegetables, 3 oz. bread
		Females	4 oz. cooked meat free from bone, 12 oz. vegetables, 3 oz. bread
		Males & females	1 lb fish occasionally (in lieu of meat)
	Tuesday & Thursday	Males	Meat pie (containing 4 oz. uncooked meat free from bone), 16 oz. vegetables
		Females	Meat pie (containing 3 oz. uncooked meat free from bone), 12 oz. vegetables
	Saturday	Males	1½ pints pea soup (containing 3 oz. uncooked meat), 8 oz. vegetables, 5 oz. bread and 1 oz. cheese
		Females	1 pint pea soup (containing 3 oz. uncooked meat), 6 oz. vegetables, 4 oz. bread and 1 oz. cheese
	Tea	All days	Males
Females			1 pint tea, 5 oz. bread and ½ oz. butter, or 5 oz. seed cake

Fig. 10 Patients' diet, 1894⁹⁸

Arthur Nichols in his letters to his family would comment on the food, which, considering he was from a fairly middle-class background, he mostly viewed quite favourably. A typical entry mentioned they had corned beef, sauerkraut and potatoes for lunch and seed cake and tea in the evening.⁹⁹ Many patients were undernourished when they were admitted, either due to poverty or their mental condition, and the asylum was quite successful in helping them to put on weight. This success was, however, achieved at a price; the drip-feeding of patients and the harassment of those who would not eat are evidence of the control exerted by the asylum. It can also be seen as caring, thus illustrating the two facets of the asylum which often went hand in hand. The asylum felt, sometimes erroneously, that it knew best how to treat the patients.¹⁰⁰

⁹⁸ Medical Superintendent's Report 1894, BRO 35510.

⁹⁹ Admission book BRO 40513/C/2/7, 33.

¹⁰⁰ Even Rogerian counselling, which boasts of being non-judgemental, often bullies patients into making their supposedly own decisions.

The Environment

The asylum was originally designed for 200 patients, which soon proved inadequate. Extensions were added in 1873, 1876, 1889 and 1893 which brought the number of patients up to nearly 1000.¹⁰¹ It became a large and complex institution, indeed, it had a vegetable preparation room measuring 48 feet by 27.¹⁰² Thus how the building was perceived by the patients in 1861 may have been quite different to a perception in 1900. We know little about the inside of the building but the photograph in Fig. 13, taken in 1916, does show a fairly spartan room but with large windows. The photograph can be seen as misleading, because it was taken when the asylum was a military hospital. It then housed 1460 injured soldiers and so in our period it would have housed fewer beds. The patient Nichols wrote in 1885 that he was in a dormitory with eleven other what he calls 'unfortunates'. It had three windows and could be cold at night.¹⁰³ Other patients, if they were disturbed, were given single rooms. Other evidence from the Commissioners' Reports paints a more comfortable picture, detailing how armchairs and plaster figurines were introduced in 1864 and Dr Stephens notes how the patients had painted all the day rooms and corridors what he rather confusingly calls 'a cheerful drab tint'.¹⁰⁴ In 1885 a report commented that the airing courts provided a rather monotonous walkway and more exercise in the grounds was needed.¹⁰⁵ In the plans of Fig. 11 it is also possible to detect these closed walkways or airing courts, which can still be observed today. They can either be seen as places where the patients can be observed and controlled or a sensible arrangement to allow quite disturbed people some fresh air and exercise. Weston devotes a whole chapter to these courts, describing them as a vibrant place where all patients, unless infirm, were forced to take exercise. It was:

¹⁰¹ Early, *Pauper Palace*, 9–31.

¹⁰² Bristol Plans BRO Bristolplans/arranged/41.

¹⁰³ Admission book BRO 40513/C/2/7, 33.

¹⁰⁴ Medical Superintendent's Report 1863, 12. Wellcome Library: WLM28.BE5B86, 1860–1869.

¹⁰⁵ Visiting Commissioners Report 1885, 8. Wellcome Library: WLM28.BE5B86, 1881–1898.

A kind of carnival where the fast runner, the fool, the flighty and the fop jostle each other and many an exciting scene is witnessed, some amusing, some causing pain and pity and some fierce indignation and distain. Here might be seen the self-elected king, the beggar, doctors, lawyers and parsons, merchants, painters and philosophers, along with rogues and vagabonds.¹⁰⁶

This evocative description gives a good sense of one aspect of the asylum and its sometimes fairly wild atmosphere.

The environment in which the asylum patients lived obviously affected their experiences. Authors such as Scull and Goffman have examined the relationship between insanity and place. Scull argues that a vital feature of asylum architecture was the division of space, with some spaces allocated for those who had learned to conform. The more pleasant wards and open areas were the preserve of those deemed well enough to benefit from them. Thus the asylum was categorised by space and was itself part of a learning/conforming process.¹⁰⁷ Although asylums, including Bristol, did categorise by sex, degree of infirmity and diagnosis, the reasons were often more than just a need for control. An example of this is that patients who were suicidal or unaware of their surroundings would not be able to wander around unsupervised as it would be dangerous.¹⁰⁸ Also, single sex wards have been seen as beneficial or detrimental according to the moral and cultural beliefs of the age and, given Victorian sexual mores, it was hardly likely they would be mixed during this period.¹⁰⁹ Barry Edginton argues that although abuse and control certainly existed this was never the intention of the builders and architects of the nineteenth-century asylums. He considers they owed much to the design of the York Retreat, which originated the tenants of Moral Treatment. Thus, the designers made use of space and light to

¹⁰⁶ Weston, *Life in a Lunatic Asylum*, 40.

¹⁰⁷ Andrew Scull, 'The insanity of place,' *History of Psychiatry* 15 (2004): 417; Erving Goffman, 'The insanity of place,' *Psychiatry* 32 (1969): 357–387.

¹⁰⁸ The success of this can be seen in the low suicide rate which is explored later in this chapter.

¹⁰⁹ The fashion may have changed again for single sex wards; see Gideon Felton and Suheib Abu-Kmeil, 'Was the introduction of single-sex wards a mistake?' *Mental Health Practice* 15(5) (2002): 21–24.

promote cheerfulness and facilitate leisure and work activities.¹¹⁰ Edginton may have a rather sanguine view of the Retreat but his arguments do seem to match the design of the Bristol Asylum.



Fig. 11 The asylum in 1904¹¹¹

Clare Hickman in her study of the grounds at Brislington House, the Bristol asylum for the rich, has argued that their size and picturesque elements were designed to be therapeutic, in line with Moral Treatment theories.¹¹² Although not as grand as Brislington House, the Bristol Asylum did have extensive grounds that were well landscaped, plus areas for walking and sports such as cricket. This can be observed in Figs 11 and 12. The grounds included an area for growing vegetables, a chapel and a large number of trees (see Fig. 12).¹¹³ John Weston provides a good description of the outside of the asylum and its entrance:

¹¹⁰ Barry Edginton, 'Moral architecture: the influence of the York Retreat on asylum design,' *Health & Place* 3(2) (1997): 91–99.

¹¹¹ Bristol Plans BRO Bristolplans/arranged/41.

¹¹² Clare Hickman, 'The Picturesque at Brislington House, Bristol: The Role of Landscape in Relation to the Treatment of Mental Illness in the Early Nineteenth-Century Asylum,' *Garden History* 33(1) (Summer 2005): 47–60.

¹¹³ Bristol Plans BRO Bristolplans/arranged/41.

After passing through the porter's lodge and a gateway of more than ordinary pretensions, the building is approached by a handsome drive, five hundred yards in length... The whole is within an enclosed area of about 23 acres of irregular surface situated on the borders of a ravine through which runs a small stream.¹¹⁴



Fig. 12 The Drive at the asylum, 1916¹¹⁵

It seems that some people thought the asylum too grand for the type of patient resident there: Dr Stephens commenting, 'we have to reply to the argument that the poor do not have carpets and curtains in their own homes' and he adds rather grandly that 'it is upon the endeavour to open to them in their darkened and deplorable condition, that glimmering prospect of something better from which humanity is never entirely shut out, that the chief expectation must rest in arousing in them anything allied to self-respect. That is the basis of all amendment and it is to this that unceasing effort should be made.'¹¹⁶ This does show that the Superintendent was under pressure from the Visitors (who were linked to the council) to economise and thus he needed a strong argument to resist this. It also indicates the rather patronising effort of the Superintendent to bring the comforts and standards of his class to the paupers of the asylum, in

¹¹⁴ Weston, *Life in a Lunatic Asylum*, 11–12.

¹¹⁵ 'Beaufort War Hospital, Fishponds, Bristol,' Paul Townsend, accessed February 24, 2013, <https://www.flickr.com/photos/brizzlebornandbred/6608655987>.

¹¹⁶ Medical Superintendent's Report 1863, 10 Wellcome Library: WLM28.BE5B86, 1860–1869.

the expectation that it will somehow elevate them. On the other hand, I do not suppose the residents disliked having carpets, ornaments and attending concerts.



Fig. 13 One of the wards, 1916¹¹⁷

Patients and Staff

From the memoir of John Weston:

The night attendant could, I grieve to say, be very cruel, on one occasion take the harmless muttering little preacher by the arm, twist him out of bed and punch and kick him for a slight delinquency.¹¹⁸

I shall never forget the good-humoured pleasing manner with which the female attendant greeted me and the kindness and respect shown to me by all in that part of the house.¹¹⁹

These quotes illustrate one person's views of the relations between staff and patients, that is, that some of the attendants, particularly the male ones, could often be brutal but others were kindness personified. Weston's judgements were subjective; the female attendants may have been happy to meet a polite, reasonably well, male patient and other patients might have

¹¹⁷ Source: 'Help sought to build history of war hospital,' *Bristol Post*, accessed March 17, 2012, <http://www.bristolpost.co.uk/Help-sought-build-history-war-hospital/story-20221093-detail/story.html>.

¹¹⁸ John Weston, *Life in a Lunatic Asylum*, 66.

¹¹⁹ *Ibid.* 91.

viewed the night attendant's actions as the justified quietening of a noisy patient. From the medical notes it is difficult to ascertain the nature of relationships between staff and patients. They are almost entirely written by the doctors and no doubt do not contain some of their true feelings towards the patients.

Some of their unwitting testimony is, however, interesting. The doctors' notes sometimes betray a sense of irritation. Alice Birth was a 23-year-old domestic servant diagnosed with melancholia who went on to spend over 40 years in the asylum. She seemed to frustrate and annoy the doctors. The judgemental words 'silly' and 'lazy' occur frequently as the staff tried and failed to persuade her to join in any work or leisure activity (see Chapter 6).¹²⁰ This frustration seems to have been because she was not someone with an obvious perceptual or organic disorder, and was thus someone the staff would have expected to have been able to help. There was therefore a temptation to blame this failure on the patient.

Several authors, including Leonard Smith, have noted that asylums often had great difficulty in recruiting staff of a good calibre.¹²¹ Contemporaries, including the distinguished psychiatrist W.A.F. Browne, thought that the attendants were a pretty poor bunch. He commented: 'They are the unemployed of other professions. If they possess physical strength and a tolerable reputation for sobriety it is enough though the latter quality is frequently dispensed with.'¹²²

At Bristol the recruitment and particularly the retention of staff was a problem. The Commissioners' Report for 1894 noted that over half of the staff had been in post for less than a year and thought there were problems with the attendants.¹²³ In the notes there are sometimes letters from patients which mention staff and they are usually complimentary but the derogatory ones were probably not kept, as these notes were viewed by the Visitors and Commissioners and

¹²⁰ Admission book BRO 40513/C/3/12, 165. Admission 15/11/1894, discharged (relieved) 3/6/1932

¹²¹ Leonard Smith, *Cure, Comfort and Safe Custody*, 133.

¹²² W.A.F. Browne, *What asylums were, are, and ought to be*, 150–1.

¹²³ Medical Superintendent's Report 1894, BRO 35510.

the staff would not have wanted them to see such derogatory comments. A typical letter from the patient Edward Furze, a rope maker from Bedminster, to Dr Thompson began 'I am deputed by my father in heaven to tender to you my heartfelt thanks and gratitude for your unbounded kindness since I came to this Asylum'.¹²⁴ John Weston's book paints a somewhat different picture. He is complimentary about the Superintendent, the head attendant and some of the attendants, particularly on the female side. However, much of his book deals with what he considers the coarseness, vile language, bullying and sometimes violence of certain attendants. His *bête noir* was an attendant he nicknamed 'Bumble'. He describes several acts of cruelty or unkindness by him towards the patients in the infirmary ward. He notes that when feeding patients, who could not feed themselves, Bumble would 'wrench open their mouths with the iron spoons and then toss the food down their throats as though shovelling it into a kennel and shouting, "this is the way we cram turkeys"'.¹²⁵ He summed up his feelings about the attendants:

The manner of feeding the patients, the language used, the filthy allusions and obscene retorts, attendants vying with patients in exiting the loudest laughs; the attendants' coarse bawl, the obstreperous shove, the stamping on the toes; the pitching about the ill, the unruly and helpless patients heedless of the results: these shameful scenes tended then to strengthen my preconceived impressions that I was accused of God. Surely such attendants are unfit for their posts.¹²⁶

His testimony is certainly powerful and an antidote to the official versions in the notes but some factors do need mentioning. His phrase that he was 'accused of God' suggests perhaps a very self-accusatory mindset indicative of a depressive condition. Secondly, his style is melodramatic and his views on staff seem to be very black and white – they are either saints or sinners – and, though he was not wealthy, his writing suggests he was fairly well educated. He

¹²⁴ Admission book BRO 40513/C/2/5, 57. Admitted 3/1/1876, discharged (died) 16/12/1878.

¹²⁵ Weston, *Life in a Lunatic Asylum*, 58.

¹²⁶ *Ibid.* 53.

seems to have been a sign painter but his admission notes report him as a 'traveller'.¹²⁷ Thus there would have been a cultural affinity, based on education, with the more senior members of staff. If he came from a lower background his views on the attendant's language might have been different. His book does not suggest he made complaints to the Visitors or Commissioners, yet he obviously held them in high regard as his book is dedicated to them. These reservations apart, his testimony does present a picture of an institution that sometimes did not comply with the high ideals of Moral Treatment that it claimed to espouse. In the later years of our period things may have improved as the attendants began to receive training and by 1896 all the attendants held the Certificate of the Medico-Psychological Association.¹²⁸ The handbook for this training shows the training to be quite extensive. It did concentrate on physical care, with its section on human biology being more extensive than the author received in his training. Psychological approaches were mentioned, such as the section dealing with how to respond to someone with delusional ideas.¹²⁹

One aspect of relations between staff and patients was how they might have been affected by the changes in medical personnel. It might be thought that such changes would have had only a minor effect but this does not seem to have been the case. In Chapter 5 it will be noted that the changes in Superintendent had very dramatic changes in diagnostic patterns and Dr Thompson's predilection for the diagnosis of dementia would certainly have had an effect both on the patient and those who treated him or her. Dementia, unlike mania, was seen as mostly incurable. Dr Thompson also differed from Dr Stephens and Dr Bentham in his evaluation of a patient's health on admission. This can be seen in Fig. 9 but can be shown more dramatically if we just look at the years when the Superintendent changed. In the years before and after Dr Thompson took over the percentage considered in 'fair health' dropped from 31.5 per cent to

¹²⁷ Admission forms BRO 40513/R/1/2.

¹²⁸ Early, *Pauper Palace*, 27.

¹²⁹ The Medico-Psychological Association, *Handbook for Attendants on the Insane* (Chicago: Chicago Medical Book Co., 1909; Memphis, Tennessee: General Books, 2014). Citation refers to the General Books reprinted edition.

19.1 per cent, and in the years before and after Dr Bentham took over the rate rose from 13.3 per cent to 41.7 per cent, a particularly dramatic rise. There is also some evidence that Dr Thompson had a different attitude to women than Dr Stephens. If we examine Fig. 6, in the last two years of Dr Stephen's tenure there were 21 males and 8 females placed in seclusion but in the two years after Dr Thompson took over this changed to 52 females and only 17 males.¹³⁰ All this suggests that during Dr Stephens' time there was a greater sense of therapeutic optimism but Dr Thompson, a rather self-important individual according to Early, initiated a pessimistic period when women were to be feared and few were considered curable.¹³¹

Violence and suicide

Violence

Frank Wyatt was nine years old when admitted to the asylum in 1877. He was described as a congenital idiot. He understood very little and was prone to bouts of rage when he would lash out at members of his family who felt they could no longer cope with him. They had trained him to ask to have his hands tied when he felt he was getting angry. Once admitted, the asylum environment did not seem to help and he regularly had bouts of what was termed 'excitement' when he would kick, bite and lash out at staff or other patients. The asylum continued the family practice of tying his hands when he felt angry but this only worked for a while and on 27 July 1877 his hands were untied and he 'immediately broke several panes of glass'. He was placed in seclusion several times and regularly given morphine to sedate him. He was obviously desperately unhappy and was often found crying.¹³² He was discharged as 'relieved' presumably because his family agreed to take him back but a couple of years later he was readmitted now aged 11. The same pattern continued, but most of his violence was directed at property; he would smash his dinner plate, he often broke windows and he pulled apart a gas pipe. A typical entry describes on

¹³⁰ Wellcome Library: WLM28.BE5B86, 1860–1869, 1870–1889 and 1890–1898.

¹³¹ Early, *Pauper Palace*, 17–25.

¹³² Admission book BRO 40513/C/2/5, 132. Admitted 9/7/1877, discharged (recovered) 15/12/1877.

14 July 1887 how he 'managed to get his hands untied and pushed his head through a square pane of glass'.¹³³ The asylum's responses stayed the same: the tying of his hands, seclusion and sedation but although each of these may have provided temporary respite, nothing seemed to help and the pattern continued until his death in 1896 aged 27. His story is heartbreaking and, although by no means typical, it does illustrate the problems that violence caused the staff and other patients. The asylum failed him but it is difficult to know what else they could have done.

In the context of this study, it is not possible to ascertain how much violence there was at the asylum. It certainly existed and there are fairly frequent references to violence between patients and violence by patients on staff. The notes, however, can be misleading, as like newspapers they tend to only record notable events. Stable, placid patients who might be depressed are only rarely reported and usually with the phrase 'no change'. To fully assess the level of violence further research is needed and is beyond the scope of this study but much of the violence, particularly on the female side, seems to have resulted from people with physical conditions, particularly epilepsy and general paralysis of the insane (GPI). Florence Foster, a prostitute originally diagnosed with mania but later found to have GPI, was frequently violent and frequently placed in seclusion. She may have been violent before the symptoms of GPI appeared, but it would certainly have exacerbated any violent tendencies.¹³⁴ There were other patients who were not generally violent to other patients but damaged the ward. Certainly the wards often seem troubled; many patients were noisy and verbally aggressive, in part because of their frustrations with their conditions.

Violence or aggression of staff towards patients has been noted by Weston, and Leonard Smith suggests that the abolition of restraint (instigated by the Moral Treatment movement), which had occurred in the first half of the nineteenth century, meant that staff violence was much more likely, though he concedes that there is a very fine line between firm handling and excessive

¹³³ Admission book BRO 40513/C/2/6, 86. Readmission 11/11/1880, discharged (died) 9/11/1896.

¹³⁴ Admission book BRO 40513/C/3/9, 34. Admission 27/9/1879, discharged (died) 29/4/1884, see Chapter 5 for discussion of GPI and epilepsy.

restraint.¹³⁵ The absence of restraint at Bristol and the lack of effective sedation meant that staff were probably often firm and occasionally brutal towards the patients. By modern standards some attendants were probably fairly often brutal but patients who came from backgrounds where a high level of violence was normal would not have considered this unusual. There is evidence of complaints by patients of staff brutality. One complaint was against the attendant Edmund Ironside Dunn. The Visiting Committee instigated a prosecution against him and he was charged with 'unlawfully striking and ill-treating a lunatic', Thomas Henry Curpty, on 9 October 1883.¹³⁶ That the Committee felt it necessary to start a prosecution suggests this was a serious event, and the patient nearly died, but it also shows that staff brutality was investigated, though perhaps less serious events went unpunished. This case was heavily reported in the press and is indicative of how the press reporting of the asylum changed from glowing reports of the patients (see chapter 4) to reports of ill-treatment or deaths. This seems to have been true of all the newspapers of differing political outlooks. In this case both the *Mercury* and the *Western Daily Press* reported the case in very similar terms. The headline in the *Mercury* was "Serious Charge against an attendant at the Lunatic Asylum' compared to the somewhat similar 'Alleged ill-treatment of a patient at the Bristol Asylum' in the *Western Daily Press*.¹³⁷

Other asylums may have had more problems with staff violence. At the Sussex Asylum there seems to have been a culture of staff drunkenness which contributed to these abuses but at Bristol the medics, particularly Dr Thompson, were very strict on alcohol abuse and any attendant found drunk was dismissed.¹³⁸

Suicide

¹³⁵ Leonard Smith, *Cure, Comfort and Safe Custody*, 149.

¹³⁶ 'Lawford's Gate Petty Sessions, 'Serious Charge against an attendant at the Lunatic Asylum' *Bristol Mercury and Daily Post*, Friday, October 26, 1883.

¹³⁷ *Ibid* and *Western Daily Press* October 26 1883, 7.

¹³⁸ Gardner, *Sweet Bells*, 167.

Many of the patients were suicidal on admission, perhaps a majority of those diagnosed as suffering from melancholia.¹³⁹ A few became suicidal after admission, however, for the first sixteen years of its existence the Bristol Asylum had no suicides. The first was Mary Leworthy. She was admitted to the asylum on 8 August 1876 at 4.30pm. The following day she hanged herself, the first suicide at the hospital since it opened in 1861.¹⁴⁰ An inquest followed which was reported in some detail in the local press; her background seems to have been unremarkable and only in death was her story significant.

Shortly before her death she was a domestic servant in Ilfracombe but turned up in a distraught state at her sister-in-law's accommodation in King Street, Bristol. We know little of the antecedents to this event but she seems (the evidence is not conclusive) to have twice been convicted of theft. The first occasion was in Exeter in 1856, when she was convicted of the theft of a shawl,¹⁴¹ and the second in Bristol in 1871 when she stole a pair of boots.¹⁴² For the first, she received a prison sentence of six weeks and for the second, three months hard labour. Her convictions may have been part of a criminal lifestyle or, perhaps more likely, symptoms of a rather desperate life. Certainly her incarceration in the asylum might have seemed like another prison.

On admission she was described as being miserable and 'low in spirits'. She told the doctor that 'she was in hell'. Her sister-in-law, Lydia, with whom she was staying, said that Mary had recently tried to harm herself, firstly, by jumping out of a window and then by trying to strangle herself. In hospital she refused any food, did not sleep and was described as having religious delusions. At six in the morning she was seen by the attendant who thought she was

¹³⁹ From viewing the case-notes this seems to be the case but in retrospect the database could have included a column where it was noted if the patient was suicidal. Then by comparing this with the diagnosis a more definite assertion could be made.

¹⁴⁰ Admission book BRO 40513/C/3/8, 79. Admission 8/8/1876, discharge (dies) 9/8/1876.

¹⁴¹ 'City of Exeter Police Charge Book Entries for 28 August 1856 – 23 December 1856,' GENUKI, accessed February 24, 2014, <http://genuki.cs.ncl.ac.uk/DEV/Exeter/Police5/ChargeBook1856-2.html>. One or both of these records could possibly be about someone with the same name but the dates and place are consistent with our Mary.

¹⁴² 'Police Intelligence,' *Bristol Mercury*, August 19, 1871, 7.

more cheerful. In retrospect this seems that, like many suicides, she relaxed after committing to the decision to end her life. At eight she was found 'suspended, cold and dead'.¹⁴³ She had used her nightdress cut into strips as a noose. As Shepherd and Wright have observed, hanging was the most popular method of suicide in Victorian asylums.¹⁴⁴ The medical notes and the inquest reports go into great detail and speculation over whether the attendants had been negligent in not securing the bar from which she hanged herself. The *Bristol Mercury* described her as 'a poor creature who was tired of life'.¹⁴⁵ The inquest recorded a verdict of 'suicide by hanging whilst in an unsound state of mind'. The verdict almost certainly was the correct one and, although Berkenkotter has shown the imprecise nature of the phrase 'unsound mind', in Mary's case her suicidal thoughts were in part delusional which does indicate a severe mental condition.¹⁴⁶

Mary seems to have been from quite a deprived background; when she had work it was as a servant. Like many working people she only becomes visible to us (a later audience) when institutions of authority, the courts and the asylum, were involved. In her case the admission to an asylum was obviously a tragic failure, however, she had tried on more than one occasion to kill herself and so the family would have wanted her admitted to the asylum. The asylum had up until then been entirely successful in preventing suicide and therefore the admission was reasonable. The asylum seems to have done remarkably well in preventing suicides compared to other Victorian establishments and modern hospitals. Although the training only came in at the end of our period, the handbook for attendants gives clear advice. It states 'NEVER FOR EVEN THE VERY SHORTEST PERIOD PERMIT ANY SUICIDAL PATIENT OUT OF YOUR SIGHT NO MATTER UPON WHAT EXCUSE' (upper case used in the original).¹⁴⁷ Thus whilst in the asylum a suicidal patient was observed much more closely than a family could ever achieve and this must have saved many

¹⁴³ Admission book BRO 40513/C/3/8, 79.

¹⁴⁴ Anne Shepherd and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint,' *Medical History* 46 (2002): 176.

¹⁴⁵ *Bristol Mercury*, August 12, 1876.

¹⁴⁶ Carol Berkenkotter, 'A patient's tale of incarceration in a Victorian lunatic asylum', *International Journal of English Studies* 11(1) (2011): 1–15.

¹⁴⁷ Medico-Psychological Association, *Handbook for Attendants*, 212.

lives. The Lunacy Commission monitored suicides and they established there were 265 suicides in asylums between 1858 and 1883 and Mary was the only one from the Bristol Asylum during that period.¹⁴⁸ It is perhaps unjust to compare with modern hospitals but a study by Coser reported 21 suicides over a seven-year period at a psychiatric hospital in the 1960s.¹⁴⁹ How then did the Bristol Asylum achieve this? In the early part of the century it was common to put people at risk of suicide in a mechanical restraint but 'Moral Treatment' would not tolerate this and it was not used in Bristol.¹⁵⁰ It was noted and often highlighted in the admission notes whether a patient was suicidal but formalised suicide watches and a suicide caution card were only introduced in the 1890s.¹⁵¹ This accords with the view of Sarah York whose doctoral thesis on suicide in nineteenth-century asylums concluded, 'once admitted, dangerousness and risk continued to dictate the asylum's handling of suicidal patients'.¹⁵² It was left to the individual staff to continually assess a patient's risk. Perhaps with the Victorian view of suicide as a terrible moral crime, the staff would have been particularly vigilant.¹⁵³ Occasionally a patient would commit suicide after leaving the asylum. Samuel Morris, a 29-year-old publican, committed suicide by cutting his own throat in 1882.¹⁵⁴ He had been admitted to the asylum for a period of three months suffering from melancholia in 1877 but had been discharged as recovered. As there had been five years between discharge and his suicide the asylum could not be seen as culpable.¹⁵⁵

Conclusions

¹⁴⁸ Reported in Anne Shepherd and David Wright, *Madness, Suicide*, 176. As the Bristol Asylum took about 1 per cent of the year's admissions, the comparative rates would be 1:2.56.

¹⁴⁹ Rose Laub Coser, 'Suicide and the Relational System: A Case Study in a Mental Hospital,' *Journal of Health and Social Behaviour* 17(4) (1976): 319. In the author's personal experience this roughly equates with British hospitals in the 1990s.

¹⁵⁰ Akihito Suzuki, 'The Politics and Ideology of Non-Restraint: The Case of the Hanwell Asylum,' *Medical History* 39 (1995): 1–17.

¹⁵¹ Early, *Pauper Palace*, 26.

¹⁵² Sarah York, 'Suicide, Lunacy and Asylum in Nineteenth Century England' (PhD thesis, University of Birmingham, 2010), 140.

¹⁵³ See Barbara Gates, *Victorian Suicide: Mad Crimes and Sad Histories* (Princeton: Princeton University Press, 1988).

¹⁵⁴ *Western Daily Press*, May 23, 1882.

¹⁵⁵ Admission book BRO 40513/C/2/5, 118. Admission 12/5/1877, discharge (recovered) 23/8/1877.

We have examined several aspects of life in the asylum and several themes have emerged. Firstly, there is the disparity between the official version and the patients' view. The official account is stated in the notes and the reports of the Visitors and Commissioners. These versions are sometimes critical; for instance, they bemoan the overcrowding and they do investigate claims of abuse or pleas for release, but mostly they present a fairly rosy picture. The 1894 report by the Commissioners notes, 'it was distressing to hear the complaints of the Welsh patients from the Denbigh Asylum¹⁵⁶ but they note 'the health of the patients is remarkably good', 'their behaviour is generally orderly' and 'a good dinner is served in the hall'.¹⁵⁷ Work and leisure pursuits are noted and tabulated, the food is occasionally criticised but mostly pronounced as good. It is possible to speculate whether they would have had the same reaction if the same food was served at home. They did receive complaints but they often concluded, 'no complaints were made which seemed not to be founded on delusion alone'.¹⁵⁸ It may have been that once a patient was labelled as delusional, then any complaint might have been dismissed as part of their delusions. Certainly, as the next chapter will show, many and possibly a majority of patients did have delusional ideas but just because you wrongly think you are the Prince of Wales, it does not mean all your complaints are invalid. The press seem to have mostly followed the official version with their saccharine-coated reports of the asylum balls; investigative journalism it was not.¹⁵⁹

The patients' views, particularly the memoir of John Weston, tell a somewhat different story. Both Weston and Nichols praise the asylum grounds and their views on the food are fairly complimentary. Weston is glad of the work he is given and Nichols was able to spend most of his time painting, however, Weston paints a grim picture of the attendants on the male side with their casual brutality and uncaring manner. He is not against asylums but argues for speedier

¹⁵⁶ Commissioners' Report 1894, BRO 35510, 1.

¹⁵⁷ Ibid. 2.

¹⁵⁸ Ibid. 6.

¹⁵⁹ The Bristol Times and Felix Farley's Bristol Journal June 18 1862, 8. 'Ball at the Lunatic Asylum Stapleton,' *Bristol Mercury*, February 4, 1871, 3.

release and better supervision of the attendants.¹⁶⁰ The patients' versions should not be taken as the 'correct' version – it rests mostly on the views of one man who had a book to sell – but it is a version that should not be ignored.

There is an interesting contrast with Berkenkotter's study of William Marshall's testimony to a Parliamentary Committee concerning what he thought of as his wrongful incarceration. Like this study, she notes the disparity between patients' and medical accounts but she also suggests that it is 'a strong indictment of the weaknesses in the medico-legal system in the Victorian era, despite its protocols and its safeguards to protect the patient from illegal confinement'.¹⁶¹ Thus, like authors such as Sarah Wise, she concentrates on wrongful confinement despite the fact that she admits Marshall probably suffered from what is currently known as a manic depressive illness.¹⁶² The doctors did misdiagnose him but as manic depression did not exist as a diagnosis that was not surprising. The testimony of patients such as Marshall and Weston does show the inherent biases which the background and ideas of the doctors made inevitable and of the abuses suffered by patients. However, wrongful confinement, although it undoubtedly existed, was only a small aspect of these abuses and mostly suffered by the upper classes. This view is supported by Beveridge who studied a large number of patients' letters and concluded they 'demonstrated that patients admitted to the Royal Edinburgh Asylum suffered from serious mental illness, and it undermines the view that the Asylum was simply a dumping ground for society's disaffected'.¹⁶³

Another theme which emerges is the difference in experience between those who partook of what the asylum offered and those who were unable or unwilling to do so. Most did some sort of work but about a third did not. The concerts and balls were popular but again about one third did not attend. Exercise was mandatory but still over a hundred patients were too

¹⁶⁰ Weston, *Life in a Lunatic Asylum*, 99–102.

¹⁶¹ Carol Berkenkotter, 'A patient's tale of incarceration in a Victorian lunatic asylum,' *International Journal of English Studies* 11(1) (2011): 12.

¹⁶² Sarah Wise, *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England* (London: Bodley Head, 2012).

¹⁶³ A.A. Beveridge, 'Voices of the mad: patients' letters from the Royal Edinburgh Asylum, 1873–1908,' *Psychological Medicine* 27(4): 899.

unwell to join in.¹⁶⁴ Most would have enjoyed their food but those who had to be cajoled or bullied into eating probably dreaded meal times. For some who refused to join in, it may have helped them to maintain their self-respect but for many others who were too unwell, life in the asylum was both miserable and tragic.

This chapter has shown a number of instances of both the care and control which the asylum provided. In the areas studied both features occur simultaneously. Patients were provided with a decent diet, occupational and leisure activities, pleasant grounds and a possibility of release. However, you did not ask to be put there and once there your existence was tightly controlled. You were also told when and what to eat and when and what work to do. If you did not want to eat, pressure was put on you to do so. Some of the staff were caring, some were cruel and although you might be released, about half died in the asylum. This dual aspect was summed up unwittingly by a reporter visiting the asylum: 'Everything is in order, everything is wonderfully neat and clean. Everything betokens the existence of strict rule and rigid system. Dr Stephens keeps his great mad family in perfect order.'¹⁶⁵

¹⁶⁴ Medical Superintendent's Report 1894, BRO 35510, 30.

¹⁶⁵ Press clipping unidentified but in BRO M/BCC/MEH/3/2 and entitled 'A night amongst the mad folk'.

Chapter 5: Diagnosis, Illness and Treatment

We begin this chapter with the story of John Longman. His case is particularly important because we have letters and accounts that he wrote about his illness and his evocative descriptions tell us more about what it was like to have a very serious mental condition than the usual accounts written by the doctors.

John Longman was one of thirteen children, born in 1840 to Emanuel and Mary and his early life was spent in Manhill, a village in Dorset. He became a stonemason and in March 1862 he married Charlotte and together they had six children. In about 1870 they moved to Bristol.¹ Thus far a fairly ordinary life, neither rich nor poor, there was no history of mental problems in his family and his children were healthy. He could read and write and his religion was Methodist. In the autumn of 1876 he began to change: he became irritable, his sleep became erratic and he found it difficult to work. He communicated less with his family and when he did talk it often seemed incomprehensible with references to God and the devil. His condition deteriorated, he stopped work completely, which must have been difficult for the family as he had a wife and six children to feed. The exact circumstances surrounding his admission are unclear but his family may have gone to the Poor Law authorities. He arrived at the asylum at 3.10pm 13 December 1876. He was 36 at the time and he was to spend another 36 years in the asylum until his death in 1912. On admission he was described as 'very excited' and told the doctor he had seen the devil who was driven away by two angels.²

His admission seems to have had a devastating effect on his family; his wife could not manage all the children and three of them were looked after by friends, Charles and Ellen Bird.

¹ Censuses for 1861 and 1871, 'Census and Electoral Rolls,' Ancestry, accessed June 8, 2016, <http://search.ancestry.co.uk/search/category.aspx?cat=35>.

² Admission book BRO 40513/C/3/5, 105. Admission 13/12/1876, discharge (died) 31/7/1912.

However, by the time of the 1891 census the family (minus John) was back together again and included grandchildren.³

During the first few years of his time in the asylum, he seems to have been particularly troubled. He is often described by that favourite Victorian word 'excited'. He talked mostly to himself and when asked who he was talking to, he replied 'my father'. His diagnosis was mania and his main symptoms were delusions and hallucinations often of a paranoid nature although, as G.E. Berrios has shown, if he had been admitted a few years later the diagnosis would have been of a type of psychosis.⁴ Very few patients wrote about their symptoms but he wrote about them in a piece entitled 'my delusions'. Interestingly, the title suggests he accepted that what he saw was not real. Alternatively, the title could have been to appease the doctors and the fact that his writings were kept in the medical notes suggests they were interested in this written confirmation of mental illness. He lists seven numbered delusions. Some are fairly straightforward, such as one which states 'a supernatural voice spoke to my neighbour of arsenic, I supposed the voice to be that of a man'.⁵ The last entry is more troubling and difficult to understand:

A supernatural sound as of rattling a box cover on box and dropping of a rod on bedroom floor, I supposing the sound was natural. I suppose both poisons were for me and the charge of the gun to shoot me and the pistol snaps a trial to do so.⁶

These are clearly the thoughts of a very disturbed man. In a rather poetic way he has described a man expecting to die either from poisoning or shooting. It is reminiscent of a horror

³ Censuses for 1881 and 1891, 'Census and Electoral Rolls,' Ancestry, accessed June 8, 2016, <http://search.ancestry.co.uk/search/category.aspx?cat=35>.

⁴ G.E. Berrios, 'Historical aspects of psychoses: Nineteenth century issues,' *British Medical Bulletin* 43(3) (1987): 484–494.

⁵ Admission book BRO 40513/C/2/5, 105.

⁶ *Ibid.*

film but for him it seems real and must have terrified him.⁷ Throughout his time in the asylum he seems to have had these visions which were both visual and audible. In another piece, he wrote:

I wanted to tell you of a man I saw laying a foundation stone. The man was standing on the foundation stone and I thought he is an angel from god.⁸

It is difficult to know if this person existed. There may have been a stonemason working in the asylum grounds who John perceived as an angel. He is explicit about his voices and the extract below does give us a sense of what it was like to have his experiences:

I wish I could have someone to tell of the action in my head causing the visions to be heard in different sounds. The first excited voice was a voice I knew, the second were a strange voice. The first voice was to my right and the second to my left.⁹

The last passage does convey a sense of what he was experiencing and, with all this going on in his head, relating to others at the same time must have been very difficult. In 1896 it was written in the notes, 'he still sees visions' and again in 1903, 'he writes the most ridiculous verses about millennial angels and draws indecent pictures'.¹⁰ His writings often had religious aspects and his visions often included angels, but why these ones were millennial is a mystery, unless he thought the recent turn of the century was the start of a new millennium.

He does not seem to have made any friends in the asylum and in a letter to a friend wrote, 'I am staying with a company of men that speak and dance like devils'.¹¹ This seems to be evidence of how his illness affected his relationships. There was further evidence of this in the way his relationship with his wife deteriorated. During a visit from his wife, he had to be removed

⁷ It seems similar to films such as Polanski's 'Repulsion' in which the main character hallucinates all sorts of frightening auditory and tactile hallucinations. 'Repulsion – review,' *The Guardian*, accessed March 12, 2014, <http://www.theguardian.com/film/2013/jan/03/repulsion-review>.

⁸ Admission book BRO 40513/C/2/5, 105.

⁹ Letter attached to above.

¹⁰ Admission book BRO 40513/C/3/5, 105.

¹¹ Letter in admission book BRO 40513/C/2/5, 96.

from the visitors' room because of his foul language and he told the staff his wife was a whoremonger.¹² He then wrote to his wife and claimed that the child she brought with her was not his, but that of a man called Dowling and that she was pregnant with another child by the same man. However, he ends the letter with a plea for her to visit him again.¹³ There is no way to know if there was any truth to his allegations but they seem more likely to be symptoms of his condition. He seems to constantly misinterpret events and people's actions and from these misinterpretations his mind devises paranoid conspiracies against him.

Although he was not very sociable, he did draw and write poetry albeit of a rather strange kind. The following verses do seem to be an account of what he actually sees, which the staff do not seem to have appreciated:

Doctor doctor what in eyeball
Move for sight to see a man fall
What in eye do move for vision
When on ground the form it threw

Do the colour move from whiteness
When we see an angel brightness
Do the white mould up the man
That before the sight do stand

We see a man form on the ground
We see a man form and tumble down
We see in the form with foot and leg
And head on top of old hat peg.¹⁴

¹² Admission book BRO 40513/C/3/5, 96, July 11, 1877.

¹³ Letter in notes dated July 3, 1877, BRO 40513/C/3/5, 73.

¹⁴ Poem quoted in notes, admission book BRO 40513/C/2/5, 110, July 4, 1882.

He does, however, seem to have improved or at least calmed down as the years passed. There are fewer mentions of him being 'excited' and by 1888 he was reported as working usefully in the tailor's and later the shoemaker's shop. He attended the church services and the weekly dance regularly and, although he continued to experience delusional voices and visions, he perhaps was less troubled by them. He began to accept both the institution and his bizarre symptoms; he had adapted to his situation.

The aetiology of John's condition is, like most mental problems, difficult to determine. His religion seems to have had an effect on the nature of his symptoms and being labelled as insane may have been particularly difficult for a Methodist. Certainly, John Wesley thought that 'mental disorder was a form of psychic struggle in which God and the Devil battled for the psychosomatic control of the subject'.¹⁵ Longman certainly saw his own problems in a similar fashion. His visions often included both the devil and angels. John's story is not a happy one; his delusions wrecked his home life and made his stay in the institution much more difficult. He made no friends and was suspicious of the staff and once threatened to attack the Medical Superintendent for not discharging him.¹⁶ At least he did leave evidence that give us insight into his experiences.

Diagnosis

The title of this chapter suggests the classical medical model for a medical problem. When a patient is symptomatic, their illness is diagnosed and this will suggest an effective treatment. For some illnesses, this works very well; for nineteenth-century psychiatry it did not. This chapter will examine the causes of this and the misery which these illnesses caused for the patients at the Bristol Asylum. The chapter is also evidence for the view of this study that much of the historiography of asylums and their patients is flawed because it is mostly written either by clinicians with little historical training or insight, or by historians with scant knowledge or interest

¹⁵ Paul Laffey, 'John Wesley on Insanity,' *History of Psychiatry* XII (2001): 477.

¹⁶ Admission book BRO 40513/C/2/5, 10.

in the conditions from which the patients suffered. German Berrios, the distinguished historian of psychiatric diagnoses and who is the exception to this suggestion, affirms, 'there has been little research into the history of psychiatric symptoms' and what there is has usually been written by clinicians who 'need the assistance of professional historians'.¹⁷

In 1890 George Joseph Silman had a delusion that there was a battery in his head that was draining the life out of him. He presented himself at a police station asking them for help with this and, not surprisingly, he was admitted to the asylum. During this period, a delusion such as this was considered sufficient evidence of insanity. Bucknill and Tuke, who were influential British psychiatrists of this period, wrote in 1858 that a person cannot have a delusion 'without the mind being unsound'.¹⁸ This was during the period when Dr Thompson was in charge and he diagnosed George as suffering from dementia. A few years later when Dr Bentham had taken over, his symptoms had not changed but his diagnosis was now mania.¹⁹ This case suggests that the impetus for an admission was often an event in the community, in the patient's home or, in this case, their presentation at a police station. The justification by the psychiatrist was the presence of a delusion. Once admitted, his case had to be categorised and this categorisation, in the form of a psychiatric diagnosis, proved problematic.

Berrios has shown how the urge to classify came to the fore in the natural sciences in the seventeenth century and by the end of the eighteenth century medical science had fully incorporated this idea into its epistemological paradigms. In psychiatry, this nosological framework has proved contentious. A basic issue is whether symptoms such as delusions have an ontological invariance. That is, if the symptoms have a biological basis they will exist in the same form in different historical periods. Proof of this biological basis has proved elusive and the social causes of insanity and the relationship between psychiatric symptoms and differing cultures has

¹⁷ German Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996), 12.

¹⁸ J.C. Bucknill and D.H. Tuke, *A Manual of Psychological Medicine* (London: John Churchill, 1862), 128.

¹⁹ Admission book BRO 40513/C/2/8, 161. Admission, 8/3/1890. Discharge (died) 28/9/1926.

been stressed by other writers from Giné y Partagás, in the eighteenth century, to the social constructionists of the twentieth century.²⁰ By the start of our period, in the mid-nineteenth century, the psychiatric profession was established and Misbach and Stam have shown how their desire for professional acceptance was a strong incentive to produce a supposedly scientific set of diagnoses.²¹ However, according to Gerald Grob, for a classification to be effective there needs to be agreement on the nature of the phenomenon, the classes to be used and how these are to be sorted into categories. Such agreement was not usually forthcoming due to localised social, cultural and political pressures. Horwitz and Grob concluded that ‘their nosology was to all intents and purposes, nearly useless’.²² Those wishing to medicalise insanity were encouraged near the end of our period, when Kraepelin introduced a series of criteria for diagnoses, including the concept of schizophrenia. It should, however, be noted that, according to Kendler and Jablensky, Kraepelin had a much more diverse idea of insanity’s aetiology than many of his later adherents.²³ Thus in the nineteenth century classification was very imprecise and based purely on symptoms rather than any causal link. This impression and its effects were very apparent at the Bristol Asylum.

Psychiatric diagnoses are important in that they affect the patient’s experience. They affect the treatment that the patient is given. In the late nineteenth century there was not the current array of psychotropic drugs which are given for particular diagnoses but there were some treatments for particular conditions. At Bristol during Dr Thompson’s era patients with the diagnosis of mania were often given the drug hyoscine. Dr Thompson wrote an article in the *Lancet* praising its efficacy.²⁴ Thus George Silman with his initial diagnosis of dementia was not

²⁰ Berrios, *The History of Mental Symptoms*, 8.

²¹ Judith Misbach and Henderikus Stam, ‘Medicalizing Melancholia: Exploring Profiles of Psychiatric Professionalization,’ *Journal of the History of the Behavioural Sciences* 42(1) (Winter 2006): 41–59.

²² Allan Horwitz and Gerald Grob, ‘The Chequered History of American Psychiatric Epidemiology,’ *The Milbank Quarterly* 89(4) (2011): 62.

²³ K.S. Kendler and A. Jablensky, ‘Kraepelin’s concept of psychiatric illness,’ *Psychological Medicine* 41(6) (2011): 1119–1126.

²⁴ George Thompson, ‘On the use of the Hydrobromate of Hyoscine in the Treatment of Recurrent and Acute Mania,’ *The Lancet* 1(3362) (February 4, 1888)218-219.

given this drug and by the time his diagnosis had changed to mania, Dr Bentham was in charge and he did not seem to use hyoscine.

The two diagnoses we are going to consider, mania and dementia, were perceived very differently. Mania was considered eminently curable but dementia was considered to be almost always incurable and these perceptions affected how patients were treated.²⁵ If someone is pronounced incurable they were likely to be sent to the chronic case wards, where they seem to have been given very little attention. The records of these wards are very limited, with years passing without an entry in a patient's case notes.²⁶ They were the two most common diagnoses at Bristol with 1397 cases of dementia (27 per cent) and 1939 cases of mania (38 per cent) (see Fig. 2). However, with figures taken from our database and pivot tables we can show in Fig. 1 below that the Superintendents had a massive effect on which diagnosis the patient was given. Throughout his tenure (1861–1870), the percentage of patients given the diagnosis of mania by Dr Stephens never dropped below 60 per cent, but as soon as Dr Thompson (1870–1890) took over the number more than halved varying from 12 to 34 per cent. When Dr Bentham took over in 1890, the figures rose again, but not to the heights of Dr Stephens's time. The diagnosis of dementia follows a similar but inverted pattern. Dementia was only given as a diagnosis by Dr Stephens in 3.7 per cent of cases, but in Dr Thompson's time it was usually about 40 per cent, a tenfold increase.²⁷ We do not know how diagnoses in other asylums varied by the tenure of a doctor but the figures for other asylums show the inconsistencies of the diagnoses. At the Devon County Asylum, Melling and Forsythe show that only 13 per cent of patients were classified as having dementia, Crompton has a figure of 23.9% for the Worcester Asylum and Wright 10.8% for

²⁵ Daniel Tuke, 'Of Mania,' in *A Manual of Psychological Medicine*, eds. J.C. Bucknill and D.H. Tuke (London: John Churchill, 1862).

²⁶ Admission book BRO 40513/C/5.

²⁷ There was an anomaly in 1882 with only 9 per cent but this was because they virtually stopped registering a diagnosis so most were categorised as 'unknown'. Perhaps this shows an acknowledgement on behalf of the doctors how arbitrary these judgements were. It went against the rules set out by the government. On the other hand, it could have been laziness.

the Buckingham Asylum.²⁸ This suggests both that there was no clear agreement on diagnostic criteria and that it was Dr Thompson, whose overall figure for dementia was 34%, who was particularly out of step in his diagnostic views.²⁹

These huge changes could not have been due to changes in the nature of the admissions: the procedure did not change and, as they regularly remarked, the Superintendents had little control over who was admitted.³⁰ Thus the doctors, who were responsible for the patients' diagnoses, had very little agreement in the nineteenth century as to the definition and nature of these two conditions. Some historians, though mostly ignoring the meaning of these terms, have often used them mistakenly especially when they compare them with current diagnostic criteria. Arieno suggests that 'the symptoms of schizophrenia today are strikingly similar to the symptoms attributed to mania, monomania and dementia in the mid-nineteenth century'.³¹ Some people with these nineteenth-century labels had some of these symptoms, some of the time, but many had symptoms completely at odds with a diagnosis of schizophrenia.

Mania was defined as 'insanity with excitement' by the eminent psychiatrist Henry Maudsley³² but this tells us little and there was a fundamental disagreement as to whether mania was an affective disorder or a disorder of the intellect. Berrios has charted how an agreement as to the nature of the term only emerged at the end of the century, when it became coupled with melancholia as examples of 'emotional insanity'.³³ Dementia, likewise, was a rather vague term, with the only agreement being that it was a form of mental impairment. Tuke divided it into the

²⁸ Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845–1914* (London: Routledge, 2006), 62. Frank Crompton, 'needs and desires in the care of pauper lunatics: Admissions to the Worcester Asylum 1852–1872' in Dale and Melling (eds.) *Mental Illness and Learning Disability*, 50, David Wright, 'Delusions of gender: Lay Identification and Clinical Diagnosis of Insanity in Victorian England' in Andrews and Digby (eds.), *Sex and Seclusion*, 161.

²⁹ For the years of his tenure 683 patients were diagnosed with dementia out of 2010, source database using the the categories 'diagnosis' and 'admission year'.

³⁰ Medical Superintendent's Reports, Wellcome Library: WLM28.BE5B86, 1860–1869, 1870–1890 and 1890–1898.

³¹ Marlene Arieno, *Victorian Lunatics: A Social Epidemiology of Mental Illness in Mid-Nineteenth-Century England* (Cranbury, NJ: Associated University Presses, 1989), 90.

³² Henry Maudsley, quoted in Berrios, *The History of Mental Symptoms*, 314.

³³ G.E. Berrios, 'Of Mania: An Introduction,' *History of Psychiatry* 15(1) (2004): 105–124.

acute and chronic types with the acute being rare and the only curable form. Thomas Clouston posited five types of the disease, all of which were incurable.³⁴ The discharge figures for dementia at the asylum were 22 per cent classed as recovered and a further 7.5 per cent classed as relieved (see Fig. 2). This shows that the conceptions of Clouston and Tuke were not in accord with the way the diagnosis was used at Bristol.

The change from Dr Stephens to Dr Thompson was linked to their personalities and views but also reflected a change in society's attitude to asylums. During Dr Stephens's time, the ideas of Moral Management were very much in vogue with most new asylums endorsing their principles and these included an optimistic view of the prognosis for asylum patients. Later in the century, the asylums began to increase in size and were filled with chronic patients who had no chance of recovery. This produced a much more pessimistic outlook.³⁵ Thus diagnosing patients with a condition that was considered irreversible was more likely and made the doctors immune to criticism if they failed to recover. Indeed, according to Hill and Laugharne, 'irreversibility was also becoming part of its [mania] meaning by the 1870s'.³⁶ The wonder is that, despite this label, so many did manage to recover. It does show the vagaries of diagnoses during this period. Other diagnoses such as melancholia seem to have been more universally applied and more in accord with our current ideas or at least those of the medical profession. Melancholia developed into the diagnosis of depression and, though there is still no agreement as to whether depression should be treated as an illness, the symptoms of someone diagnosed as melancholic seem similar to today's symptoms of depression.³⁷

³⁴ Berrios, *The History of Mental Symptoms*, 172–207.

³⁵ Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (London: Allen Lane, 1979), 188–194.

³⁶ Richard Hill and Richard Laugharne, 'Mania, dementia and melancholia in the 1870: admissions to a Cornwall Asylum,' *Journal of the Royal Society of Medicine* 363(96) (2003): 362.

³⁷ Berrios, *The History of Mental Symptoms*, 315.

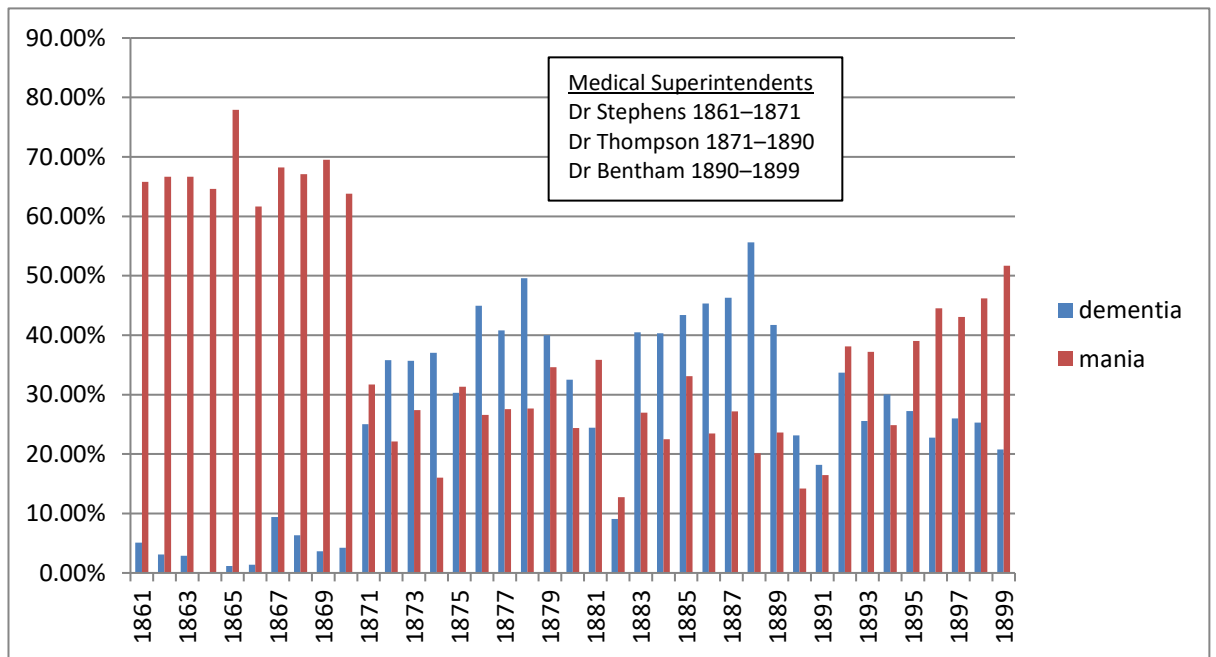


Fig. 1 Percentages of patients given diagnosis of mania or dementia by year³⁸

The Illnesses and their Symptoms

Despite the uncertainty and variable nature of these diagnoses, the patients who were admitted were suffering from mostly very serious conditions which severely affected their lives. As Sarah Wise has documented, some wealthy people managed to incarcerate their relatives for financial gain.³⁹ For the ordinary families, admission to an asylum was often a financial disaster and often led to the break-up of families such as the Longmans. Thus for someone to be admitted, their condition probably had to be serious enough for the family to be better off (financially and/or emotionally) without them. Some people were admitted with conditions that were not what is currently deemed to be psychiatric, including epilepsy or alcoholism. However, the alcoholics admitted with delirium tremens (there were only 12 for our whole period) were mostly treated successfully, with 11 being discharged as recovered within a year of admission. Fig. 2

³⁸ Figures from database pivot table using yearly figures for 'diagnosis'.

³⁹ Sarah Wise, *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England* (London: Bodley Head, 2012).

shows the diagnoses and their results. Despite the problems with these categories, it is useful to note how patients diagnosed with certain conditions fared much better than others. In terms of comparing recoveries with deaths, general paralysis was the most untreatable condition, with only two recoveries and these may have been wrong diagnoses.⁴⁰ The patients with puerperal mania, which we would now term puerperal psychosis, usually recovered, with 53 recoveries and only 7 deaths. This suggests that, for these conditions, the diagnoses were fairly accurate and that they were distinct conditions with specific prognoses. These figures are similar to other asylums with the North Wales Asylum reporting a recovery rate of 75 per cent for puerperal mania.⁴¹ Of the most common diagnoses, melancholia offered the best prognosis, followed by mania and then dementia (see Fig. 2). Interestingly, but not surprisingly, the recovery rate for dementia during Dr Stephens's period was only 14.6 per cent, compared to 31.8 per cent in Dr Thompson's time.⁴² This perhaps suggests that the patients diagnosed as such in Dr Stephens's time were more likely to have a serious cognitive impairment that impaired their thinking to the extent that they could not be discharged.

⁴⁰ One of these patients was quickly readmitted and died shortly after.

⁴¹ S. Tschinkel, M. Harris, J. Le Noury, D. Healy 'Postpartum psychosis: two cohorts compared, 1875–1924 and 1994–2005,' *Psychological Medicine*, 37 (2007): 534.

⁴² Figures calculated using pivot tables comparing categories 'diagnosis' and 'admission year'.

Diagnosis	Died	Escaped	Not improved	Recovered	Relieved	Transferred	Grand Total
Amentia	11	0	0	3	2	0	16
Confusion	1	0	0	0	1	1	3
Delirium tremens	1	0	0	11	0	0	12
Delusional insanity	14	0	0	16	6	3	39
Dementia	829	4	4	315	104	127	1383
Died before certified	3	0	0	0	0	0	3
Dipsomania	0	0	0	2	0	0	2
Epilepsy	8	0	0	3	0	0	11
General paralysis of the insane (GPI)	17	0	0	2	0	0	19
Hysterical mania	0	0	0	5	0	1	6
Idiocy	30	0	1	2	13	1	47
Imbecility	69	0	0	14	22	9	114
Mania	729	5	13	853	140	190	1930
Melancholia	319	4	3	466	64	54	910
Melancholic mania	2	0	0	1	0	0	3
Monomania of suspicion	1	0	0	0	0	2	3
Partial insanity	1	0	0	1	1	0	3
Puerperal mania	7	0	0	53	3	2	65
Puerperal melancholia	1	0	0	2	0	0	3
Religious mania	1	0	0	1	1	0	3
Senile dementia	54	0	0	5	7	5	71
Senile mania	24	0	0	7	1	2	34
Senile melancholia	2	0	0	1	0	0	3
Not known	160	2	2	141	21	14	340
Not certified insane	8	0	0	18	6	0	32
Not recorded	11	0	0	8	0	7	26
Grand Total	2303	15	23	1930	392	418	5081

Fig. 2 Diagnoses and results⁴³

⁴³ Figures calculated using pivot table comparing categories 'diagnosis' and 'result'. Some minor categories have been omitted from this table to make it more readable.

Some writers have used these diagnostic terms somewhat uncritically: David Wright, an otherwise excellent historian, suggested that dementia was ‘a general term used to describe a decline in cognitive functioning usually, though not exclusively, associated with old age’.⁴⁴ At Bristol only 188 patients (13.7 per cent) diagnosed with dementia were over 60 whilst 739 (53.9 per cent) were under 40; therefore at Bristol at least it had little correlation with old age.⁴⁵ This shows the importance of contemporary writers understanding this term as it was used in the nineteenth century.

Comparison of Recovery Rates

One of the key suggestions of this study is that the patient’s experience in the asylum was determined more by what they suffered from than either their background or anything the asylum did for good or ill. As we have seen, using the asylum’s diagnostic terms, especially for the conditions of dementia and mania, is problematic. However, if we use the figures from our pivot tables and from the tables in Chapter 2 we can use recovery rates to compare diagnoses with other factors. Fig. 3 below shows comparisons between a poor area compared to an affluent one (Bedminster to Clifton), male and female, young and old, literate and illiterate and the different occupational categories used by the census. These show very little variance except, not surprisingly, there was a 15 per cent difference in recoveries between young and old. There is also a low level of recovery for those who could not read or write but this can mostly be accounted for by those suffering from imbecility, who would only rarely be able to read and write and had only an 11 per cent recovery rate. With the diagnoses that are reasonably trustworthy, i.e. general paralysis, melancholia, puerperal mania and imbecility, the results are quite startling. Puerperal mania had a recovery rate of over 80 per cent and melancholia over 50 per cent, both figures

⁴⁴ David Wright, ‘Delusions of Gender: Lay Identification and Clinical Diagnosis of Insanity in Victorian England’, in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (Amsterdam: Rodopi, 2004), 162.

⁴⁵ Figures from database using pivot table comparing categories ‘age’ and ‘diagnosis’.

being higher than any other of our categories. Conversely, imbecility and general paralysis produced much lower figures than any other category.

Writers such as Melling and Forsythe have looked at recovery rates in relation to categories such as gender and found, as this study has, a distinct but not huge higher rate in favour of females for all the most common conditions.⁴⁶ A few authors have examined recovery in relation to diagnosis but both the studies of Renvoize and Beveridge⁴⁷ and Yorston and Haw,⁴⁸ use the retrospective diagnosis of schizophrenia. As Berrios has shown, retrospective diagnoses are generally very problematic and using the term schizophrenia particularly so.⁴⁹ This is evidenced by the fact that Renvoize and Beveridge concluded that 64.1 per cent of their sample satisfied their criteria for schizophrenia, whilst Yorston and Haw found only 3.5 per cent.⁵⁰ Even allowing for the differences in their sample populations these disparities suggest this approach is, at best, flawed. These studies do, however, show a large range of recovery rates, with Yorston and Haw finding rates varying between 8.6 per cent for organic diseases and 40.2 per cent for affective disorders.⁵¹ Renvoize and Beveridge could only find one schizophrenic, who recovered, so is not statistically relevant.⁵²

It is thus difficult to compare this study's findings with other work, but it is evidence that the condition from which the patient suffered was the main factor in determining whether they would recover.

⁴⁶ Melling & Forsythe, *The Politics of Madness*, 105.

⁴⁷ Edward Renvoize and Allan Beveridge, 'Mental illness and the late Victorians: a study of patients admitted to three asylums in York, 1880–1884,' *Psychological Medicine* 19 (1989): 19–28.

⁴⁸ Graeme Yorston and Camilla Haw, 'Old and mad in Victorian Oxford: a study of patients aged 60 and over admitted to the Warneford and Littlemore Asylums in the nineteenth century,' *History of Psychiatry* 16 (2005): 395–421.

⁴⁹ G.E. Berrios, 'Retrospective diagnosis and its vicissitudes,' *History of Psychiatry* 24 (March 2013): 126–128.

⁵⁰ Renvoize and Beveridge, 'Mental Illness,' 21; Yorston and Haw, 'Old and mad,' 409.

⁵¹ Yorston and Haw, 'Old and mad,' 411.

⁵² Renvoize and Beveridge, 'Mental Illness,' 21.

Category		Recovery rate
Address	Bedminster	42.23%
	Clifton	44.54%
Sex	Female	42.90%
	Male	32.86%
Age	21–30	43.32%
	61–70	28.09%
Occupation	Agricultural	34.74%
	Commercial	34.30%
	Domestic	44.98%
	Industrial	35.49%
	Non-productive	39.64%
	Professional	37.16%
Education	Neither read nor write	24.26%
	Read only	40.10%
	Read and write	42.22%
Diagnosis	Dementia	22.70%
	Mania	43.99%
	Imbecility	12.27%
	Melancholia	51.10%
	Puerperal mania	81.54%
	GPI	2.17%

Fig. 3 Comparison of recovery rates⁵³

Due to the aforementioned problems with diagnoses, we will examine the patients' conditions more in terms of their symptoms and will look at four areas: those with GPI, those with epilepsy, those with delusions and those with affective symptoms. This categorisation is made as

⁵³ Figures obtained from database using categories 'diagnosis' and 'result'.

it seems to coincide with the different types of experiences and suffering which the patients in each category faced.

Epilepsy

Of the conditions which are now seen as non-psychiatric, epilepsy was the most common at the asylum. Dr Bentham, the Medical Superintendent, asserted in 1890 that there were 120 patients with epilepsy, which was about one fifth of the patient population.⁵⁴ There were only 11 patients for our entire period who had epilepsy as the prime diagnosis. There were 562 patients noted as having epilepsy and their primary diagnosis was most commonly given as dementia.⁵⁵ Many of their symptoms, including memory loss, aggression and confusion, seem to have been a result of their epilepsy, not their primary diagnosis.⁵⁶ For most of these cases epilepsy was their main problem and this is evidenced by the fact that they were housed in their own wards (male and female), presumably so they could be better observed. Fits were very frequent and the table below (Fig. 5) shows that in 1869 there were 12,462 fits from an average of 52 patients. Thus a patient with epilepsy could expect on average to have about five fits a week. This must have had a devastating effect on the sufferer and would have been difficult for the largely untrained attendants. On each epilepsy ward (one male, one female) there were about 120 fits each week. Although the majority (65 per cent) of patients diagnosed with epilepsy were to die in the asylum, 22 per cent did recover, though the recovery would not have been from their epilepsy but rather from a concomitant psychiatric illness.

Epilepsy had for many centuries been associated with mental disorder. The convulsions and postictal behaviour (postictal being the period following an epileptic fit), which could include violence, confusion and loss of memory, was thought to be proof of the link between them.⁵⁷ In

⁵⁴ Donal Early, *'The Lunatic Pauper Palace' Glenside Hospital Bristol 1861 – 1994* (Bristol: Friends of Glenside Hospital Museum, 2003), 26.

⁵⁵ See pivot table categories 'diagnosis' and 'physical problems'.

⁵⁶ Andres Kanner, 'Psychiatric issues in epilepsy: The complex relation of mood, anxiety disorders and epilepsy,' *Epilepsy and Behaviour* 15 (2009): 83–87.

⁵⁷ *Ibid.* 83.

the Middle Ages it was thought to be contagious, hence the need for them to be incarcerated. This very negative view of epilepsy led to much discrimination and Connecticut actually passed laws against epileptics in 1895 which restricted their freedom of movement.⁵⁸ Later research does show a correlation between mood disorders and epilepsy and this is bidirectional, that is, those with mood disorders are more likely to suffer from epilepsy and also those with epilepsy are more likely to develop mood disorders.⁵⁹ Other research shows that, following a fit, patients were likely to suffer from confusion and psychotic ideas which, in 22.8 per cent of cases, led to violence.⁶⁰ Interestingly, melancholia was the diagnosis for only 5.16 per cent of those with epilepsy, compared to 17 per cent for the whole asylum population.⁶¹ All the diagnoses of patients with epilepsy are shown in Fig. 4 below.

Diagnosis	Epilepsy in numbers	Percentage of those with epilepsy
Amentia	4	0.71%
Confusion	1	0.18%
Congenital idiot	1	0.18%
Delirium tremens	2	0.36%
Delusional insanity	2	0.36%
Dementia	233	41.46%
Epilepsy	10	1.78%
Idiocy	18	3.20%
Imbecility	42	7.47%
Mania	176	31.32%
Melancholia	29	5.16%
Senile dementia	2	0.36%
Not known	31	5.52%
Not certified insane	6	1.07%
Not recorded	5	0.89%

Fig. 4 Diagnoses of patients with epilepsy⁶²

⁵⁸ Shawn Masa and Orrin Devinsky, 'Epilepsy and Behaviour: A Brief History,' *Epilepsy and Behaviour* 1 (2000): 37.

⁵⁹ Kanner, 'Psychiatric Issues,' 83.

⁶⁰ Kousuke Kanemoto, Yukari Tadokoro & Tomohiro Oshima, 'Violence and postictal psychosis: A comparison of postictal psychosis, interictal psychosis and postictal confusion,' *Epilepsy and Behaviour* 19 (2010): 162–166.

⁶¹ Figure obtained from pivot table comparing categories 'diagnosis' and 'physical problems'.

⁶² Ibid.

Month	Male				Female			
	No. of epileptics	Day	Night	Total	No. of epileptics	Day	Night	Total
January	24	162	200	362	24	256	440	696
February	25	210	149	359	24	216	415	631
March	26	202	234	436	25	218	491	709
April	29	210	219	429	27	257	479	736
May	24	215	207	422	24	283	396	679
June	23	210	231	441	26	240	459	699
July	26	182	195	377	26	294	568	862
August	27	216	220	436	25	198	390	588
September	27	192	182	374	23	177	329	506
October	27	223	193	416	22	182	221	403
November	25	219	181	400	22	233	290	523
December	28	226	185	411	24	227	340	567
Total	–	2467	2396	4863	–	2781	4818	7599

Fig. 5 No. of fits during the year 1881⁶³

The Lifton Family and Epilepsy

Sidney Charles Lifton's family was well known to the asylum. Isaac, his father, had several admissions starting in 1871. His sons, Frederick and Sidney, both had long admissions and died in the hospital. On his wife's side, two cousins were also residents there. The family, however, were not insane; their curse was epilepsy and this was the cause of most of their troubles.

In 1861 they were a fairly prosperous family; Isaac and his wife Jane had five children and Isaac's job as a bootmaker generated enough income for them to have a live-in servant. The 1871 census shows them still together just prior to Isaac's first admission.⁶⁴ Sidney was the youngest of

⁶³ Figures from Wellcome Library: WLM28.BE5B86 1870–1889.

⁶⁴ '1871 England Census,' Ancestry, accessed March 19, 2014, <http://search.ancestry.co.uk/search/db.aspx?dbid=7619>.

the five and his relatively cosy life had, by the time of his admission on 20 April 1887, turned into something of a nightmare. His father, after two admissions in 1871–2 and again in 1881, had died in 1885. His brother Frederick was having fits and by November 1887 had been incarcerated in the asylum. Sidney's career in the Rifle Brigade had been terminated due to his epilepsy.⁶⁵

On admission he was described as 'stupid and indifferent' and would not speak or reply to questions. Later, when somewhat recovered, he told them he had no memory of what happened and that he was 'daft'.⁶⁶ Sidney had been brought to the asylum by a constable who found him wandering in the street in a confused state. This seems typical of a postictal state.⁶⁷ His brother Rowland, however, states he had been very low prior to admission and his notes classify him as suicidal. This shows how the asylum either seemed to not understand how Sidney would not have been responsible for his actions, or was indifferent to his plight. It also shows his own low self-esteem in describing himself as daft and thus confirming the link between mood disorder and epilepsy. Sidney spent the last eleven years of his life in the asylum, dying in March of 1898 aged only 37. We have three sources of evidence for his time spent there: the nursing notes, the fairly frequent assessments of the medical staff and his own voice in the form of letters written to the Medical Superintendent and the Visiting Committee. Certainly for the early years he was not happy to be there. He describes how he was 'out in the airing court, I jumped the wall and was brought back and placed in a signal (seclusion) room for four days'.⁶⁸

His letters show a proud man, proud of his trade as a hairdresser (as was his brother Frederick) and his career in the army⁶⁹. Most of all he wants to show that he is a man and, in doing so, to show he is ready for discharge. In a letter to Dr Thompson, the Medical Superintendent, (see below) he implores him to discharge him, at least on a trial basis. He

⁶⁵ Admission books BRO 40513/C/2/7, 214. Admission 20/4/1887, discharge (died) 12/3/1898.

⁶⁶ Ibid.

⁶⁷ P. Widdess-Walsh and O. Devinsky, 'Historical perspectives and definitions of the postictal state,' *Epilepsy and Behaviour* 19 (2010): 96–99.

⁶⁸ Letter in admission books BRO 40513/C/2/7, 214.

⁶⁹ Ibid.

promises to 'act the man'.⁷⁰ Because he is incarcerated and because he cannot work, he cannot be a man. As Marjorie Levine-Clark has shown, for many men, admission to an asylum was an attack on their manliness.⁷¹ For Sidney this was very evident. He had been a soldier, the height of manliness, but had to leave because of his epilepsy. His admission meant he could not work as a hairdresser and he gained the opprobrium of being labelled a pauper. He also could no longer provide for his family. It is little wonder he saw his incarceration in terms of a loss of his manhood. Several feminist writers, including Showalter, have suggested that during the Victorian era the idea of insanity became feminised and, although this approach has not been without its critics, it could be argued that for someone like Sidney to be thought of as mad was another slight to his manhood.⁷²

Letter to Doctor Thompson:

Dear Sir

Will you kindly give me my discharge, or get it for me I know you are able to, if you like, I will promise that I will act the man as long as I can, you must only trust me, who are you to trust that is the question, I am Sidney Charles Lifton, I can yes I can go out and work, I am if ever I was ready to do anything if you will place confidence in me, do try me once, you could have me back again without anyone knowing it, so do try me, even me.

Sidney Charles Lifton

Both the nursing notes (14 June 1887) and his own letter describe how he smashed a door with a broom.⁷³ Other nursing notes report him as striking another patient (1 July 1887) and

⁷⁰ Ibid.

⁷¹ Marjorie Levine-Clark, 'Embarrassed Circumstances: Gender, Poverty and Insanity in the West Riding of England in the Early-Victorian Years,' in *Sex and Seclusion*, eds. Andrews and Digby, 123–148.

⁷² For a review of the debate around gender and madness, see Andrews and Digby, *Sex and Seclusion*, 8–44.

⁷³ Ibid.

injuring his left eye (2 August 1887).⁷⁴ What is not clear is whether these incidents were a direct result of his epilepsy or related to his anger. He is regularly noted in the hospital medical journals and he seems to have been placed in seclusion more than any other patient during the period 1887–90.⁷⁵ Whether this was for his own safety is unclear but he was given fairly frequent injections of hyoscine, which was a powerful sedative but which a previous Medical Superintendent had said should not be used for epilepsy.⁷⁶ Epilepsy did dominate his life but when not affected by his condition he did function fairly well and there is a report of him playing in a cricket match. It is stated he became abusive during the match.⁷⁷ It is difficult to know whether this verbal abuse was related to his epilepsy. His untreated epilepsy would certainly have affected his brain but it is a mistake to automatically attribute all behaviour to a patient's disease or condition. By April 1891 his physical condition is described as feeble but he was to live for another seven years. He died in March 1898.⁷⁸ This was recorded in the *Bristol Mercury*: 'On Saturday afternoon last he was seized by a severe epileptic fit, and the attendant who was near him loosened his tie and laid him on the ground. The deceased suddenly changed colour and although everything was done to revive him, he died within a few minutes.'⁷⁹ This newspaper report shows how the reporting of the asylum had changed from hagiographic accounts of their brilliance to stories of death and violence. It also shows the vulnerability of those with epilepsy. Nowadays a simple injection of diazepam would have saved him but then there was no treatment.⁸⁰

Sidney's story is certainly not a happy one but he is an example of someone who does not conform. He will not play the role of a satisfied inmate: he gets angry at a cricket match, he tries

⁷⁴ Admission book BRO 40513/C/2/7, 214.

⁷⁵ Medical journal BRO 40513/J, 86–90.

⁷⁶ Early, *Pauper Palace*, 19.

⁷⁷ Admission book BRO 40513/C/2/7, 214.

⁷⁸ Medical Report BRO 40513/C/11/1.

⁷⁹ 'Inquests in Bristol,' *Bristol Mercury and Daily Post*, March 19, 1898, 7.

⁸⁰ 'Treatment and care for seizures that last more than 5 minutes and for status epilepticus,' Epilepsy Action, accessed September 26, 2014, <https://www.epilepsy.org.uk/info/treatment/status-epilepticus>.

to leave the asylum and he gets into fights. He certainly did not understand the nature of his own condition but then nor did the institution. The condition was still in many minds associated with devilry and the often bizarre or violent behaviour of those with the condition probably meant their treatment was often harsh.⁸¹

General Paralysis of the Insane (GPI)

It is now known that GPI was in fact an advanced form of syphilis. There had been suggestions that this disease was connected to syphilis from 1857 but generally this was dismissed until 1913, when the Japanese scientist Hideyo Noguchi proved the presence of the organism, then called *spirochaeta pallida*, in the brain of a patient who had died of GPI.⁸² Melling and Forsythe in their study of Devon asylums concluded that 'there is good reason to believe that the term [GPI] was widely used along with dementia to encompass a wide range of disorders rather than restricted to symptoms of syphilitic infection'.⁸³ Although this was certainly true of dementia, the death rate for GPI, which far exceeded any other disease, and the confirmation of the diagnosis at an autopsy (the majority of the Bristol asylum patients received an autopsy) suggest that, although there may have been a few misdiagnoses, it was not a range of disorders.

The lives of those in the asylum with GPI do not make for pleasant reading; their brevity being some sort of solace. Edward Colston Hale's story is fairly typical, unusual only in that he managed to live for over two years after admission. On entering the asylum he was described as being 'deficient in memory, his speech clipped and his lips tremulous'. He claimed to have two brains and was a 'Bristol wonder'.⁸⁴ His stepfather William, who ran a public house with Edward's mother, stated that Edward's troubles began a few years ago after a proposed marriage had fallen through at the last minute. Edward had become distraught and had spent all his savings (about

⁸¹ Gordon Holmes, 'Evolution of Clinical Medicine Illustrated by the History of Epilepsy,' *British Medical Journal* 2(4461) (July 6, 1946): 1–4.

⁸² G. Davis, 'The most deadly disease of asylumdom: general paralysis of the insane and Scottish psychiatry, c.1840–1940,' *Journal of the Royal College of Physicians of Edinburgh* 42 (2012): 266–273.

⁸³ Melling and Forsythe, *The Politics of Madness*, 131–2.

⁸⁴ Admission book BRO 40513/C/2/9, 102. Admission 5/8/1892, discharge (died) 29/10/1894.

£70) on some sort of binge which might have included a sexual liaison which lead to his illness. Sometime after this, Edward's memory began to become deficient and he exhibited delusions of grandeur (over-emphasising his own importance). However, on admission his physical health was still regarded as 'fair' so it seems he was not yet in the later stages of the illness. He seems to have been well liked by the staff, he helped out on the ward and this continued even as his health began to fail. He is described on 29 August 1892 as being 'perfectly happy in his surroundings and full of benevolent intentions'.⁸⁵ This pleasant if deluded state did not, however, last and he began to have fits. In June of the following year, a Special Report suggests he was 'in a state of complete dementia'. He continued to deteriorate, was often described as 'foolish' and began to exhibit haematomas on his limbs.⁸⁶

Edward's photograph below (Fig. 6) seems to show him in a feeble state. As photography was not introduced until after his admission, the picture was probably taken near the end of his life. The hand clasped to his hand seems to be for reassurance, he probably did not understand what was happening. His haematomas developed into abscesses and he died on 29 October 1894, he was 28 years old. His story has the makings of Victorian melodrama: the thwarted love affair, the reaction taking in sex and drink and the descent into madness. This is, however, to do him a disservice. Without catching syphilis he may have had a decent life – he had a good job as a lithographer – and may have married. His story is not a parable; he was just unlucky. As previously described, Edward had delusions of grandeur (in contemporary terminology 'grandiose delusions') and, as the next section on delusions shows, in affective terms it was better that your delusions were grand as it made you feel better.

⁸⁵ Ibid.

⁸⁶ Ibid.



Fig. 6 Edward Colston Hale⁸⁷

GPI has been termed ‘the most deadly disease in asylumdom’ with good reason, as there was no treatment and was always fatal.⁸⁸ The symptoms were increasingly horrific. They are characterised by Davis as:

In the first, patients would exhibit slight defects of speech, uncoordinated facial muscles, eye irregularities and mental exaltation. Unless the patient died of exhaustion or convulsions, he would be expected to pass into the second stage, characterised by increased muscular incoordination, paralysis and mental enfeeblement. The final stage

⁸⁷ Photograph from admission book BRO 40513/C/12, 102.

⁸⁸ Davis, ‘The most deadly disease of asylumdom,’ 266–73.

was said to be one of fairly complete paralysis and ‘mental extinction’, the complete loss of intellectual and physical functions culminating in certain death.⁸⁹

As the patient neared death, and 55 of the admissions to Bristol with this disease died within three months, Clouston observed they exhibited a ‘mental enfeeblement and mental facility’, ‘delusions of grandeur and ideas of morbid expansion or self-satisfaction’.⁹⁰

The figures for GPI in Fig. 7 give a very false impression of the numbers of patients afflicted with this disease. On admission it was rarely given as a diagnosis and most were given the diagnosis of dementia. However, if we look at the physical problems entered into the admission books, the number afflicted rises to 337. Of these, 280 were men, which was 11.2 per cent of the male admissions.⁹¹ Nationally the figures are almost exactly the same, with 11.3 per cent of male admissions having the disease in 1901.⁹² This is still probably an underestimation of the actual numbers, as the disease was often not confirmed until a post-mortem was completed. For those with the advanced form of the disease, life was short and the following chart shows that the majority died within a year and only 34 survived more than three years. These may have had an early stage of the disease on admission which may have been due to concomitant psychological problems.

Months from admission to death	Number of patients
0 to 1	21
1 to 3	34
3 to 12	95
12 to 36	112
36 to 120	27
over 120	7

Fig. 7 Deaths of patients with GPI in months⁹³

⁸⁹ Ibid.

⁹⁰ Thomas Clouston, *Clinical Lectures on Mental Diseases* (London: J. and A. Churchill, 1896), 378.

⁹¹ Figures from pivot table using the categories ‘physical problems’, ‘sex’ and ‘result’.

⁹² Fifty-sixth Report of the Commissioners in Lunacy, 1902.

⁹³ Chart produced from pivot table using categories ‘duration calculation’, ‘physical problems’ and ‘result’.

GPI was mostly a male disease with over five times as many men diagnosed as women (272 to 51).⁹⁴ There also seems to be some correlation between class and the disease with the affluent Clifton and Westbury districts having respectively 4.45 per cent and 4.94 per cent of their patients diagnosed with the disease, compared to 7.47 per cent and 8.03 per cent for the poorer areas of Bedminster and St Philips.⁹⁵ Not surprisingly, the area with the highest rate for this disease with 11 per cent, was St Nicholas, which was said to have a large number of brothels.

Delusions

When compiling the database for this study, the author noticed that a large number of patients were described as having delusions. This was a larger number than the author expected from his time as a psychiatric nurse. As the aforementioned problems with the diagnoses of mania and dementia made them problematic as distinct categories that could be examined, it was decided to study those with delusions as a category. This was also because having delusional thoughts seemed to be a major factor in many of the admissions and one which severely affected their progress and lives in the asylum.

The asylum's 1895 Special Reports provide many vivid examples of the extent and variety of the delusions from which the patients suffered.⁹⁶ Some may seem bizarre, like the delusions of Alfred Cope that he was a friend of Napoleon or Emily Minty who thought she was an heir to the throne. Other ideas must have made life very difficult for the patient. Eliza Solace thought she was violated every night and Edward Hughes had the rather common delusion that people were trying to poison him.⁹⁷

A delusion has been defined as 'a belief that is clearly false and that indicates an abnormality in the affected person's content of thought. The false belief is not accounted for by

⁹⁴ Figures from database using category 'physical problems'.

⁹⁵ Figures from pivot table using categories 'physical problems' and 'address'.

⁹⁶ Admission book BRO 40513/C/11.

⁹⁷ Ibid.

the person's cultural or religious background or his or her level of intelligence.⁹⁸ Perhaps not all the delusions described in the admission books would meet this definition and Louise Hide has suggested that for some patients with GPI 'these accounts were, indeed, illusions, that is, erroneous interpretations of painful and bewildering bodily sensations and the agencies that caused them. As such, they can be analysed as pain narratives.'⁹⁹ These, however, are in a minority and the table below (Fig. 8), which was compiled from two years of the admission books, shows at least half of the patients were thought to have delusional thoughts.

Today the nature of delusions is much debated and a recent article by Lisa Bortolotti and Kengo Miyazono has shown both how little agreement there is on the nature of delusions and how most theories have severe logical flaws.¹⁰⁰ This study will not enter this philosophical minefield and will just examine delusions as identified by these nineteenth-century doctors. Since the twentieth century, delusions have been seen as key criteria for the diagnosis of schizophrenia and indeed many of the patients at the Bristol Asylum do seem to have had some sort of condition whose symptoms would currently have them labelled as having schizophrenia. However, with a sizeable minority the delusions seem to have been associated with either an organic illness, like the case of Edward Hale, or with melancholia. In the male figures for 1885, seven of those with delusions had a diagnosis of melancholia.¹⁰¹ These figures are in accord with Robinson's study of delusions in Scotland which showed a high percentage of patients with delusions.¹⁰² His study also showed that there were more patients with delusions in the late nineteenth century than in the 1970s.¹⁰³

⁹⁸ Chandra Kiran and Suprakash Chaudhury, 'Understanding Delusions,' *Industrial Psychiatry Journal* 18(1) (January–June 2009): 3.

⁹⁹ Louise Hide, 'Making sense of Pain: Delusions, Syphilis and Somatic Pain in London County Council Asylums c. 1900,' *19: Interdisciplinary Studies in the Long Nineteenth Century* 15 (2012):1.

¹⁰⁰ Lisa Bortolotti and Kengo Miyazono, 'Recent Work on the Nature and Development of Delusions,' *Philosophy Compass* 10(9) (September 2015): 636–645.

¹⁰¹ Admission book BRO 40513/C/2/7.

¹⁰² A.D.T. Robinson, 'A Century of Delusions in South West Scotland,' *British Journal of Psychiatry* 153(2) (1988): 163–167. The percentage varied from 47 per cent of males with depression having delusions to 100 per cent of females with schizophrenia having delusions.

¹⁰³ *Ibid.*

The figures for this study and that of Robinson are not definitive proof that there were more delusions in the nineteenth century, as what constituted a delusion is affected by differing societal and individual standards.

Year	Gender	No delusions	Delusions
1885	Male	30	30
1885	Female	37	25
1892	Male	23	45
1892	Female	26	48
Total		116	148

Fig. 8 Number of patients described as having delusions for the years 1885 and 1892¹⁰⁴

Many authors have examined the nature of delusions. Foucault saw them as little different from general foolishness, whilst Wittgenstein saw them as the antithesis of certainty and the bi-products of a disordered brain.¹⁰⁵ This study will not enter this debate, as its concern is with how these delusions affected the patients. Some people have thoughts which can definitely be described as delusional but if their delusions do not affect their actions or emotions and if they do not tell others, particularly psychiatrists, then they are unlikely to adversely affect their lives. If Domenico Scandella, the miller from Ginzburg's *The Cheese and the Worms*, had kept his mouth shut about what the moon was made of (he thought cheese and worms), he might not have come to the attention of the Italian Inquisition.¹⁰⁶ Unfortunately the people in the asylum had delusions which affected their actions and they told others about them.

There are many different types of delusions, however, as Leonard Smith remarks, for those admitted to asylums there were basically two main categories: grandiose and persecutory. Grandiose delusions are when the person believes they have higher status or abilities than they

¹⁰⁴ Figures in table from admission books for 1885 and 1892, BRO 40513/C/2/7 and BRO 40513/C/3/10.

¹⁰⁵ Michel Foucault, *Madness and Civilization* (London: Random House, 1965), 94-116; L. Wittgenstein, *On Certainty* (New York: Harper and Row, 1969), 140-149.

¹⁰⁶ Carlo Ginzburg, *The Cheese and the Worms: The Cosmos of a Sixteenth-Century Miller* (Baltimore: John Hopkins University Press, 1980), 70-91.

actually possess, and persecutory delusions when they think people are plotting to do them harm.¹⁰⁷ Sometimes the delusions are in part based on reality, such as in the famous case of James Tilly Matthews who was sent to Bedlam in 1797 after claiming he was being threatened by an Air Loom machine and that he was a government secret agent. The Air Loom did not exist but he was a government secret agent.¹⁰⁸

The delusions of Eliza Solace and Edward Hughes of being violated or poisoned (see start of section) are clearly delusions of persecution. The case of George Joseph Silman, who was mentioned in the section on diagnosis and who thought he had a battery in his head, is more difficult to categorise. As Louise Hide has suggested, some delusions are best conceptualised as pain narratives when they are related to actual bodily sensations, but there is no evidence that it was a misinterpretation of something that was actually happening in his body.¹⁰⁹ It could be seen as a form of persecutory belief, that someone had placed the battery there in order to persecute him. However, his belief is probably best seen as what the nineteenth-century writer T.S. Clouston termed a 'delusion of unseen agency'.¹¹⁰ With these, outside agencies control the patient's body, often by inserting contraptions or devices into them. Beveridge found a number of similar cases in his study of patients' letters in Edinburgh.¹¹¹ Silman's belief led him to think he was dying and that his life was being drained away by electricity. He then presented himself at a police station begging for help. His delusions and the emotions resulting from them had meant he could not work and his family did not know what to do with him. The asylum did not help him and he hated it there, in part because they could not rid him of this battery. At one point he escaped, was recaptured and then claimed he was glad to go back. Some delusions fade away or the person

¹⁰⁷ Leonard Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* (London: Leicester University Press, 1999), 100.

¹⁰⁸ His story is told in the excellent book by Mike Jay, *The Influencing Machine: James Tilly Matthews and the Air Loom* (London: Strange Attractor Press, 2012).

¹⁰⁹ Louise Hide, 'Making Sense of Pain'.

¹¹⁰ Clouston, *Clinical Lectures on Mental Diseases*, 378.

¹¹¹ Allan Beveridge, 'Voices of the mad: patients' letters from the Royal Edinburgh Asylum, 1873–1908,' *Psychological Medicine* 27(4) (July 1997): 899–908.

learns to live with them. George's delusion was fixed and he spent the last 36 years of his life in the asylum, the only change being he stopped referring to what was in his head as a battery but rather as electricity. His delusion had adapted to mains electricity.¹¹² This relates to Beveridge's study of delusions in which he noted that they often keep technologically up to date. New technologies seem to provide an explanation for the patients' troubles.¹¹³

Persecutory delusions produce strong emotions of fear whilst grandiose delusions have a more beneficial emotional effect. Edward Hale (see start of chapter) had grandiose delusions that were a result of his GPI but until the very last stages of his illness he seems to have been quite happy, perhaps because of these delusions.¹¹⁴ Research by Garety et al. has shown that those with grandiose delusions 'were predicted to have less negative self-evaluations and lower anxiety and depression, along with higher positive self and positive other evaluations' than persecutory ones.¹¹⁵

The problem with grandiose delusions is that they affect your behaviour. If a patient like Emily Minty, thought they were a member of the royal family, they were unlikely to feel satisfied with their actual occupation (in Emily's case, as a domestic servant).¹¹⁶ Life for many was doubtless one of sustained frustration at not being recognised for what they felt they were. If a person has grandiose beliefs, his or her situation in a lunatic asylum was going to seem incompatible with the status they believe that they possess. Whether such people needed to be in an asylum is another question, but, as with other conditions, families found it very difficult to cope with these people and the asylum presented an alternative.

The story of Sarah Wright is an example of someone whose delusions and her subsequent behaviour led to a long and unhappy existence in the asylum. She was admitted to the asylum on

¹¹² Admission book BRO 40513/C/2/8, 161.

¹¹³ Beveridge, 'Voices of the Mad,' 901–902.

¹¹⁴ Admission book BRO 40513/C/2/9, 102. Admission 5/8/1892, discharge (died) 29/10/1894

¹¹⁵ Philippa A. Garety et al., 'Differences in Cognitive and Emotional Processes Between Persecutory and Grandiose Delusions,' *Schizophrenia Bulletin* 39(3) (2013): 629.

¹¹⁶ Admission book BRO 40513/C/3/12, 90. Admission 11/11/1893, discharge (relieved) 2/11/1928.

11 November 1896, she was 41 years of age and married to Francis Charles Wright, a joiner. The admission seems to have been at the instigation of her husband. He described how for the last two months she had begun to have strange delusions, including that she was being electrified with wires. She had then started to become violent and was now completely unmanageable at home. Her subsequent actions, ideas and letters indicate that his testimony was an accurate one. He initially visited his wife in hospital and as her letter (partially reproduced below, Fig. 9) shows, he sent her food.¹¹⁷ In later years he seems to have not visited her and evidence from the 1911 census suggests he may have formed another relationship as he was living with his son aged 11 and housekeeper whilst his wife had been incarcerated for 15 years.¹¹⁸

Mr F. C. Wright
18 Dalrymple St.
Bristol

Edgemoor,
St Bristol
Oct 26. 1897

Copy.

My Dearest Husband,

I thank you very much for the
love of good things to eat. I received
it allright. the cake is very good.
so were the pears. I eat all of them
Saturday night. I was not let go for
a walk on Saturday outside. I was
insulted instead as usual by them
all; so that they send a bad
character of me into Bristol is all
they can think of day and night
when they are awake, and curse
my worn and shabby-looking face
which is made so by them; I
desest them, I shall tell you what

Fig. 9 Sarah Wright's letter to husband, 1897¹¹⁹

¹¹⁷ Ibid.

¹¹⁸ '1911 England Census,' Ancestry, accessed June 8, 2016, <http://search.ancestry.co.uk/search/db.aspx?dbid=2352>.

¹¹⁹ Letter from admission book BRO 40513/C/3/13, 72. Admission 11/11/1896, discharge (died) 2/3/1936.

On admission she was described as eccentric and peculiar with various delusions, including that the Queen had told her to go to the Duke of Beaufort's and that at night she could hear people getting into the roof and making their way to the cellars. Physically, the doctors stated she was 'in good condition', a description which would not have been applied to many of the admissions and indicates both that she did not come from a deprived background and that prior to admission she had not been neglecting herself. Her problems were all in the mind.

Sarah was born in the small Gloucestershire village of Broomslerrow (now named Bromesberrow), which is in the Forest of Dean. She was one of seven children but two of her brothers had died in accidents, as had her father. Her mother had died aged 65 of old age. After she married Charles, she had a baby daughter whom unfortunately died at a young age and she did not have any further children. This may have been a causal factor in the onset of her psychiatric problems. At the time of her admission they lived at Dalrymple Road, a fairly prosperous area of Bristol which now would be classed as Montpelier.¹²⁰



Fig. 10 Sarah Wright in 1896¹²¹

¹²⁰ Admission book BRO 40513/C/3/13, 72.

¹²¹ Photograph from admission book BRO 40513/C/3/13, 72.

Reproduced above is a photograph of Sarah taken shortly after admission (Fig. 10). It is unusual in that most of the patients' photographs were taken outside against one of the asylum walls and they were nearly always shot head-on. Sarah's photo seems to have been taken inside and she is in profile. This probably indicates a certain determination to have things her way. Although photographs can be deceptive, a minute after it was taken she might have been smiling but she seems to have wanted the world to know she was not happy to be there. She had not accepted there was anything wrong with her and she never did.

Many patients in the asylum were initially angered by their admission but if they remained there for a long period many began to accept their lot and to make the best of their situation. For many years, this does not seem to have been the case with Sarah. A Special Report on her on 21 October 1913 states she 'refuses to answer questions, hears voices of persons not present but is in a fair state of bodily health'. A further entry in her notes from June 1914 states she was 'very deluded and abusive, inclined to be violent'.¹²²

The asylum was taken over by the military during the First World War and the patients sent to other asylums. Sarah was sent to the Cotford Asylum near Taunton. It cannot have helped her paranoid mental state to be moved far from her home and she probably saw the move as further evidence of persecution. On 11 November 1919 she was returned to the Bristol Asylum where she remained until her death on 2 March 1936.¹²³ During this period her delusions endured, including the idea that medical officers had burst into her husband's house and crippled him for life (Special Report, 24 October 1928) and that there was something strange and abnormal inside her body (Special Report, 26 October 1933).¹²⁴ She is, however, gradually reported as being less irritable if left alone. For the last fifteen years of her life she worked in the sewing room and this seems to have given her some stability and purpose. In 1934, once she had begun to deteriorate physically, she was visited by her sister-in law but not her husband. She

¹²² Chronic Case Book BRO 40513/C/4/1, 144.

¹²³ Post-mortem Records BRO 40513/C/18/25.

¹²⁴ Special Reports for 1928 and 1933, BRO 40513/C/11.

gradually became weaker but retained her delusions of persecution to the end. Her cause of death was listed as pancreatic cancer.¹²⁵

Evidence from the case notes and the letter reproduced above indicates she suffered from a serious mental condition which dominated her life. This condition produced persecutory thoughts such as those in her letter, which stated that the staff 'send a bad character of me into Bristol' and that her 'worn and shabby face which is made so by them'.¹²⁶ The latter quote also indicates a profound lack of self-esteem. Her condition was probably not helped by her stay in the asylum; being forcibly incarcerated will undoubtedly increase ideas of persecution. Her delusions varied over time but they were always of a persecutory kind. Speculation as to what her life would have been like if she had not gone to the asylum is in some ways futile but given the nature of her delusions its unlikely to have been a happy one. Sarah lived until age 81, which is evidence of the physical care provided; she lived half her long life in the asylum. The causes of her delusions are not obvious, the loss of her only child may have been a factor and there may have been marital problems but essentially it is difficult to attribute the cause to her family, the asylum or society. She had a condition or illness which gave her thoughts which devastated her life, a condition which to this day we have no very effective treatment.

Melancholia and Puerperal Mania

The conditions which we have so far focused on have had fairly poor recovery rates and our examples have been mostly of people who spent long periods in the asylum. This is somewhat misleading and many patients did recover, so in this section we examine two conditions which had a fairly good prognosis. For exact figures see Fig. 2.

We do not know if Margaret Walsh would have jumped from the Clifton Suspension Bridge. The bridge staff saw her acting oddly and they restrained her, as they had restrained many

¹²⁵ Admission book BRO 40513/C/3/13, 72.

¹²⁶ Ibid.

others before and after. It was 22 October 1892 and if she had succeeded Margaret would have been the 30th person to commit suicide from the Clifton Suspension Bridge.¹²⁷ The Bridge remains a popular attraction for would-be suicides. Since they erected barriers, the suicide rate has halved; you have to be a lot more determined now.¹²⁸

Margaret was sent to the Bristol Asylum and diagnosed as suffering from melancholia. It was not her first admission; she had only been discharged from the asylum four months previously. Her background had initially been not particularly deprived. In 1871 she is listed as living in Charles St, St James and was married to Charles, a shoemaker. Her occupation was as a dressmaker. She had two young sons.¹²⁹ More children followed and the family moved to Wales.¹³⁰ Shortly before she was admitted for the first time, her material conditions seem to have worsened, as she was admitted from the workhouse.¹³¹

On admission after being brought from the Suspension Bridge she was described as 'silent and depressed'.¹³² Although she had an address in St Philips, she was considered to be very poor and one of the causes of her admission was listed as 'privation'. Indeed, her gaunt face seen in the photograph below (Fig. 11) suggests someone who has had a hard life.¹³³ A caution card was issued for her, which meant she was considered actively suicidal and had to be closely observed. She was also found to be three months pregnant, which may have added to her desperation.

¹²⁷ *Morning Post* (London, England), November 26, 1891, 3.

¹²⁸ Mike Nowers and David Gunnell, 'Suicide from the Clifton Suspension Bridge,' *England Journal of Epidemiology and Community Health* 50(1) (February 1996): 30–32.

¹²⁹ '1871 England Census,' Ancestry, accessed June 8, 2016, <http://search.ancestry.co.uk/search/db.aspx?dbid=7619>.

¹³⁰ '1881 England Census,' Ancestry, accessed June 8, 2016, <http://search.ancestry.co.uk/search/db.aspx?dbid=7572>.

¹³¹ Admission book BRO 40513/C/3/6, 56.

¹³² Admission warrant (not numbered) BRO 40513/R/4/17.

¹³³ Photograph in admission book BRO 40513/C/3/6, 56.



Fig. 11 Margaret Walsh in 1892¹³⁴

As in her first admission Margaret recovered quite quickly, the caution card was revoked and on 7 July gave birth to a healthy child. One month later she was discharged as recovered.¹³⁵ Her freedom was not to last long and her husband reported that soon after discharge she tried to hang herself. In December of the same year she was readmitted and although her diagnosis was still melancholia she seemed very different. She was described as wildly excited and was violent to both staff and other patients. She did not recover quickly on this occasion and was to spend seven years in the asylum. Her violence continued and her diagnosis was changed to mania. Today she might be labelled as manic depressive or bipolar, as she exhibited both depressive phases and periods of manic behaviour.

Melancholia is usually seen as virtually the same as the current diagnosis of depression. Hill and Laugharne state that by the 1870s the diagnosis of melancholia was 'clearly akin to today's depression'.¹³⁶ However, Harris et al. found that in the North Wales area during the period 1875–1924 of the 853 patients diagnosed with melancholia only 494 met the current criteria for depression.¹³⁷ Thus although similarities exist, they are by no means identical conditions. For

¹³⁴ Photograph in admission book BRO 40513/C/3/12, 7. Admission 22/11/1892, discharge (recovered) 7/8/1893.

¹³⁵ Ibid.

¹³⁶ Simon Hill and Richard Laugharne, 'Mania, dementia and melancholia in the 1870s: admissions to a Cornwall asylum,' *Journal of the Royal Society of Medicine* 96 (July 2003): 361.

¹³⁷ Margaret Harris et al., 'The incidence and prevalence of admissions for melancholia in two cohorts (1875–1924 and 1995–2005),' *Journal of Affective Disorders* 134 (2011): 45–51.

many of the patients, threatened or attempted suicide, seemed to have been closely associated with a diagnosis of melancholia. The numbers of those diagnosed with melancholia and their prognosis at Bristol match those of similar institutions. At the Exminster Asylum, Melling and Forsythe found that 14.7 per cent of their patients were diagnosed with melancholia, compared to 18.1 per cent at Bristol. Their recovery rates were even more similar with 50.7 per cent recovered at Exminster and 51.1 per cent at Bristol.¹³⁸ Many of those diagnosed with melancholia exhibited symptoms that would be consistent with a contemporary diagnosis of depression, including suicidal thoughts, loss of appetite, poor sleep and lethargy.¹³⁹ What seems unusual to contemporary eyes are the number of symptoms that today would be termed psychotic. This is illustrated by the following examples who were all diagnosed with melancholia and who all recovered.

Emma Day, a 42-year-old married paper bag maker, was a patient for four months in 1893 and was admitted after she tried to drown herself. She described on admission how she 'hears voices of her employer saying she has stolen paper bags'.¹⁴⁰ Rosa Ann Lucas, a 38-year-old housewife from Barton Hill complained that she 'constantly hears voices that threaten her'.¹⁴¹ Mary Ann Payne, a 32-year-old charwoman said that 'letters from Jesus Christ come to her in her sleep'.¹⁴²

Most of the examples we have so far examined are of women and there were more women diagnosed with melancholia than men, with 544 women and 368 men. Similar results were found by Melling and Forsythe, with 567 women and 346 men at the Exminster Asylum.¹⁴³ Patients diagnosed with melancholia were often admitted after an attempt to kill themselves. George Frederick Hill was a 68-year-old gas works labourer who had made several attempts to kill

¹³⁸ Melling and Forsythe, *The Politics of Madness*, 70–71.

¹³⁹ 'Depression,' Mental Health Foundation, accessed December 7, 2013, <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/D/depression/>.

¹⁴⁰ Admission book BRO 40513/C/3/12, 31. Admission 16/3/1893, discharge (recovered) 3/7/1893.

¹⁴¹ Admission book BRO 40513/C/3/12, 22. Admission 30/1/1893, discharge (recovered) 17/4/1893.

¹⁴² Admission book BRO 40513/C/3/12, 16. Admission 14/12/1892, discharge (recovered) 17/4/1893.

¹⁴³ Melling and Forsythe, *The Politics of Madness*, 71.

himself, including jumping out of a window. He had also been violent to his wife and had delusions that people were trying to murder him. It is probably significant that he drank heavily and the fact that he became more cheerful after only one week seems to confirm this. His diagnosis was melancholia but his admission does seem very related to his drinking and he was discharged after a few weeks.¹⁴⁴

Walter Stanley Crocker was a 25-year-old single clerk who lived in St Pauls. His photograph below (Fig. 12) shows a respectable but serious young man. He was experiencing several melancholic symptoms, including not sleeping and barely eating. He expressed a desire to cut off his own head because of his wickedness. His father said he had been strange for about six months and had some odd religious ideas. His admission on 4 June 1894 seems to have been precipitated by him attacking his father. A caution card was issued but rescinded after a few weeks. Like many patients with melancholia he recovered quite quickly and was discharged after three months.¹⁴⁵



Fig. 12 Walter Stanley Crocker, 1894¹⁴⁶

Puerperal mania could be seen as a great success story for the asylum. With a recovery rate of 81.5 per cent and with another 5 per cent relieved, the vast majority of those afflicted had

¹⁴⁴ Admission book BRO 40513/C/2/10, 73. Admission 13/6/1894, discharge (recovered) 6/8/1894.

¹⁴⁵ Admission book BRO 40513/C/2/10, 70. Admission 4/6/1894, discharge (recovered) 8/10/1894.

¹⁴⁶ Photograph in admission book BRO 40513/C/2/10, 70.

a positive outcome (see Fig. 2). This is not to suggest that it was not a serious condition. Our examples will illustrate how unwell the women were before recovering. The number of women diagnosed with this condition was low at Bristol, with only 2.6 per cent, compared to a national average of 7 per cent.¹⁴⁷ This can be explained again by the diagnostic peculiarities of the different doctors. For the period when Dr Bentham was in charge the rate was 6.3 per cent, which is close to the national average, but for the periods of Dr Thompson and Dr Stephens the rate was only about 1 per cent.¹⁴⁸ The very high recovery rate and the disparity with national figures suggest that the earlier period underdiagnosed the condition. If the diagnoses during Dr Bentham's time had been incorrect and the patients had a different condition then, as all other conditions had much lower recovery rates, the rate would have been lower for his period, which it was not.

Hilary Marland, probably the foremost writer on puerperal insanity, has suggested that part of the reason for the high recovery rate was that the refuge which the asylum offered was a welcome relief from the pressures at home, which the recent birth had greatly increased.¹⁴⁹ This was undoubtedly an important factor but it does seem to be a condition that women generally recover from whatever the treatment.¹⁵⁰ It has been suggested by Mahé and Dumaine that the sudden drop in oestrogen levels following childbirth is a cause of puerperal psychosis and as the levels return to normal the patient usually recovers.¹⁵¹

Annie Smart (seen below in Fig. 13) was a 22-year-old woodturner living in Bedminster, who was admitted to the asylum on 11 November 1892. She had become unwell three weeks after giving birth. She was refusing food, sleeping badly and had developed a number of

¹⁴⁷ D.M. Loudon, 'Puerperal Insanity in the Nineteenth Century,' *Journal of the Royal Society of Medicine* 81 (February 1988): 76–79.

¹⁴⁸ Rate calculated from pivot tables using the categories 'revised diagnosis' and 'admission year'.

¹⁴⁹ Hilary Marland, 'Maternity and Madness: Puerperal Insanity in the Nineteenth Century,' (seminar paper, UKCHNM, April 2003), accessed October 6, 2015, <http://www.nursing.manchester.ac.uk/ukchnm/publications/seminarpapers/maternityandmadness.pdf>.

¹⁵⁰ S. Tschinkel et al., 'Postpartum psychosis: two cohorts compared, 1875–1924 and 1994–2005,' *Psychological Medicine* 37 (2007): 529–536.

¹⁵¹ V. Mahé and A. Dumaine, 'Oestrogen withdrawal associated psychosis,' *Acta Psychiatrica Scandinavica* 104 (2001): 323–331.

delusions, including that she had been crucified, with her body going to hell and her soul to heaven. This delusion may have been associated with her childbirth, the trauma of which perhaps produced a revulsion for her body. The notes suggested she was in a poor state of bodily health with several abscesses on her body and for the next few months she remained unwell with reports of her tearing up her clothes. She then began to improve, her abscesses cleared up and her delusions abated. On 20 April 1893 she was discharged as recovered.¹⁵²



Fig. 13 Annie Smart, 1892¹⁵³

Annie's case was fairly typical of puerperal mania in terms of symptoms and length of admission.¹⁵⁴ Alice Jane Wells was slightly different and probably more serious. Alice was a 29-year-old married housewife who had recently delivered a stillborn child. Thus grief was part of her condition, which was still diagnosed as puerperal mania. On admission she was described as having a 'wildness of expression, fierce language, absurd delusions and an absolute and wilful silence'.¹⁵⁵ This suggests she expressed delusions whilst remaining silent which would be quite a

¹⁵² Admission book BRO 40513/C/3/12, 4. Admitted 11/11/1892, discharged (recovered) 20/4/1893.

¹⁵³ Photograph in admission book BRO 40513/C/3/12, 4.

¹⁵⁴ 53 out of 65 women with puerperal mania were discharged within a year, Source database, pivot table using categories 'diagnosis' and 'length of stay'.

¹⁵⁵ Admission book BRO 40513/C/3/12, 2. Admitted 26/10/1892. Discharged (recovered) 28/12/1895.

feat. Her picture below (Fig. 14) does suggest a suspicious air, but the suggestion of wilfulness says more about the doctor's frustration at their inability to get her to talk, than an objective evaluation of her mental state. It was stated that she was extremely depressed and on 14 November 1892, two weeks after admission, she tried to gouge her eyes out. After this, a caution card was issued for her to be closely observed. Two weeks later she attempted to suffocate herself and was still not eating. She was fed by tube and did not eat voluntarily until August of the next year. She recovered very slowly, her delusions continued and only in November 1895, three years after admission, was her caution card cancelled. She did, however, get well and after a successful week's trial at home she was discharged on 28 December 1895. Her case illustrates the severity of puerperal insanity; she could easily have died. The asylum's response was very controlling, the constant surveillance and tube feeding kept her alive but probably increased her paranoia.¹⁵⁶



Fig. 14 Alice Jane Wells, 1892¹⁵⁷

¹⁵⁶ Ibid.

¹⁵⁷ Photograph in admission book BRO 40513/C/3/12, 2.

Treatment

In the twentieth century, much of a patient's experience in an asylum/psychiatric hospital would have revolved round various treatments. Pamela Michael in her excellent book on the care and treatment of the mentally ill in Wales noted treatments including psychotropic medication, ECT, insulin therapy, leucotomies and malarial treatments.¹⁵⁸ Similar treatments were employed in Bristol but they all date from the twentieth century, beyond our period. Thus, what is currently considered treatment was largely absent from nineteenth-century asylums. In many ways this was not so terrible; most of the twentieth-century treatments were ineffective and sometimes barbaric.¹⁵⁹ Treatment, however, can be considered in a number of ways; the word asylum in Middle English meant refuge, which was what the asylum provided.¹⁶⁰ A refuge could be a place of safety where, out of a difficult environment, a person could recover. Conversely, it could be the place where a family or the state could keep a difficult person effectively in prison. Our asylum probably provided both.

The asylum did not offer much in the way of physical or pharmaceutical treatments nor anything resembling psychotherapy or psychoanalysis. It did, however, believe, especially in the early years, that it could cure people. The asylum claimed to adhere to the tenets of Moral Treatment (see Chapter 2). In some respects, this was true, including providing work and fresh air exercise. Figures taken from the table in Fig. 1, Chapter 4 show that 88 per cent of patients had outdoor exercise and 68 per cent did some sort of work. The asylum also rarely used restraint, but according to the testimony of John Weston, the patients were not always treated humanely (see Chapter 4).¹⁶¹ Thus, although the increasing number of asylum patients was seen as a failure of

¹⁵⁸ Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800–2000* (Cardiff: University of Wales Press, 2003), 252.

¹⁵⁹ Ibid. 161–4; Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2003), 202–5.

¹⁶⁰ 'Asylum,' Oxford Dictionaries, accessed June 16, 2013, <http://www.oxforddictionaries.com/definition/english/asylum>.

¹⁶¹ John Weston, *Life in a Lunatic Asylum*.

Moral Treatment, at Bristol it can be argued that it was only partially implemented and a fully humane system might have achieved better results.

In the mid twentieth century medication became the primary treatment for mental health problems but in the second half of the nineteenth century options were limited. At the Bristol Asylum several medical treatments were tried. In 1863 Dr Stephens used tincture of sambul root to treat epilepsy after it was recommended by Dr Boyd of the Somerset Asylum but it had little effect.¹⁶² Dr Thompson was very interested in a range of new medical treatments and was a pioneer in the use of the sphygmograph, which was a primitive form of pulse measurement (see Fig. 15 below). This he applied to many different conditions but thought it particularly useful in treating GPI.

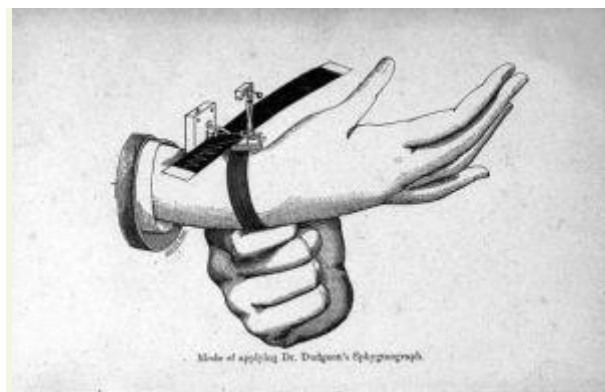


Fig. 15 Robert Ellis Dudgeon's 'pocket sphygmograph'¹⁶³

After using the device on a number of patients with GPI, he concluded that it was 'a disease owing to a considerable extent to persistent spasm of the vessels'.¹⁶⁴ He felt that if this spasm could be eliminated it might prove a cure and, to this end in 1871, he treated the patients with the calabar bean. He initially reported some success but was later forced to admit he was mistaken. He later used jaborandi, also with little success.¹⁶⁵ Sedatives, including morphine, were

¹⁶² Medical Superintendent's Report 1863, Wellcome Library: WLM28.BE5B86, 1862–1869.

¹⁶³ Picture from 'Medical technology in the asylum,' Asylum Science, accessed February 25, 2014, <http://asylumscience.com/tag/sphygmograph>.

¹⁶⁴ George Thompson, 'The Sphygmograph in Lunatic Asylum Practice,' *West Riding Lunatic Asylum Medical Reports* 1 (London: J & A Churchill, 1871): 58-70.

¹⁶⁵ Early, *Pauper Palace*, 18.

increasingly used in our period but the drug most used at Bristol and whose use was pioneered by Dr Thompson was hyoscine. In an article in the *Lancet* he states it had been recommended as a sedative and several of his contemporaries advocated its use as such. He used it to treat mania and detailed the beneficial effect it had on several patients. One was Emma Elizabeth Hooper, who spent 26 years in the asylum from 1882 to 1908. Her diagnosis was of congenital syphilis and he described her life as 'one of continual excitement, she fought, scratched, bit and tore her clothes. She had to be forcibly fed.' After being given hyoscine she fell asleep and was calmer on waking. She had many relapses but the hyoscine was said to have always helped.¹⁶⁶ Another patient who suffered from epilepsy, Frederick Lifton, and whose story is told earlier in this chapter, was also said to benefit from the drug. However, although it does seem to have had some beneficial effects, it seems to be acting entirely as a sedative. The fact that other institutions did not take up its use, suggests it may have had some serious drawbacks. It does seem to be treating mania by putting the patient to sleep. It was probably beneficial to the patient and was certainly beneficial to the staff.

Perhaps the most common drug used was alcohol. Niall McCrae has examined the beer ration in asylums. He notes it was stopped in the mid 1880s, as a result of psychiatry's increasing medicalisation and the influence of the temperance movement.¹⁶⁷ The Bristol Asylum did likewise and McCrae seems reasonable in condemning this abolition; the beer was weak, the patients were only given half a pint and there seems to be few reports of drunkenness. However, spirits, especially brandy and whisky, were very often given for a wide variety of reasons from constipation to melancholia. Beer or spirits were often used to stimulate a patient's appetite, an example being Joseph Smith whose beer was stopped on the 8th June 1879 after he started to eat normally.¹⁶⁸

¹⁶⁶ George Thompson, 'On the use of the Hydrobromate of Hyoscine in the Treatment of Recurrent and Acute Mania,' *The Lancet* 1(3362) (February 4, 1888): 218.

¹⁶⁷ Niall McCrae, 'The Beer Ration in Victorian Asylums,' *History of Psychiatry* 15(2) (2004): 155–175.

¹⁶⁸ Admission book BRO 40513/C/2/5, 160.

Conclusions

A very obvious and undeniable conclusion that emerges from this chapter is that the diagnostic system during this period was, at best, seriously flawed. The conditions which have been found to be physical in origin, namely epilepsy and general paralysis of the insane (GPI), have very specific symptoms and seem to have mostly been correctly diagnosed. Of the other most common conditions there does seem to have been a consistency of diagnosis with melancholia, even though many of the patients had concomitant delusional and affective symptoms. The other conditions seem unduly prone to the particular beliefs of the current Medical Superintendent. The diagnosis of puerperal mania went up sixfold after a change of doctor; mania went up a similar amount when Dr Thompson replaced Dr Stephens. Other studies have produced diagnostic figures which as we have seen, varied greatly. Thus the figures for different conditions varied and this study, with its ability to view the diagnostic figures over time, has shown that the doctors' views on diagnosis were an important factor in these variations. As Brown has shown, in the twentieth century, the validity of psychiatric diagnosis rested on contentious epistemological assumptions.¹⁶⁹ In the nineteenth century the practice of psychiatric diagnosis rested on even shakier ground.

Another conclusion from this chapter is that those admitted, whatever their diagnosis, were mostly seriously unwell, either psychologically or physically. The majority had some sort of delusions and most of those with affective disorders had attempted or threatened to commit suicide. The case of John Longman shows how an unending array of thought disorders can completely transform a person's perceptions and with Sarah Wright a fixed persecutory delusion imprisoned her as much as her actual incarceration. Those who did manage to recover were often just as unwell, but for a shorter period. Alice Jane Wells would have probably died from lack of

¹⁶⁹ J.F. Brown, 'Epistemological differences within psychological science: A philosophical perspective on the validity of psychiatric diagnoses,' *Psychology and Psychotherapy: Theory, Research and Practice* 75 (2002): 239–250.

food or by suicide without the asylum and Margaret Walsh was obviously a suicide risk. Lastly, those with either GPI or epilepsy had physical illnesses of the most severe kind.

The popular perception that the patients in a Victorian asylum were largely a bunch of misfits, pregnant single women and the very poor whose main problem was that society wanted them out of the way is far from the reality of the Bristol Asylum. Whatever the cause of these patients' problems (and society's and families' intolerances would be a factor), the symptoms of their conditions were profound and life-destroying. In historiographical terms, there has in recent years been a welcome emphasis on the lives of the asylum patients. Excellent studies, such as Louise Hide's work on the period up to the First World War, have shown how the patients' lives were affected by the institutions and their personnel.¹⁷⁰ What is lacking in these studies and what the patient's stories from this chapter have illustrated, is how their mental conditions affected their lives. John Longman, Sarah Wright and Edward Hale had conditions that devastated their lives, and if we want to document the nature of the asylum patient experience, this must be acknowledged.

¹⁷⁰ Louise Hide, *Gender and Class in English Asylums, 1890–1914* (New York: Palgrave Macmillan, 2014), 146–171.

Chapter 6: The Photographs of the Asylum Patients



Fig. 1 Alice Kate Birth, 1894¹

This is Alice Kate Birth. The photograph shows a young woman. She looks sad. From the photograph this is all we can definitely discern. From her medical notes and the census we can know more.

Alice was baptised on 23 February 1872 in St George's parish, Bristol.² She was one of ten children and in 1881 lived with her parents and six of her siblings in the St Augustine's area of Bristol.³ She became a domestic servant and in 1891 was living in the house of John Walls, a tailor, where she was one of three servants. She left this position after what her mother termed 'a fit of

¹ Photograph from admission book BRO 40513/C/3/12, 165. Admitted 15/11/1894, Discharge (relieved) 3/6/1936.

² Bristol Parish Register (1596352).

³ '1881 England Census,' Ancestry, accessed June 9, 2016, <http://search.ancestry.co.uk/search/db.aspx?dbid=7572>.

temper'.⁴ Another position did not work out and she became very despondent, which culminated in her trying to jump out of a window. She was refusing food and on 15 November 1894 was admitted to the asylum. On admission, she told them her mother was trying to poison her and she was given a diagnosis of melancholia. Most people, especially young women, recover from melancholia but Alice did not and was to stay in the asylum until 1932.⁵ She was then moved to a nursing home until her death in 1962.⁶

During her long stay there are very few entries in her notes and most state 'no change' or 'nothing new to note'. She did very little, she did not work and only rarely spoke. The entries are often judgemental and the words 'lazy', 'silly', 'lost' and 'childish' are often used. She was tiny (4 ft 8½ in.) but obviously physically robust.⁷ She never seemed to get ill and lived to the age of ninety.

Given the knowledge reported above and the author's background in psychiatric nursing the photograph evokes certain responses. A copy of the photograph hangs in the author's living room and is thus very well known to him. It produces two very distinct impressions. Firstly, she seems to want to be saved. Her look says 'poor me', 'I cannot cope with life' and 'I need a saviour'. The staff at the asylum probably felt they wanted to save her and initially they may have felt very protective, especially given her size and youth. This response, however, would have soured and the second impression the picture is that she did not want to take responsibility for herself and would do nothing to help herself. She wanted a magical recovery and when it did not occur, she withdrew. The very judgemental words used by the staff are certainly not helpful but they are understandable. Their comments seem to suggest they felt she never matured but if you are incarcerated in an institution which controls much of your life, you do not get the life experiences which usually help people to mature.

⁴ Admission book BRO 40513/C/3/12, 165.

⁵ Ibid.

⁶ 'England & Wales, Death Index, 1916–2007' (7b, 204), Ancestry, accessed June 9, 2016, <http://search.ancestry.co.uk/search/db.aspx?dbid=7579>.

⁷ Ibid.

The last paragraph is certainly problematic in terms of evidence. John Berger suggests, quite reasonably, that there is, when considering photographs as evidence, an 'abyss between the moment recorded and the moment of looking'.⁸ This chapter examines that abyss in terms of what the photographs of the asylum patients can tell us. This will entail looking at the history of the depictions of insanity and the use of patient photographs. Why were they produced and what can they tell us about the patients as individuals and as a community? It will be suggested that the initial hopes for this type of photography were ill-founded but that later criticism was also flawed.

The admission books of the Bristol Lunatic Asylum began to include photographs of the patients in 1893, though the practice had mostly died out by the end of our period. From these books I have acquired 722 photographs, many were in a very poor condition so they have been digitally restored, using Photoshop, to something like their original state. In order to evaluate these photographs as historical evidence, it is necessary to place them in context.

Visual Historical Evidence

Visual evidence has been traditionally denigrated as second rate by most historians, though this has been challenged in recent years. Peter Burke points out that prehistoric cave paintings and Egyptian tomb art are universally thought of as indispensable for understanding those cultures.⁹ Roy Porter emphasised the importance of visual sources and suggested a more coherent and vigorous method of interpreting these images.¹⁰ More recently, the rise of 'cultural history' has partly been dependent on the use of visual evidence. It is difficult to imagine a history of football or fashion without the use of images.¹¹ Burke argues convincingly that images should not be used just as evidence in the 'strict sense of the term' but should also be used for 'the

⁸ John Berger, *Understanding a Photograph*, ed. Geoff Dyer (London: Penguin, 2013), 64.

⁹ Peter Burke, *Eyewitnessing: The Uses of Images as Historical Evidence* (London: Reaktion Books, 2001).

¹⁰ Roy Porter, 'Seeing the Past,' *Past and Present*, 118 (1988): 186–205.

¹¹ Katy Layton-Jones, 'Introduction: Visual Collections as Historical Evidence,' *Visual Resources* 24(2) (2008): 105–107.

impact of the image on the historical imagination'.¹² Thus images help the historian to use their 'historical imagination' in order to present a narrative of the subject in question.

Photography as Evidence

The invention and use of photography in the nineteenth century was hailed by many as an escape from the subjectivity of painted images. It was thought that there was now a medium which constructed an objective, scientific reality. The *Lancet* claimed in 1859 that 'photography is essentially the art of truth and the representative of truth in art. It would seem to be the essential means of reproducing all forms and structures which science seeks for delineation.'¹³ The portrait photograph became very popular. Also, compared to a painting, a portrait photograph was cheap and as the century progressed became much cheaper. Thus photography seemed an objective and democratising technology.¹⁴ Allan Sekula quotes from a newspaper report hailing the advent of photography: 'it is the first universal language addressing itself to all who possess vision, and in characters alike understood in the courts of civilization and the hut of the savage'.¹⁵ These suggestions have been very effectively attacked by a wide variety of authors. Fundamentally they suggest photography is not objective and in analysing a photograph the power relations between the subject, the photographer and the photograph's commissioners need to be established.

Photography is not an objective depiction of reality because, as Berger states, photography is basically about choice.¹⁶ The photographer chooses the subject, the framing, gives instructions to the subject and most importantly decides when the photograph is to be taken. Photographs are moments in time. After the photograph is taken the photographer has control over the printing and processing. If you tell five people to photograph the same object you will get

¹² Burke, *Eyewitnessing*, 13.

¹³ Quoted in Tim Putnam et al., *The Block Reader in Visual Culture* (Abingdon: Routledge, 1996), 234.

¹⁴ Asa Briggs, *A Victorian Portrait: Victorian Life and Values as seen through the Work of Studio Photographers* (New York: Harper and Row, 1989).

¹⁵ *The Daily Chronicle* (Cincinnati) January 1840 quoted in Allan Sekula, 'The Traffic in Photographs', *Art Journal* 44(1) (1981): 17.

¹⁶ Berger, *Understanding a Photograph*, 17–21.

very different results.¹⁷ Sontag derides photography's claims to realism and concludes it has a 'relative weakness in conveying truth'.¹⁸ She thinks that because photographic realism is deceptive, it is basically untruthful. It can, however, be argued that, although photography is not wholly objective, photographs are related to the object photographed. The photographs by the five people of the same object would be different but the object would probably be recognised in all of them.

John Tagg and Berger have both examined how photographs in a capitalist state are used in the interests of the ruling class. Influenced by Foucault and Walter Benjamin, they show how photography promotes consumption in advertising and how the coercive instruments of the state have used photography for surveillance of their citizens.¹⁹ Tagg describes how in the nineteenth century, state power augmented by a newly formed police force controlled its citizens and how photography became an instrument of this oppression. In the prisons, factories, hospitals and asylums, photography was a tool for surveillance. Tagg's analysis has merit but it seems rather mechanistic and although surveillance was an aspect of photography's use in these places, it also had less sinister uses. This should be evidenced when we examine its use at the Bristol Asylum. Berger's work is more subtle; he demonstrates how the ruling elite uses images, but suggests also how it can be used as a form of resistance to a ruling hegemony.

Allan Sekula is perhaps the most interesting writer on photography and his work is particularly relevant to this study. He argues that 'during the second half of the nineteenth century, a fundamental tension developed between uses of photography that fulfil a bourgeois conception of the self and uses that seek to establish and delimit the terrain of the other. Thus

¹⁷ Susan Sontag, *On Photography* (London: Penguin, 1977).

¹⁸ *Ibid.* 112.

¹⁹ John Tagg, *The Burden of Representation: Essays on Photographies and Histories* (Basingstoke: Macmillan Education, 1988), 66–105; Berger, *Understanding a Photograph*, 3–17. They were both particularly influenced by Walter Benjamin, 'The Work of Art in the Age of Mechanical Reproduction' (1936), in *Illuminations: Essays and Reflections*, ed. Hannah Arendt, trans. Harry Zohn (New York: Schocken Books, 1968).

every work of photographic art has its 'lurking, objectifying inverse in the archives of the police'.²⁰ From this he suggests that photography has two distinct functions, the repressive and the honorific, and that in institutions the former is dominant. What his analysis lacks is a sense of fluidity between these functions; as Rawling asserts, 'these two honorific and repressive functions can ebb and flow within a single image or collection or across a whole range of patient photographs'.²¹

Images of Insanity

The depiction of people with mental health problems has a long history and a long and contentious historiography. Foucault, with his gift for the unsubstantiated generalisation, claimed that 'from the fifteenth century on, the face of madness has haunted the imagination of Western man'. And he suggests that Bosch's painting 'The ship of fools' is evidence of a symbolic and literal out-casting of the insane.²² Roy Porter disputes this interpretation showing that no 'ship of fools' left England and that there were many different responses to insanity in this period.²³ Simon Cross argues persuasively that depictions of madness need to be seen in their historical context and that this will show both continuities and changes.²⁴

²⁰ Allan Sekula, 'The Traffic in Photographs,' *Art Journal* 44(1) (1981), 16.

²¹ Katherine Dorothy Berry Rawling, 'Visualising Mental Illness: Gender, Medicine and Visual Media, c.1850–1910' (unpublished PhD thesis, Royal Holloway, University of London, September 2011), 192.

²² Michel Foucault, *Madness and Civilization* (London: Random House, 1965); L. Wittgenstein, *On Certainty* (New York: Harper and Row, 1969), 12.

²³ Roy Porter, *Mind-Forg'd Manacles, A History of Madness in England from the Restoration to the Regency* (London: Weidenfeld and Nicolson, 1987), 17.

²⁴ Simon Cross, *Mediating Madness: Mental Distress and Cultural Representation* (Basingstoke, Palgrave Macmillan, 2010), 34–69.



Fig. 2 Ship of Fools (c. 1490–1500) Louvre, Paris²⁵

The most eminent historian of the depiction of insanity, Sander Gilman, has documented these continuities and changes and argues that the depictions of insanity suggest what he eruditely describes as 'a visual continuum of otherness'.²⁶ It is an affirmation of difference between the sane and the insane. We do not look like this, we may sympathise but we are different. Artists such as Gericault (1791–1824) were commissioned to paint the insane and show the physiological differences that their condition produced. Gericault completed his brief, but privately admitted he could not see any differences.²⁷

In Britain our visual perception of madness has been dominated from the eighteenth century by the Hogarth picture of the Bethlem Asylum (see Fig. 3). This distressing image of the privileged classes viewing the insane as a form of entertainment has influenced the popular idea of what asylums were like. Leaving aside whether the depiction is a plausible representation, Bethlem was until the mid-nineteenth century a fairly small institution, housing never more than a hundred patients, and as Allderidge has argued, it was not representative of asylums during

²⁵ Source: 'Ship of Fools,' Luke Mastin, accessed October 1, 2014, http://www.lukemastin.com/testing/hieronimus/magnify_ship.html.

²⁶ Sander L. Gilman, *Seeing the Insane* (Lincoln: University of Nebraska Press, 1982), 7.

²⁷ Cross, *Mediating Madness*, 57.

this period and its notoriety was not entirely justified.²⁸ Although the idea of viewing the insane as a form of entertainment is reprehensible, it must be seen as another example of perceiving the insane as 'other'. The view was, 'they are very different from us so we can laugh at them'.²⁹



Fig. 3 'The Rake's Progress', William Hogarth³⁰

Generally, as authors such as Otto Wahl have shown, madness has been depicted in a very negative fashion. Insane men were aggressive monsters who needed to be restrained (see Fig. 4), whilst women were seen as 'sexually provocative and self-abusing'.³¹

²⁸ Patricia Allderidge, 'Bedlam: Fact or Fiction?' chapter in, Bynum, W.F. Porter, Roy & Shepherd, Michael (Eds.). *The Anatomy of Madness*, 17-33.

²⁹ In today's world it is no longer OK to laugh at black people but fat people are seen as fair game.

³⁰ 'File:William Hogarth 019,' Wikimedia Commons, accessed June 10, 2016, https://commons.wikimedia.org/wiki/File:William_Hogarth_019.jpg.

³¹ Jane E. Kromm, 'The Feminization of Madness in Visual Representation,' *Feminist Studies* 20(3) (1994): 2.

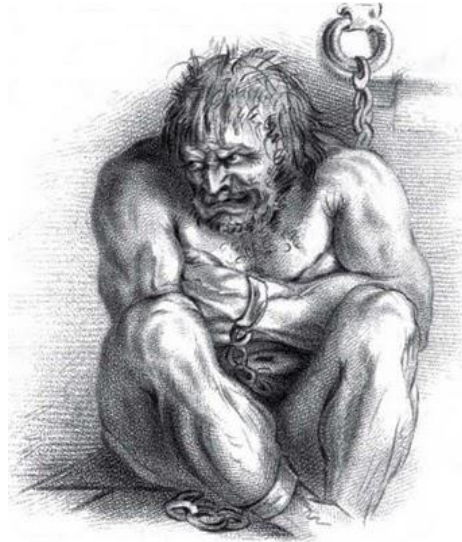


Fig. 4 Charles Bell's 'Madness'³²

The Victorian writers thought insanity was always detectable by sight³³ and this is evidenced by Alexander Morison's illustrations of various types of insanity, which he produced in a book entitled 'The Physiognomy of Mental Diseases'.³⁴ An example of his work can be seen later in the chapter as Fig. 26, which supposedly depicts mania.

Simon Cross has emphasised the change in representation that the use of photography constituted and how some contemporaries thought that the crude stereotypes of the past could be eliminated and objectivity obtained.³⁵ Dr Hugh Diamond, the Superintendent of the Surrey Lunatic Asylum, pioneered the photographing of patients in an asylum in 1856. Diamond assumed photography to be totally objective and would show 'the well-known sympathy which exists between the diseased brain and the organs and features of the body'.³⁶ Both such assumptions would prove to be problematic. He saw the photographs as having three uses. Firstly, they were therapeutic because the patient enjoyed having their picture taken and benefited from seeing

³² Photograph in Gilman, *Seeing the Insane*, 91.

³³ John Conolly, *An Inquiry Concerning the Indications of Insanity with Suggestions for the Better Protection and Care of the Insane* (London: John Taylor, 1830), 113.

³⁴ Alexander Morison, *The Physiognomy of Mental Diseases* (London: Longman, 1843).

³⁵ Cross, *Mediating Madness*, 57–69.

³⁶ Hugh W. Diamond, 'On the Application of Photography to the Physiognomic and Mental Phenomena of Insanity,' in *The Face of Madness: Hugh W. Diamond and the Origin of Psychiatric Photography*, ed. Sander L. Gilman (New Jersey: Brunner-Mazel, 1976), 20.

how unwell they had been. Secondly, he thought the pictures were an aid to diagnoses as it was then believed that particular conditions could be diagnosed by examining a patient's outward appearance. Lastly, the patients sometimes needed to be identified, so the photographs were an obvious help. He summed up his view:

In conclusion I may observe that photography gives permanence to these remarkable cases, which are types of classes, and makes them observable not only now but for ever and it presents also a perfect and faithful record, free altogether from the painful caricaturing which so disfigures almost all the published portraits of the insane as to render them nearly valueless either for purposes of art or science.³⁷

Although Diamond's patients were photographed, technical limitations of the era meant that they could not be reproduced except as engravings. These were produced often in a disingenuous way to emphasise the suggested diagnosis. As a number of authors, including Berkenkotter, have commented, the well-known photograph of a woman with 'religious melancholy' (Fig. 6) is significantly changed in the engraving (Fig. 5). The newly produced downward glance gives her a more melancholic air and she was now leaning on books showing the religious literature which had so troubled her.³⁸

³⁷ Hugh Diamond, 'On the Application of Photography to the Physiognomic and Mental Phenomena of Insanity,' (Read to the Royal Society, May 22, 1856) reprinted in *The Face of Madness: Hugh W. Diamond and the Origin of Psychiatric Photography*, ed. Sander L. Gilman (New Jersey: Brunner-Mazel, 1976).

³⁸ Carol Berkenkotter, 'Capturing Insanity: The Wedding of Photography and Physiognomy in the Mid-Nineteenth-Century Medical Journal Article,' in *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia: University of South Carolina Press, 2008), 51.



Fig. 5 Original photograph³⁹



Fig. 6 Engraving of 'Religious Melancholy'⁴⁰

Further evidence of the subjective nature of Diamond's photographs lies in his choice of subjects. In 'Seated Woman with Bird' Diamond shows a woman holding a dead bird (Fig. 7). The woman looks somewhat eccentric and the dead bird leads us to believe she is insane. This may have been the case but they did not have to show her holding the dead bird; Diamond wanted to show us she was insane and manipulated the image to prove his point.

³⁹ 'Religious Melancholy "Seeing the Insane" by Hugh [Welch] Diamon[d], 1856,' Are you Mental, accessed September 3, 2014, <http://areyoumental.tumblr.com/post/146097872/wingsandfins-higherhills-religious-melancholy>.

⁴⁰ 'Five – The Image of the Hysteric,' UC Press E-Books Collection, 1982–2004, accessed June 10, 2016, <http://publishing.cdlib.org/ucpressebooks/view?docId=ft0p3003d3&chunk.id=d0e16276&toc.depth=1&toc.id=d0e16276&brand=ucpress;query=hugh%20diamond#1>.



Fig. 7 'Seated Woman with Bird'⁴¹

Diamond was not alone in his interest in photographing the insane and the most famous and comprehensive attempt to use photography as a psychiatric diagnostic tool occurred at the Salpêtrière Institute in Paris. Here they built extensive photographic facilities and numerous patients were photographed in their nosological quest. This doomed idea led to many dubious practices, none more so than in the attempt to delineate the nature of hysteria. Under the leadership of Jean-Martin Charcot they hired young women who, under instruction, exhibited hysterical symptoms which they then photographed. The most famous of these was Augustine, a 15-year-old who proved very adept as displaying whatever was needed, often wearing very little

⁴¹ 'Hugh Welch Diamond (British – Seated Woman with Bird – Google Art Project,' Wikimedia Commons, accessed February 2, 2014, [http://commons.wikimedia.org/wiki/File:Hugh_Welch_Diamond_\(British_-_Seated_Woman_with_Bird_-_Google_Art_Project.jpg](http://commons.wikimedia.org/wiki/File:Hugh_Welch_Diamond_(British_-_Seated_Woman_with_Bird_-_Google_Art_Project.jpg).

as the picture below shows.⁴² Augustine spent several years as his model, but then in 1880 she disguised herself as a man and escaped from the institution never to be heard of again.⁴³



Fig. 8 Augustine as hysteric, photo by Charcot⁴⁴

The photographs of Diamond and Charcot have been easy targets for writers such as Tagg, who, taking their inspiration from Foucault, have argued that far from being therapeutic they were a form of social control.⁴⁵ The painting by André Brouillet called, 'At the Medicine School' (Fig. 9 below), which is of a lesson at the Salpêtrière, brilliantly captures what Judith Surkis has suggested were the 'gendered dynamics of the institution's scopophilic regime'.⁴⁶

⁴² Georges Didi-Huberman, *Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière* (Paris: Éditions Macula, 1982).

⁴³ Andrew Scull, *Hysteria: The Disturbing History* (Oxford: Oxford University Press, 2009), 122.

⁴⁴ Source: Freud Museum London, accessed January 9, 2013, http://www.freud.org.uk/file-uploads/small/hysteric_2_2.jpg.

⁴⁵ Tagg, *The Burden of Representation*, 28–29.

⁴⁶ 'Alice Winocour's *Augustine*,' Judith Surkis, 'Fiction and Film for French Historians', accessed June 10, 2016, <http://h-france.net/fffh/the-buzz/alice-winocours-augustine/>.



Fig. 9 'At the Medicine School', André Brouillet 1887⁴⁷

These writers view photography in the context of inmates of an institution, as essentially repressive, voyeuristic and, as Jane Kromm has suggested, part of the feminisation of the visual depiction of madness. Certainly the depictions of Charcot are both sexist and exploitative and present a very male 'gaze'.⁴⁸ As we shall see, certain aspects of the Bristol photographs can also be seen as male voyeurism.

There is little doubt there are repressive aspects to these photographs and there is usually a power differential between the subject and photographer.⁴⁹ A number of authors have suggested they also fulfil other functions, claiming the subjects are not always passive receivers of their institution's control. Peter Doyle's study of the mugshots of Sydney criminals has emphasised elements of exhibitionism. He argued that the subjects were displaying themselves to the camera and thus were partially in control of the resultant image.⁵⁰ Although asylums were undoubtedly very controlling institutions, they never had total control and the photographs from

⁴⁷ 'André Brouillet,' Cultured, accessed October 8, 2013, http://wiki.cultured.com/people/Andre_Brouillet/.

⁴⁸ Jane E. Kromm, 'The Feminization of Madness in Visual Representation,' *Feminist Studies* 20(3) (Autumn 1994): 507–535.

⁴⁹ I would argue that in some cases, for instance, when a wealthy person commissions a portrait of themselves, the power lies with them and not the photographer.

⁵⁰ Peter Doyle, 'Public eye, private eye: Sydney police mug shots, 1912–1930,' *Scan – Journal of Media Arts and Culture*, accessed April 6, 2014, http://scan.net.au/scan/journal/display.php?journal_id=67.

this study show elements of both control and agency. A recent work by Rory du Plessis suggests that asylum photographs do convey an element of the subject's individuality.⁵¹ Susan Sidlauskas in her study of the photographs of patients from the Holloway Asylum concludes that her images 'compel a rethinking of the imagined incompatibility between institutional photography and personal agency'.⁵²

The Bristol Asylum Photographs

Interpreting the Images

As we have seen, the study of history has been traditionally dominated by written sources, with visual ones either ignored or used for merely illustrative purposes.⁵³ What has yet to happen is agreement on methods and philosophy in analysing visual sources. David Perlmutter has stepped into this epistemological minefield and has produced what is perhaps the most comprehensive guide to the methods for using visual evidence. This study will utilise some of his ideas; in particular, his identification of the different 'elements of meaning in visual analysis' seems useful.⁵⁴ These elements include the functional meaning of the pictures. Is it meant to convey a message, provide information or is it merely a decoration? The picture may have expressional meaning. Is the photographer or the subject trying to convey a particular emotion? Certainly in Fig. 1 Alice seems to be trying to show the institution how bad she was feeling. That pleading look in her eyes was not produced by the photographer, it was hers. Perlmutter also suggests the images may have what he terms a 'rhetorical-moral meaning'. This suggests the authors of the images may have wanted to convey a particular message to the viewers.⁵⁵ The

⁵¹ Rory du Plessis, 'Beyond a clinical narrative: casebook photographs from the Grahamstown Lunatic Asylum, c. 1890s.' In 'Archival addresses: photographies, practices, positionalities,' ed. Leora Farber, special issue, *Critical Arts* 29(supplement 1) (2015): 88–103.

⁵² Susan Sidlauskas, 'Inventing the Medical Portrait: Photography at the 'Benevolent Asylum' of Holloway c. 1885–1889,' *Medical Humanities* 39 (2013): 29.

⁵³ David Perlmutter, 'Visual Historical Methods – Problems, Prospects, Applications,' *Historical Methods* 27(4) (1994): 167–184.

⁵⁴ *Ibid.* 4.

⁵⁵ *Ibid.* 4–5.

asylum may have been trying to show that these patients were people who needed the institution's care or control.

The first questions to ask about these images are why were they produced and what was their function? They would undoubtedly have been influenced by other institutions that had begun to photograph their inmates. Diamond's ideas were well known and would have influenced the Bristol Asylum. More generally, photographing the patients was in line with the Victorian promotion of both the idea of progress and the urge to classify. The hope was to produce what Berkenkotter has termed 'a scientifically based Victorian nosology'.⁵⁶ Diamond's ideas will be discussed in our examination of the Bristol Asylum's photographs.

The introduction of photography should be seen in conjunction with how society was changing. Technical advances, particularly the increase in camera shutter speed and the ease of reproduction, meant it became possible to produce photographs that were fairly sharp and could be printed and placed in the case notes. Similarly, today's databases of patient records have emerged, in part, because the technology to produce them has come into existence. Also, introducing new technologies makes an institution appear to be progressive. Electricity, telephones and photography were nineteenth-century technical innovations and the asylum introduced all three.⁵⁷

We also need to look at who the photographs were produced for; who was the audience for these images? As far as we know they were only placed in the admission books and the only people to view these would be the staff, possibly a few of the patients and, most importantly, the Hospital Visitors and Lunacy Commissioners. In assessing hundreds of the patients' cases notes, the author did not find a single mention of a patient or family viewing the portraits. Thus if any did see their photographs it was not considered significant. The Visitors and Commissioners were both powerful bodies, the former consisting of eminent Bristolians, often including the mayor,

⁵⁶ Berkenkotter, *Patient Tales*, 65.

⁵⁷ Donal Early, *'The Lunatic Pauper Palace' Glenside Hospital Bristol 1861 – 1994* (Bristol: Friends of Glenside Hospital Museum, 2003), 17–25.

and the Commission was an influential governmental body.⁵⁸ The Visitors came every two weeks and had the power to discharge patients or change asylum policy. The Visitors held such sway because they represented the council, who financed the asylum. The photographs might have impressed the Visitors as showing diligence and were 'modern' and it is the contention of this study that some of the photographs, particularly those taken on discharge, were at least in part aimed at showing the Visitors and Commissioners what a good job they were doing.

There are two major problems with any interpretation of these photographs. Firstly, the question of whether the photographs should be 'read' with or without other information about them. John Berger shows how little information a photograph is likely to give if seen without contextual data. He claims that seen in this way 'it tells us nothing of their [the subjects'] significance'.⁵⁹ This is undoubtedly true but is not most evidence like this? You would not take a sentence from the medical notes and interpret it without reference to the rest of the document. The medical notes are a series of separate pieces of information which, taken together, help us to build a picture both of the patient and the writer of the notes. All evidence needs context for historical understanding. An Egyptian hieroglyph or the nineteenth-century use of the term 'dementia' need to be contextualised to be of use as evidence. These photographs can be seen as just further pieces of information, albeit evidence that has to be analysed using different methods. Geoff Dyer suggests that words and images can form 'an integrated, mutually enhancing relationship'.⁶⁰

The other problem is that the viewer inevitably brings their own views and experiences to their interpretation of these pictures. We also need to take into account that our attitude and exposure to photographs has changed in the 120 years since these photographs were taken. Therefore, one has to examine one's own attitudes and beliefs and thus the author's time as a psychiatric nurse is obviously relevant. This experience is helpful in that how a patient looks when

⁵⁸ Visiting Committee Report 1894, BRO 35510.

⁵⁹ Berger, *Understanding a Photograph*, 62.

⁶⁰ Geoff Dyer, 'Introduction,' in *Understanding a Photograph*, John Berger (London: Penguin, 2013), xii.

they are depressed, manic or just fed up were common visual experiences for the author that others might not have. This experience should help in interpreting these photographs. However, this was the 1890s, not the late twentieth century, and how people posed for photographs was different and how they expressed emotion may have been different. What we see in a photograph varies between individuals and is undoubtedly based on that person's previous experiences. Recent research has suggested that some facial expressions suggesting an emotion are universal. Also, there is now computer software which claims to detect particular emotions from a photograph.⁶¹

It is also necessary to look at the attitudes to photography at that time and technical aspects which would influence these photographs. It is a mistake to think that the subjects would not have been conversant with the medium of photography. By the 1850s, photography had become a popular pursuit and many families were having their portraits taken.⁶² The first mass-market camera had been produced by Kodak in 1888.⁶³ Also, by the 1890s cameras were using much faster shutter speeds so there was less need for the sitter to keep still. This, however, was only true for outside shots which explains why nearly all the Bristol Asylum photographs were shot outdoors.⁶⁴ There were also photographic conventions which were different from our own time; in particular, it was not expected that people would smile. These were official photographs which, then and now, expected the subject to adopt a serious expression.

From 1893 it became normal practice to photograph the patients, usually soon after their admission. These photographs were displayed prominently in the case notes with the photographs taking up a quite large space. This is illustrated by the picture below (Fig. 10) of Emily Sessions who was admitted in 1894. Yet only three years later the photographs had got smaller as

⁶¹ Ilias Maglogiannis, Demosthenes Vouyioukas and Chris Aggelopoulos, 'Face detection and recognition of natural human emotion using Markov Random Fields,' *Pers Ubiquit Comput* 13 (2009): 95–101.

⁶² John Falconer and Louise Hide, *Points of View: Capturing the 19th century in Photographs* (London: The British Library, 2009).

⁶³ Asa Briggs, *A Victorian Portrait* (London: Harper and Row, 1989), 212.

⁶⁴ *Ibid.* 11.

evidenced by our picture of Ada Vissell (Fig. 11). Later they got even smaller and often were not taken at all. It is not known if this was a financial decision but the photographs certainly became less of a priority.



Fig. 10 Emily Sessions, 1894⁶⁵

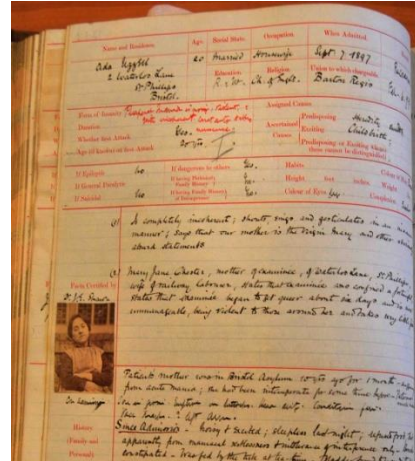


Fig. 11 Ada Vissell, 1897⁶⁶

The photographs in our collection were taken at the asylum, normally outside, with the asylum's distinctive windows often visible. It is unclear who actually took the photographs. It may have been one of the staff or possibly a Mr Dunscombe. He provided the photographic supplies, but was also a keen photographer and a member of the Bristol photographic and optical family who still run opticians in Bristol.⁶⁷ They certainly used their own camera, described as a 'photographic apparatus', which was purchased in December 1893, for the then princely sum of £5 7s 6d.⁶⁸

Before we examine the photographs, we need to address the nature of these images and the effect of artistic considerations on how they are presented. The photographs presented in this study have been digitally enhanced, hopefully to make them closer to their original state. Any changes one makes inevitably alters the viewer's perception of the photograph; however, time

⁶⁵ Admission book BRO 40513/C/3/12, 129. Admission 1/5/1894, discharge (recovered) 9/7/1894.

⁶⁶ Admission book BRO 40513/C/3/13, 143. Admission 7/9/1897, discharge (recovered) 6/2/1999.

⁶⁷ Admission book BRO 40513/C/5/3. There are entries for photographic supplies every few months normally costing a pound or two.

⁶⁸ Admission book BRO 40513/C/8/1, 318.

and neglect have also changed them. The digital restoration was thought necessary because many of the photographs were badly faded and the subject could barely be recognised. There was also an attempt to make them appear, at least approximately, as they would have been when produced. Faded Victorian photographs tend to be viewed in a romanticised fashion and this distracts from how the photographs should be viewed. Thus the saturation was usually reduced to rid them of some of the sepia tone which has nostalgic overtones. It might be argued we should have used the photographs as we found them, however, just by reproducing them one inevitably changes them. To leave them in their original state seems to give a spurious sense of authenticity. These points are illustrated by the three versions of the photograph below of a patient from the asylum (Figs. 12, 13 and 14). Fig. 12 is the picture without any changes except those involved in the transition to this page. The subject's features are barely recognisable and it does seem reasonable to make the picture clearer, but this involves many options. In Fig. 13, which is the one used for the archive, the features are recognisable and he looks, for want of a better word, normal and has rather kind-looking eyes. Fig. 14 is a bit more dramatic; he seems a bit harsher. This is obviously a subjective view but it has to be seen that the resulting images are partially influenced by the image manipulator, but this is inevitable if you want to produce a recognisable image.



Fig. 12⁶⁹

Fig. 13⁷⁰



Fig. 14⁷¹

In addition to the desire to create an image faithful to the original, there is also a tendency to create an image with artistic merit. The image below (Fig. 15) is, I think, striking and poignant. When restoring the image, I have not removed the writing which has partially seeped through from another page. This would not have been on the original, so it can be argued that this decision was not a restoration. This may be true but the writing does seem to say something about the effect of the institution on the woman: the bureaucracy is pressing down on her and leaving its mark. Thus the photograph should be viewed not as a comment on the subject but as an evocation of what the effect the institution may have had on patients like her. This view is subjective and contentious but these images can have multiple meanings and uses.

⁶⁹ Admission book BRO 40513/C/2/10, 96. Admitted 23/10/1894, discharge (died) 25/11/1905.

⁷⁰ Ibid.

⁷¹ Ibid.

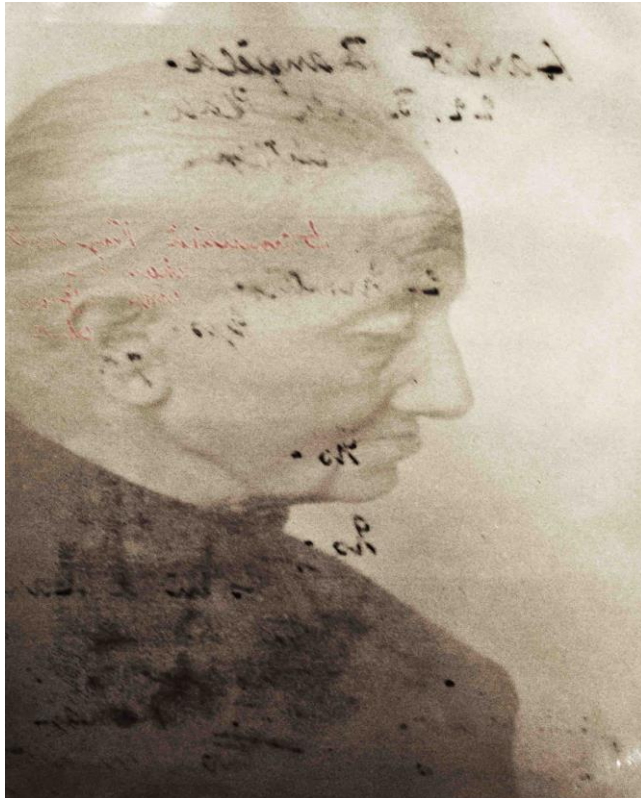


Fig. 15⁷²

Diamond's Three Contentions applied to the Bristol Photographs

1. *Were the Photographs Useful as a Diagnostic Tool?*

The Victorian's claim to be able to diagnose specific maladies from such photographs is largely dismissed by modern authors. This claim will be examined using our images. However, even if his claims are unjustified it could be due to the very inexact nature of Victorian diagnoses (see Chapter 5). Thus there may be suggestions of certain emotional or psychiatric conditions within these pictures, even if they do not correspond to Victorian diagnoses. In Victorian times the term 'idiot' or 'imbecile' was used for what we might now term a learning disorder. With some of these conditions there are certain facial characteristics, such as with Down's Syndrome.⁷³ It might be expected that the photographs would be suggestive of people with learning disorders. The photographs below are all of people who have been diagnosed as 'idiots' or 'imbeciles'.

⁷² Admission book BRO 40513/C/3/13, 95. Admission 2/1/1897, discharge (died) 15/4/1897.

⁷³ M. Selikowitz, *Down Syndrome: The Facts* (Oxford: Oxford University Press, 1997).

To modern eyes, these photographs do not suggest people who obviously have learning difficulties. Most viewers of the picture of the lady in Fig. 16, Maria Eastman, would probably guess she was not highly intelligent, but not obviously impaired. Interestingly, the photograph shows her full-body whilst the others are from the chest up. This seems to indicate a desire to show that she was rather large. They seem to be suggesting that there is a link between obesity and low intelligence. This is an attitude which is still current, as evidenced by rather dubious research promoted by the Daily Mail, which suggests a similar link.⁷⁴ The man in Fig. 17, Simon Long, seems shy of the camera and is averting his eyes; he looks sensitive. Suggesting he looks sensitive is in part subjective, but our brains recognise minute facial differences, which are difficult to articulate, but which send a message to the brain that this person is sensitive, intelligent or sad. You would not guess that he had a learning difficulty and perhaps he did not, as the diagnostic criteria often seem almost random.⁷⁵ This is evidenced by our other two examples. In Fig. 18, Florence Harding, and Fig. 19, Sarah Say, they both look troubled. Florence looks sad⁷⁶ and Sarah has an intense gaze that might suggest anger, which can be seen as a reasonable response to being incarcerated against one's will.⁷⁷ Their diagnoses of imbecility seems strange when the notes also assert that both could read and write. It may have been that a refusal to answer a doctor's questions might be interpreted as intellectual inability, whereas it might have been either anger or a severe depression causing muteness. Thus these photographs, rather than being evidence of mental impairment, can be seen as evidence of the inexact nature of the Bristol Asylum's diagnoses.

⁷⁴ Admission book BRO 40513/C/3/12, 96; Admission 2/1/1897, discharge (relieved) 13/7/1894. 'Obese people lose IQ through 'Homer Simpson effect', *Daily Mail*, accessed August 24, 2014, <http://www.dailymail.co.uk/news/article-410505/Obese-people-lose-IQ-Homer-Simpson-effect.html>.

⁷⁵ Admission book BRO 40513/C/3/2/10, 171. Admission 15/7/1895, discharge (died) 2/10/1913.

⁷⁶ Admission book BRO 40513/C/3/13, 51. Admission 16/7/1896, discharge (recovered) 30/12/1896.

⁷⁷ Admission book BRO 40523/C/3/13, 18. Admission 26/3/1896, discharge (died) 26/3/1927.



Fig. 16 Maria Eastman⁷⁸

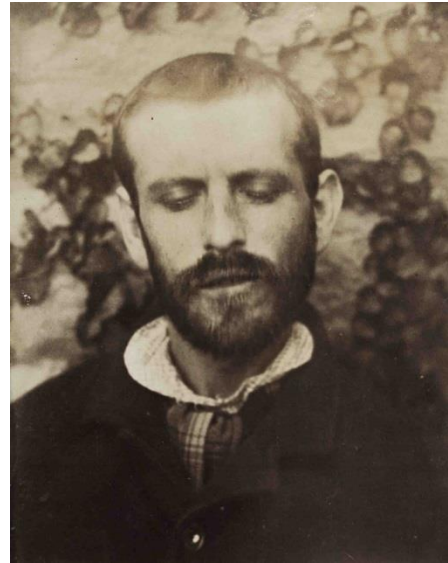


Fig. 17 Simon Long⁷⁹

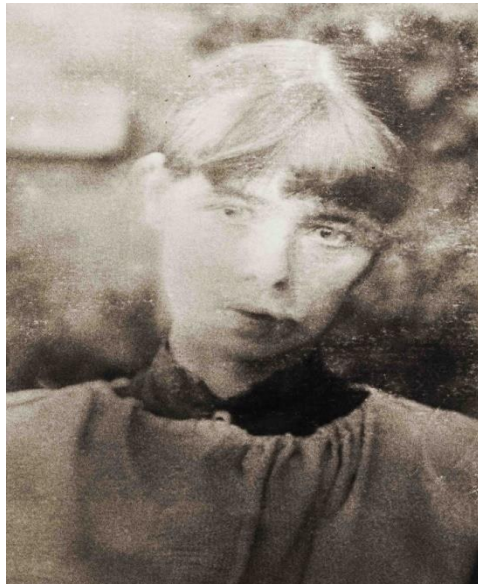


Fig. 18 Florence Louisa Harding⁸⁰



Fig. 19 Sarah Say⁸¹

The diagnosis of melancholia seems straightforward. It roughly equates to our idea of depression.⁸² Although you would not expect the changes in physiognomy that Diamond predicted, you would expect those diagnosed to at least look very sad. The study therefore picked

⁷⁸ Admission book BRO 40513/C/3/12, 96.

⁷⁹ Admission book BRO 40513/C/3/2/10, 171.

⁸⁰ Admission book BRO 40513/C/3/13, 51.

⁸¹ Admission book BRO 40523/C/3/13, 18.

⁸² Allan Beveridge, 'Madness in Victorian Edinburgh; a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873–1908,' *History of Psychiatry* 6 (1995): 135.

the six of the saddest looking patients, who are seen in Figs 20–25. This is obviously a subjective view and might be influenced by one’s own experience of sadness and depression. Only one of these photographs is of a man and it was much more difficult to discern obvious melancholic signs in the male photographs. This was probably due to men generally not wanting to show their emotions but it could have been that the photographer was more tolerant of emotion in women and told the men to pull themselves together (or the Victorian equivalent).⁸³ Of the six chosen, two, Eliza Hill (Fig. 20) and Emily Neale (Fig. 21) were diagnosed as suffering from melancholia but the other four, Edward Case (Fig. 22), Emily Shepherd (Fig. 23), Ellen Richman (Fig. 24) and Mary Ann Gale (Fig. 25), were classified as suffering from dementia. Dementia was seen by the Victorians as almost synonymous with any cognitive impairment, even if this was temporary, and, as Berrios has shown, there is a strong link between affective and cognitive impairment.⁸⁴ Thus all these people had good reason to look sad, though how much of this was due to their incarceration, rather than illness, is difficult to ascertain. Examination of these patients’ notes helps us to further interpret these pictures. Edward, our solitary man, had alcohol problems and he does seem to have the look of the alcoholic, with very unfocused eyes and a hangdog expression.⁸⁵ Ellen looks particularly distraught, probably because she suffered from what the Victorians termed ‘General Paralysis of the Insane’ (GPI), which as we have seen in Chapter 5, was actually an advanced form of syphilis (unknown to the Victorians).⁸⁶ In its later stages, it involved severe mental impairment and what might be seen as sadness in Ellen’s photograph was probably fear and bewilderment as to what was happening to her. She died three years after admission.⁸⁷ The pictures on their own might also be misleading in terms of recovery. If we view Eliza, who seems like a morose but fit young woman, and Mary, an elderly lady perhaps in

⁸³ Patrick Gomez, Armin von Gunten, Brigitta Danuser, ‘Content-specific gender differences in emotion ratings from early to late adulthood’, *Scandinavian Journal of Psychology*, 12/2013, Vol. 54, Is. 6, 451-458.

⁸⁴ G.E. Berrios, ‘“Depressive pseudodementia” or “Melancholic dementia”: a 19th century view,’ *Journal of Neurology, Neurosurgery, and Psychiatry* 48(5) (May 1985): 393–400.

⁸⁵ Admission book BRO 40513/C/2/10, 177. Admission 30/7/1895, discharge (recovered) 4/9/1895.

⁸⁶ Beveridge, ‘Madness in Victorian Edinburgh,’ 135–139.

⁸⁷ Admission book BRO 40513/C/3/13, 149.

terminal decline, we might expect Eliza to have recovered but not Mary. In fact Eliza spent the next nine years in the asylum and died aged 25 whilst Mary recovered after three months.⁸⁸



Fig. 20 Eliza Hill⁸⁹



Fig. 21 Emily Neale⁹⁰

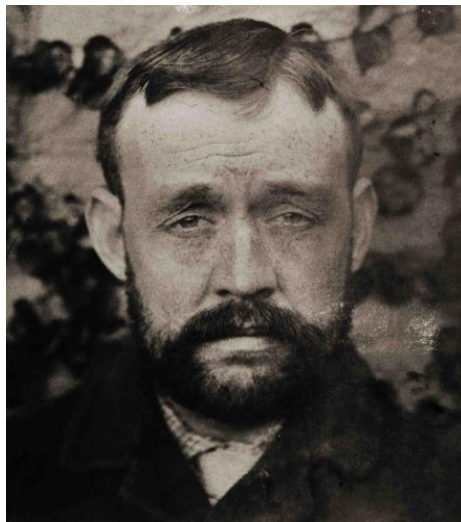


Fig. 22 Edward Case⁹¹



Fig. 23 Emily Shepherd⁹²

⁸⁸ Admission books BRO 40513/C/3/12, 17. Admitted 29/12/1892, discharged (recovered) 6/5/1893 and BRO 40513/C/3/13, 165. Admitted 22/11/1897, discharged (recovered) 9/3/1898.

⁸⁹ Admission book BRO 40513/C/3/12, 215. Admitted 29/5/1895, discharged (died) 18/2/1904.

⁹⁰ Admission book BRO 40513/C/3/13, 139. Admitted 29/7/1897, discharged (died) 25/8/1898.

⁹¹ Admission book BRO 40513/C/2/10, 177. Admitted 30/7/1895, discharged (recovered) 4/9/1895.

⁹² Admission book BRO 40513/C/3/13, 165.

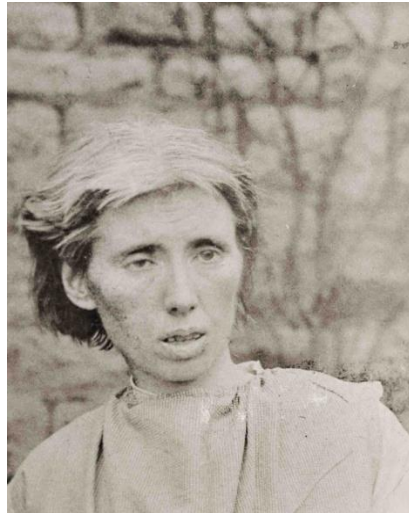


Fig. 24 Ellen Richman⁹³



Fig. 25 Mary Ann Gale⁹⁴

Of all the nineteenth-century diagnoses, mania has been depicted in the most outlandish and unsympathetic manner. The drawing below (Fig. 26) by Alexander Morison was one of the less outrageous versions which came from his book called 'The physiognomy of mental diseases', but still conforms to popular stereotypes with the bulging eyes and ferocious stare.⁹⁵



Fig. 26 'Mania'⁹⁶

⁹³ Admission book BRO 40513/C/3/13, 149. Admitted 30/9/1897, discharged (died) 21/3/1901.

⁹⁴ Admission book BRO 40513/C/3/13, 165. Admitted 22/11/1897, discharged 9/3/1898.

⁹⁵ Alexander Morison, *The Physiognomy of Mental Diseases* (London: Longman, 1843), 5.

⁹⁶ 'The physiognomy of mental diseases,' Internet Archive, accessed June 11, 2016, <https://archive.org/stream/physiognomyofmen00mori#page/n13/mode/2up>.

People who were diagnosed with this condition looked somewhat different. The six photographs below were chosen randomly (except for considerations of the quality of the pictures) from a list of patients with the diagnosis of mania. On viewing them, no diagnostic link is obvious. Two of the pictures, Fig. 27, Grace Attwood Biggs, and Fig. 28, Charles West, do perhaps seem to conform to the stereotype of the manic patient. Grace certainly seems to have quite a fixed stare. She gives the impression that she did not want to be photographed, but this impression is accentuated by the darkness of the print and she certainly does not seem to be elated.⁹⁷ Charles West is staring at the sky which does give the impression he was very distracted, but a second later he might have been facing the camera.⁹⁸ Certainly none of the photographs seems to show signs of elevated mood, one of the key characteristics of mania. Two of the patients, Annie Button (Fig. 29) and Christina Pike (Fig. 30) actually look depressed. Annie was said to have had an alcohol problem, so her 'mania' on admission may have been related to her drinking. She was discharged as 'recovered' a few months later and this adds to the suggestion that the asylum did find it very difficult to distinguish between mania and an alcohol-induced state.⁹⁹ The two Davises (Figs. 31 and 32) both look very ordinary and their photographs would not have looked out of place in a Victorian living room.¹⁰⁰ These photographs, rather than confirming the medical diagnosis, seem in many (and perhaps most) cases, to be evidence of the often fairly arbitrary nature of psychiatric diagnosis in the nineteenth century.

⁹⁷ Admission book BRO 40513/C/2/12, 160. Admitted 19/10/1894, discharged (recovered) 6/5/1895.

⁹⁸ Admission book BRO 40513/C/3/11, 80. Admitted 9/3/1898, discharged (died) 20/2/1904.

⁹⁹ I.M. Salloum et al, 'Impact of Concurrent Alcohol Misuse on Symptom Presentation of Acute Mania at Initial Evaluation,' *Bipolar Disorders* 4(6) (2002): 418–421.

¹⁰⁰ Admission book BRO 40513/C/2/11, 79 and 95. Admitted 9/2/1897, discharged (transferred) 16/11/1897 and admitted 12/4/1897, discharged (died) 26/6/1899.



Fig. 27 Grace Attwood Biggs¹⁰¹

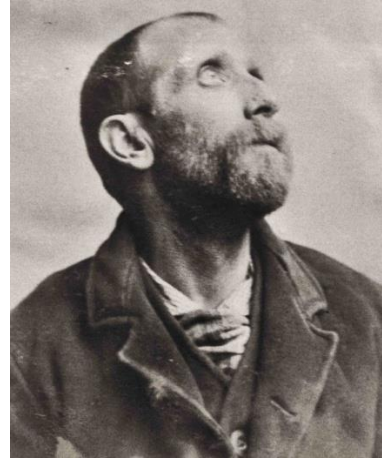


Fig. 28 Charles West¹⁰²



Fig. 29 Annie Button¹⁰³



Fig. 30 Christina Pike¹⁰⁴

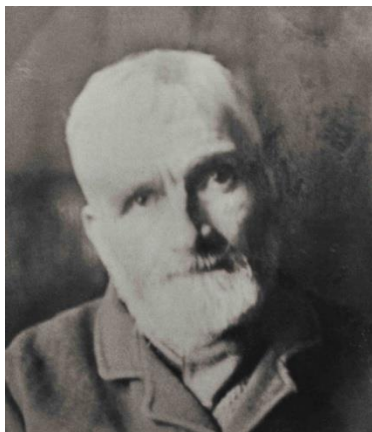


Fig. 31 James Davis¹⁰⁵

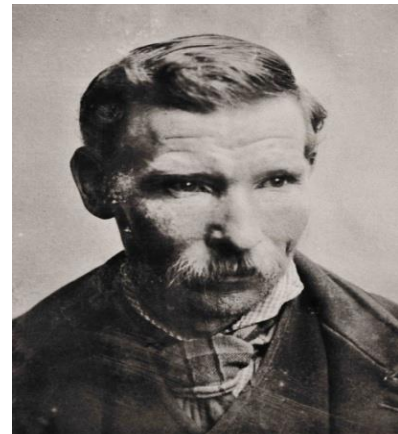


Fig. 32 Charles Davis¹⁰⁶

¹⁰¹ Admission book BRO 40513/C/2/12, 160.

¹⁰² Admission book BRO 40513/C/3/11, 80.

¹⁰³ Admission book BRO 40513/C/3/12, 229.

¹⁰⁴ Admission book BRO 40513/C/3/12, 166.

¹⁰⁵ Admission book BRO 40513/C/2/11, 95.

¹⁰⁶ Admission book BRO 40513/C/2/11, 79.

Were these Photographs used as a Diagnostic Tool at the Bristol Asylum?

The fact that these photographs do not seem to be an accurate way of determining a person's diagnosis does not mean they were not used in that way. The photographs were taken some time shortly after the patients were admitted. They would not have been photographed actually on admission, as they would often have been too disturbed. Also, the photographs had to be taken during the day in order to get enough light and many would have been admitted after dark. Lastly, in the photographs most of the patients are not wearing their own clothes but are wearing the standard hospital attire. This can be seen in Figs. 18 and 19 for the women and Figs. 31 and 32 for the men. These clothes do not seem to have been given to the patients until they needed them and some continued to wear their own clothes. Thus, the doctors would not have been able to see these photographs until after they had been taken and then developed and printed, which would have been some time after admission. During the admission process a diagnosis was usually written into the notes. Examination of the notes shows that the ink and handwriting in most of the sections were the same and thus probably completed at the same time. This can be seen in Fig. 10, which shows the notes of Emily Sessions. All the information seems to have been written at the same time except her education which is in pencil and this information was presumably ascertained at a later date.¹⁰⁷ Thus the photographs would not have been available when the diagnosis was made. With a few patients such as Ada Vissell (Fig. 11), the notes show that the diagnosis was obviously written later. However, her notes reveal that on admission she was 'completely incoherent, she shouts, sings and behaves in a completely insane manner, she says her mother is the Virgin Mary and other absurd statements'.¹⁰⁸ The doctors did not need a photograph to tell them Ada was manic. Generally, why would the doctors use a photograph when they had the person in front of them? A photograph does not give you their speech or their movement. The photographs may have been used as interesting discussion

¹⁰⁷ Admission book BRO 40513/C/3/12, 129. Admitted 1/5/1894, discharged (recovered) 9/7/1894.

¹⁰⁸ Admission book BRO 40513/C/3/13, 143. Admitted 7/9/1897, discharged (recovered) 6/2/1899.

subjects in the doctors' meetings, but would not have been used for diagnosis. They are perhaps more useful for historians, because we don't have the live person to examine.

2. Were these Photographs a Therapeutic Benefit to the Patients?

The second of Diamond's assertions was that they benefited the patient. He cites the example of the manic patient who was shown different photographs of herself in different stages of her illness. He claims it gave her more insight into her condition and made her more grateful for the treatment she received.¹⁰⁹ T.N. Brushfield of the Chester Asylum photographed his patients and wrote that, 'the patients are very gratified at seeing their own portraits'.¹¹⁰ Although we should not doubt Diamond's individual example or Brushfield's assertion, most of the photographs certainly do not support the contention that the patients enjoyed having their photograph taken. If we examine all the photographs in Appendix 2, few show signs of enjoying the experience. Many do have the neutral gaze typical of the Victorian portrait but a fairly large proportion look morose. This is not surprising; they were unwell and had just been admitted to a lunatic asylum. It is unlikely that at Bristol the patients were shown their photographs, as they were placed in the medical notes, which the patients would not have been allowed to see.¹¹¹ A few might have been shown copies of the photographs but there is no evidence of this. There is thus little evidence to suggest the photographs benefited the patients.

3. The Photographs as Identification/Control

The photographs can be seen as part of a very extensive system of control which the asylum exerted over the lives of the patients. However, unlike their control of the patients' time and space, this experience occurred only once. It is likely that few would list it as a significant

¹⁰⁹ Diamond, 'On the Application of Photography,' 21.

¹¹⁰ Brushfield, quoted in 'Hugh W. Diamond and Psychiatric Photography,' in *The Face of Madness, Hugh W. Diamond and the Origin of Psychiatric Photography*, ed. Sander L. Gilman (New Jersey: Brunner-Mazel, 1976), 9.

¹¹¹ The viewing of patient notes by the patient is a very recent occurrence. See 'Access to health records,' Medical Protection Society, accessed November 12, 2014, <http://www.medicalprotection.org/uk/england-factsheets/access-to-health-records>.

grievance and it does not figure in any of the patients' letters which were left in the notes.¹¹² As a method of identifying the patients, the photographs were of very limited value. When patients escaped, there was no great attempt to find them. If they were found, the photographs were in a book in the asylum and would have been no help to the police unless they went to the asylum. An example is Richard Mawditt, who escaped from the asylum, despite his wife also being a patient. Nothing was heard from him for two weeks so he was discharged as 'relieved'.¹¹³ Diamond also suggests the photographs would help the doctors to identify returning patients.¹¹⁴ This could have been helpful only on a very few occasions. Most patients were not readmitted and those who needed to be identified were only those who were unable to identify themselves and who had not been identified by family, friends or officials.

Failure of the Photographic Project

Diamond, the great advocate of photographing patients, left the Surrey Asylum and started his own private asylum in Twickenham. At the new asylum he discontinued his practice of photographing patients. We do not know his reasons but this is in line with other asylums, including Bristol.¹¹⁵ Photography as a new medium was often greeted as modern, and under Diamond's influence many establishments took up the practice. Bristol is perhaps typical in that the practice was enthusiastically pursued for three or four years, half-heartedly pursued for a similar length of time and then discontinued. The practice did not yield the results that Diamond promised; it was not a great help as a surveillance tool. The failure of the practice also shows that as a control mechanism for the state it was not very effective. This study has been concerned with the dual aspects of asylum life, that is, care and control. Photographing the patients helped with neither.

¹¹² The letters are mostly concerned with trying to obtain release from the asylum.

¹¹³ Admission book BRO 40513/C/2/4, 19.

¹¹⁴ Diamond, 'On the Application of Photography,' 21.

¹¹⁵ 'Diamond, Hugh Welch (1808–1886),' J. Tucker, *Oxford Dictionary of National Biography* (Oxford University Press, 2004), accessed August 27, 2014, [http://www.oxforddnb.com/templates/article.jsp?articleid=7583&back=.](http://www.oxforddnb.com/templates/article.jsp?articleid=7583&back=)

What can the Photographs tell us about the Patients and the Asylum?

Firstly, it must be restated that without accompanying text most of the photographs tell us little. If they were found out of context you would guess from the style that they were Victorian and from the dress that they were institutional. Also, many of the photographs show people not looking terribly happy. However, these photographs are part of a text and have a context. As such they will be analysed.

The photographs are unlike most Victorian portraits, in which the sitters usually present with a serious but contented gaze.¹¹⁶ The Bristol Asylum photographs lack that artifice. The photographer obviously did not ask them to smile. The asylum certainly would not have wanted the patients to look happy except perhaps on discharge. If the Visitors and Commissioners saw large numbers of smiling people in the case books, they would have questioned whether they needed to be admitted. A few did feel like smiling. An example was Sarah Ann Tovey (Fig. 33), whose notes suggest she was not very unwell. She was a 22-year-old servant who was admitted after a failed love affair and was discharged after a few months.¹¹⁷ She may have been already recovering by the time the photograph was taken and being photographed was probably a welcome distraction.

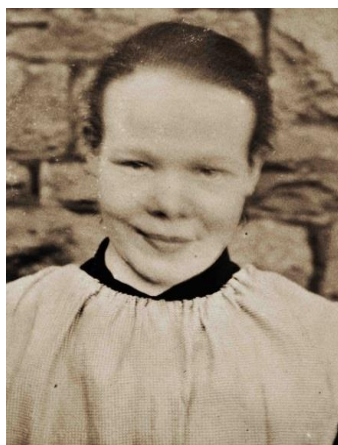


Fig. 33 Sarah Ann Tovey¹¹⁸

¹¹⁶ Asa Briggs, *A Victorian Portrait*.

¹¹⁷ Admission book BRO 40513/C/3/12, 70. Admitted 22/8/1893, discharged (recovered) 7/5/1894.

¹¹⁸ *Ibid.*

With the rest of the photographs there seem to be a variety of emotions displayed, though many could be interpreted in different ways. The picture below (Fig. 34) of Sidney Albert Edgell, shows a clearly unhappy young man; but is he depressed, paranoid or angry? He was 18 years old, worked in a chocolate factory and was a Quaker. It is also impossible to tell whether his unhappy countenance was due to his mental health or anger at his admission; most probably a bit of both. He did recover after a few months and was not readmitted.¹¹⁹ It is debatable whether particular emotions can be detected from a photograph, however, there is research that suggests that emotions produce differing physiological responses that are mostly noticeable in the face.¹²⁰ There is now digital software which utilises these physiological responses to detect particular emotions. They use a combination of physiological arousal, facial expressions and vocal intonation to determine specific emotions and they claim a success rate of between 73 and 81 per cent.¹²¹ This does suggest looking at photographs to detect emotion may be difficult but not impossible. This coincides with the idea that generally if we know someone we can tell with some certainty how they are feeling.



Fig. 34 Sidney Albert Edgell¹²²

¹¹⁹ Admission book BRO 40513/C/2/1, 65. Admitted 20/11/1896, discharged (recovered) 9/8/1897.

¹²⁰ Fatma Nazoz, 'Emotion Recognition from Physiological Signals for Presence Technologies,' *International Journal of Cognition, Technology, and Work* (Special Issue on Presence) 6(1) (2003): 1–32.

¹²¹ *Ibid.* 29.

¹²² *Ibid.*

All the photographs can be seen in Appendix 2. Individual examples can be used to strengthen a variety of viewpoints but the pictures show several 'types' of seemingly differing classes and exhibiting a variety of emotions, which makes generalisations beyond bland statements, such as many of the men had beards, difficult. Viewing is very subjective but they seem to show a mixture of sadness, anger, distraction, fear and, with many, a look of resignation. Their collective look seems to suggest 'I'm here and I might as well make the best of it.' An individual looking sad or distressed may be due to a momentary thought and not representative of that individual but dozens of people looking sad or distressed is evidence of the not terribly surprising fact that many were sad or distressed.

A few of the photographs exhibit a sense of the particular problems or fears from which the patient was suffering. In Chapter 5, Fig. 6, the photograph of Edward Hale, and in this chapter Fig. 24 of Ellen Richman, do not on their own provide a diagnosis, but do show the devastating effects of late-stage syphilis. The picture below of Harriett Abbott (Fig. 35) clearly shows someone in great distress. She was suffering from erysipelas, a painful skin condition, now easily treated with antibiotics. However, in the nineteenth century it could be deadly, as it spread to the brain and other organs. Harriett died a few weeks after this picture was taken.¹²³

¹²³ For a history of this disease see 'Ways to Die: Erysipelas,' Biomedical Ephemera, accessed February 15, 2014, <http://biomedicalephemera.tumblr.com/post/7775087538/ways-to-die-erysipelas>. Among those who died from it was the philosopher John Stuart Mill.



Fig. 35 Harriett Abbott¹²⁴

Mostly the photographs are not persuasive evidence of a particular emotion. What they do give us is a sense of that person; the image helps us to imagine what they were like, especially when combined with a reading of their day-to-day experiences as documented in the notes. Both the written words and the images are produced to a rigid set of rules. The written words are tied to categories laid down by law and subject to the views and biases of the individual doctors, which, as we have seen, can vary greatly. The images have a different set of rules which are supplied to the conventions of photography, its technical limitations and the whims of the photographer.

Another photograph which gives a vivid picture of a patient's situation is the picture below of Frank Willoughby Jones (for a fuller biography see Chapter 3). He was one of the few

¹²⁴ Admission book 40513/C/3/12/78. Admitted 2/10/1893, discharged (died) 2/11/1893.

children admitted to the asylum.¹²⁵ Most, like Frank, had some sort of brain condition.¹²⁶ Frank suffered from a severe form of epilepsy. The picture shows the doctor holding Frank, and we know that Frank was very agitated much of the time. The picture does seem to epitomise the nature of the asylum in that the doctor does seem caring but also controlling. Frank is completely in his control but the control seems necessary and fairly benign.



Fig. 36 Frank Willoughby Jones¹²⁷

Another photograph which seems to be very evocative is Fig. 37 of Margaret Bowden, a woman who was a dressmaker and had two admissions in the 1890s.¹²⁸ This picture is more difficult to interpret but it carries a considerable emotional punch. It could be a woman who had a cough or sneeze and, because of this, brought her shawl up to her mouth or that she was just cold. It might be either someone who is afraid to speak, or feels violated by the photograph and is covering up to hide from this intrusion. This photograph can be seen as evidence of Roland Barthes's suggestion (echoing Sontag) that when photographed 'I am neither subject nor object

¹²⁵ There were only ten children under ten years old admitted before 1900; see database column G. This is not to argue that those over ten were not children but those under ten seem to be a specific group with characteristics different from the general patient population. The children over ten seemed much more typical

¹²⁶ Admission book BRO 40513/C/2/11, 14.

¹²⁷ Ibid.

¹²⁸ Admission book BRO 40513/C/3/13, 61 and BRO 40513/C/3/14, 41. Admitted 3/9/1896, discharged (relieved) 15/6/1898 and readmitted 4/12/1898, discharged (died) 27/5/1903.

but a subject becoming an object. I experience a micro version of death.¹²⁹ The meaning of this photograph is elusive which is partially its appeal but also its problem as evidence.

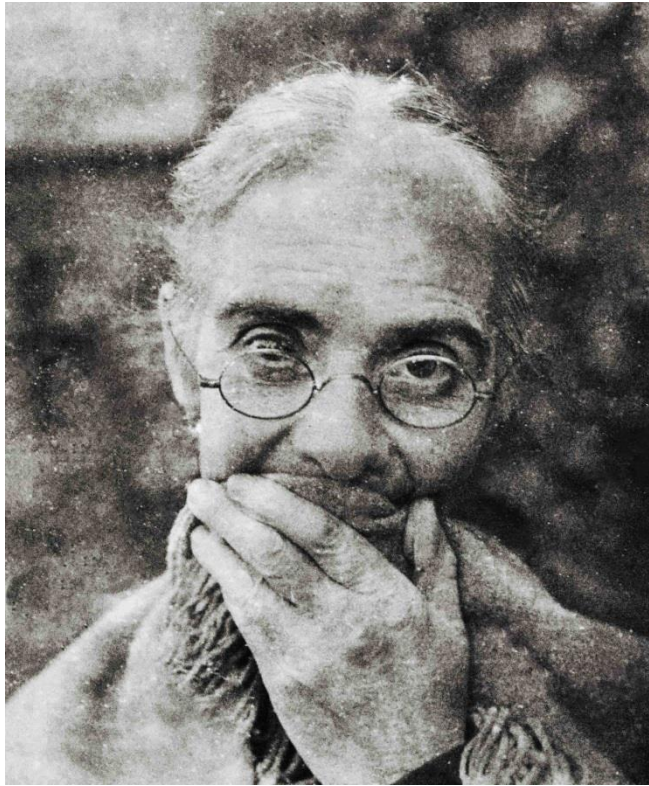


Fig. 37 Margaret Bowden¹³⁰

Evidence of the Photographs as an Archive

The images that are used in this study form an archive (see Appendix 2), which has many individual images that are valuable, but also has utility as collective evidence or quantitative data. Studies of asylum photographs have usually focused on just a few photographs. The photograph of a female patient taken by Hugh Diamond in 1856 (Fig. 6), has been used in several works and his contention that it shows signs of her ‘religious melancholy’ has been rightly much derided. For most viewers there are no such signs and he seems to have been influenced by his knowledge of the woman.¹³¹ This, however, is only one photograph and this study contends that if the

¹²⁹ Roland Barthes, *Camera Lucida: Reflections on Photography* (New York: Farrar, Straus and Giroux, 1998), 7.

¹³⁰ Admission book BRO 40513/C/14, 41.

¹³¹ Cross, *Mediating Madness*, 59–60. Also used in Gilman, *Seeing the Insane*, 170.

photographs were used selectively, several arguments, often contradictory, could be made about the evidence produced. Thus the photographs need to be examined as a whole. Another work to do this was by Dowdall and Golden, which used 800 images of Buffalo State Asylum in New York State. They were taken in the 1920s and 1930s.¹³² This work is valuable, especially as evidence of the chronic overcrowding, but some of their assertions seem based on a scant knowledge of photography or asylum life. For instance, they view the fact that the majority of photographs showing patients working were male as evidence of sexual bias by the photographer or the authorities. It may have been, but it could also be due to the fact that many of the men worked on the farm, whilst the most common female occupation was in the sewing room. Photographs were then much easier to take outside and a photograph with fields and trees is probably more interesting than one set in a sewing room. The photographs were also quite different to this study's in that all our photographs are portraits whilst the American ones are of the institution and groups of patients and staff.

Another work which looked at a large number of images is by Rawling, which looked at a huge variety of nineteenth-century depictions of mental illness, including those from the St Nicholas's Hospital, Gosforth which are quite similar to those at our asylum. She points out how similar many of the images are, with the pose, the clothes and the background usually the same.¹³³ Our images also display a uniformity in these aspects. Rawling argues that 'photographing the patients the same way strips them of their individuality and character'.¹³⁴ This is true to a certain extent but are passport photographs completely lacking in the subject's individuality? This argument is evidenced in the photographs in Fig. 38, which were chosen randomly from our archive. The pose is very similar particularly for the men, but they look quite different. Their characters, at least to a certain extent, do shine through. This may be because our

¹³² George Dowdall and Janet Golden, 'Photographs as Data: An Analysis of Images from a Mental Hospital,' *Qualitative Sociology* 12(2) (1989): 183–213.

¹³³ Katherine Dorothy Berry Rawling, 'Visualising Mental Illness,' 188–209.

¹³⁴ *Ibid.* 207.

photographs have been digitally restored, whereas Rawling's photographs do not show much detail. Generally, photographs with greater detail will give the viewer a better sense of the subject.

A gender difference is that all the men are largely head shots but many of the women are seen from the waist up, though this trend was reduced in later years. Did this show the psychiatrists' fascination with women's bodies? The women also show greater individual variety in their attire. The men seem content to just wear the very homogenous clothes supplied by the asylum but many of the women seem to be wearing either their own clothes or additions to the usual uniform, with frills or neckwear.

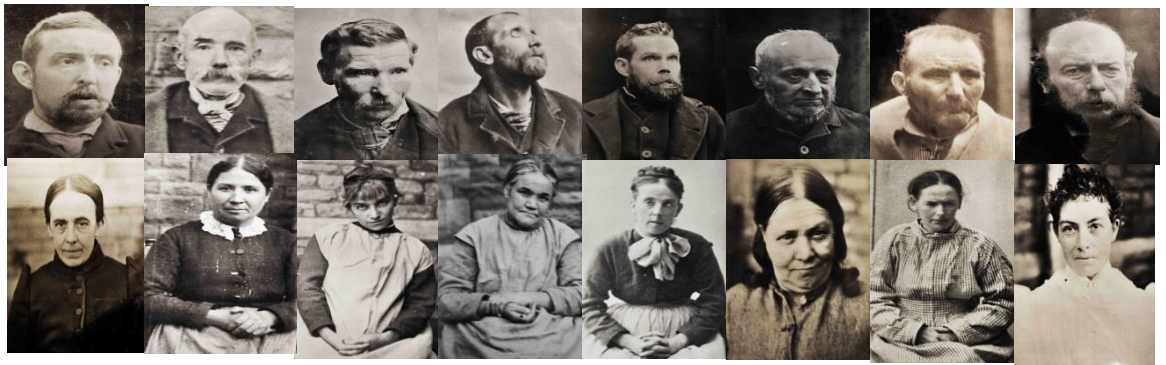


Fig. 38 Patients of the asylum chosen randomly from the admission books¹³⁵

Most have a fairly neutral look, though many look distinctly sad and some distressed. Although the poses are regimented, their facial looks are probably less regimented than in typical Victorian portrait.¹³⁶ In these photographs most of the subjects have a very similar facial expression, however, the asylum patients show more facial diversity in terms of emotion. This is probably because they were unwell or unhappy at their admission, but this seems at odds with the suggestion that these photographs were completely controlled.

¹³⁵ These photographs were consecutive admissions from the same year.

¹³⁶ Audrey Linkman, *The Victorians: Photographic Portraits* (New York: Tauris Parke, 1993).

Those who commissioned or took the photographs probably saw the subjects as the 'other', which Gilman described as how the insane are usually represented.¹³⁷ However, for modern viewers the photographs in some ways transcend this 'otherness', perhaps because we are used to seeing images of suffering. For a modern viewer the 'otherness' is mostly the consequence of temporal distance. They are primarily Victorians rather than madmen. The images give us a sense of what that community was like. Many of the photographs are quite ordinary. The people in them look like most working-class people of that time. In some respects this rescues them from 'otherness', they lose some of the rigid stereotyping of past images of insanity. In sharing the non-verbal evidence of that community, it allows us, in Peter Burke's words, to 'imagine the past'.¹³⁸

Before and after: The Admission and Recovery Photographs of Patients

The photographs so far discussed were all taken on or shortly after admission to the asylum. For a period between 1894 and 1896, photographs were sometimes taken of patients on discharge. They were, with two exceptions, mostly of women and they were mostly young or fairly young. They could have been taken for the benefit of the patients to show them how well they had done. This was suggested by Diamond, but why not men and why not older women?¹³⁹ Although young women were more likely to be discharged, this does not account for the vast gender disparity. They certainly seem to comply with what has been termed the 'male gaze'. The term was originally used by Lacan and suggests that men view women in a particular way.¹⁴⁰ These photographs certainly are evidence for Kromm's suggestion that there was a 'feminization of madness in visual representation', starting in the 1780s.¹⁴¹ They have become objects which can be used by the institution to promote its successes. The authorities were using these

¹³⁷ Gilman, *Seeing the Insane*, 7.

¹³⁸ Burke, *Eyewitnessing*, 13.

¹³⁹ Gilman, *Seeing the Insane*, 164–165.

¹⁴⁰ Burke, *Eyewitnessing*, 125.

¹⁴¹ Kromm, 'The Feminization of Madness in Visual Representation'.

photographs as a form of advertisement for the institution. They seem like precursors to the 'before and after' adverts which began in the 1930s.¹⁴² We will show how the institution chose photographs which promoted their product. The Hospital Visitors and Commissioners would see these photographs and it was to show them how well the asylum had done to cure the patients of their afflictions. These photographs were different from the others in that they were not for the benefit of the doctors or indeed for the patients; they were for the institution.

The date of these photographs is also important. For the first years of the asylum it had received a very favourable press and reviews by the Commissioners. However, as the promise of Moral Treatment began to fade, the criticisms of the asylums had increased. In 1889, writer John Tuke summed up the public perception:

'In the last few years influences have been at work productive of suspicion as to whether our system of management of lunatics is all that it should be, and tending towards doubt as to the soundness even of its principles.'¹⁴³

The asylums were on the defensive and these photographs can be seen as a response: these are our successes, look at the photographs, people do get better. They are also important in that they show more than one image of the same patient. This gives a sense of how the patient might change and to a certain extent eliminates chance uncharacteristic portraits.

Our first example of these photographs is seen in Fig. 39, which is of the woman we encountered earlier, Grace Attwood Biggs.¹⁴⁴ The 'recovered' photograph is different in several ways: firstly, and typically of these pictures, she is wearing a pretty dress. It is difficult to know whether this was at the patient's instance or the authorities'. Perhaps they just suggested that she would want to look nice for her leaving photograph. Also in this photograph, she is not staring

¹⁴² 'Before-and-after advertising,' John Foust, accessed September 14, 2014, http://www.scpres.org/eBulletin/foust_nov.pdf.

¹⁴³ John Tuke, 'Lunatics as patients not prisoners,' *The Nineteenth Century: A Monthly Review* 25(146) (1889): 595–607.

¹⁴⁴ Admission book BRO 40513/C/2/12, 19.

at the camera and this eliminates her rather piercing look of the previous picture. The second picture also makes one question the interpretation of the first as Grace looking 'manic'. This look is largely because of the dark shadows under her eyes, which emphasises her piercing look. In the second picture the dark shadows still exist, but are less noticeable because she has her face turned.



Fig. 39 Grace Attwood Biggs on admission and 'recovered'¹⁴⁵

Our second example, Fig. 40, is of Rosina Rayment and shows even greater differences in the four pictures which were placed in her notes. In the first, we have a picture which is entitled 'before admission'. It is a photograph taken in a studio with her looking attractive and respectable. This seems to have come from a family photo album. Du Plessis has analysed a similar photograph in another asylum's notes and reminds the viewer that the subject 'should not be solely defined by her institutionalisation at the asylum'.¹⁴⁶ This photo of Rosina is included to show how far she had descended from when she had been healthy. In the second photograph, taken shortly after admission, Rosina looks gaunt, her hair is rather lank and generally she does not seem to have been looking after herself. She was a servant and the notes describe a cause of her problems as being 'overwork'. In the two 'recovery' pictures she has put on weight, her hair is much smarter and she is smiling. The message is that the institution has looked after her well and

¹⁴⁵ Ibid.

¹⁴⁶ Rory du Plessis, 'Beyond a clinical narrative: casebook photographs from the Grahamstown Lunatic Asylum, c. 1890s.' In 'Archival addresses: photographies, practices, positionalities,' ed. Leora Farber, special issue, *Critical Arts* 29(supplement 1) (2015): 96.

now she is ready for the outside world.¹⁴⁷ Her story unfortunately does not have a happy ending. After her discharge in 1893 she was readmitted in 1895 and was to remain in the asylum until 1928 when she was moved to a nursing home.¹⁴⁸ The last admission has no photographs; she was no longer the asylum's poster girl.



Fig. 40 Rosina Rayment: studio portrait, on admission and two 'recovered' photographs¹⁴⁹

Most of these pictures were of young women but Louisa Ann Murray was a 50-year-old widow. Her 'recovered' picture was perhaps included because she looks both calmer (she was diagnosed with mania) and more respectable. In the second she is wearing a nice coat; she is ready for the bourgeois world.¹⁵⁰

¹⁴⁷ Admission book BRO 40513/C/3/12, 56. Admitted 27.6.1893, discharged (recovered) 7/11/1893.

¹⁴⁸ Admission book BRO 40513/C/3/12, 199. Admitted 17/4/1895, discharged (relieved) 2/11/1928.

¹⁴⁹ Admission book BRO 40513/C/3/12, 56 and 199.

¹⁵⁰ Admission book BRO 40513/C/12, 83. Admitted 12/10/1893, discharged (recovered) 11/5/1894.



Fig. 41 Louisa Anne Murray¹⁵¹

The next example, Fig. 42, of Ada Brooks, should have been on a brochure for the asylum. Even an opponent of the asylum system would concede that they seemed to have helped her. In the first picture she is thin, her eyes look as if she had not slept for some time and she looks distraught. The second picture has her looking less gaunt, but having a nasty skin condition. The message from the asylum is: we do not discharge people until they are fully recovered. In the last picture, taken when she was discharged 14 months after admission, her skin condition has gone, she looks well fed and her eyes are brighter. She even looks wealthier as she is wearing a bonnet and fur collared coat.¹⁵² There probably was a degree of manipulation of her image, but it cannot be denied that, in her case at least, the results were impressive.

¹⁵¹ Ibid.

¹⁵² Admission book BRO 40513/C/3/12, 116. Admitted 17/2/1894, discharged (recovered) 4/5/1895.



Fig. 42 Ada Brooks on admission, with skin infection and 'recovered'¹⁵³

The pictures of Emma Eginton (Fig. 43) are somewhat different in that in her recovery picture she still looks miserable. She was 48, much older than most of the other examples and she has put on weight, which is probably why the picture was included. Helping patients to gain weight was important to the asylum, even if they had to resort to tube feeding (see Chapter 4). She was a dressmaker and so it might have been expected that she would wear something better for her recovery photograph, however, she still looks drab. The system did want to present itself in a good light but, unlike a modern-day advertising agency, they were not that organised.¹⁵⁴



Fig. 43 Emma Eginton on admission and 'recovered'¹⁵⁵

¹⁵³ Ibid.

¹⁵⁴ Admission book BRO 40513/C/3/12, 138. Admitted 18/6/1894, discharged (recovered) 13/5/1895.

¹⁵⁵ Ibid.

The last of our female examples is Emma Cottrell, a 19-year-old domestic servant who lived in Hotwells, Bristol. She was severely unwell and was admitted to the asylum on 31 July 1894. She heard voices and constantly thought people were talking about her. When interviewed by the doctor she told him there were wires attached to her feet. In her admission photograph she looks gaunt and pale. Although the picture does not suggest a diagnosis she certainly looks troubled. She remained unwell for some months and then seemed quite suddenly to improve; she became less restless and stopped mentioning any voices. On 4 February 1895, she was discharged as recovered.¹⁵⁶ In her recovery picture she is not dressed up (perhaps she had no better clothes) but she looks quite different. This is partially because she is not facing the camera, unlike most of the asylum pictures which were shot face-on. A side-on look seems more natural and several of these photos (see Appendix 3) use such poses. However, her face does look more relaxed; she seems thoughtful. Apart from the institutional clothes, it seems a typical Victorian portrait.



Fig. 44 Emma Cottrell on admission and 'recovered'¹⁵⁷

There were only two 'before and after' sets of photographs of male patients and both were in a poor condition. As they were the only male patients chosen, there must have been particular reasons. The first example is of Tom Ambrose. He was a lodging house owner from

¹⁵⁶ Admission book BRO 40513/C/12, 145. Admitted 31/7/1894, discharged (recovered) 4/2/1895.

¹⁵⁷ Ibid.

Clifton and so relatively well-to-do. He was admitted in a very agitated state. He was expressing paranoid thoughts that people were out to get him. He also had visual hallucinations, including that of a dog, who he said was his protector. His admission photo is badly damaged but it can be seen that, although he does not look particularly troubled, he does not seem to have been caring for himself very well, considering his social status. He recovered very quickly and was discharged after two months.¹⁵⁸ In his discharge photograph he is transformed into an elegant gentleman. Five years later he was working as a journalist in Yorkshire.¹⁵⁹ The asylum had not only cured him but had also restored his social status.

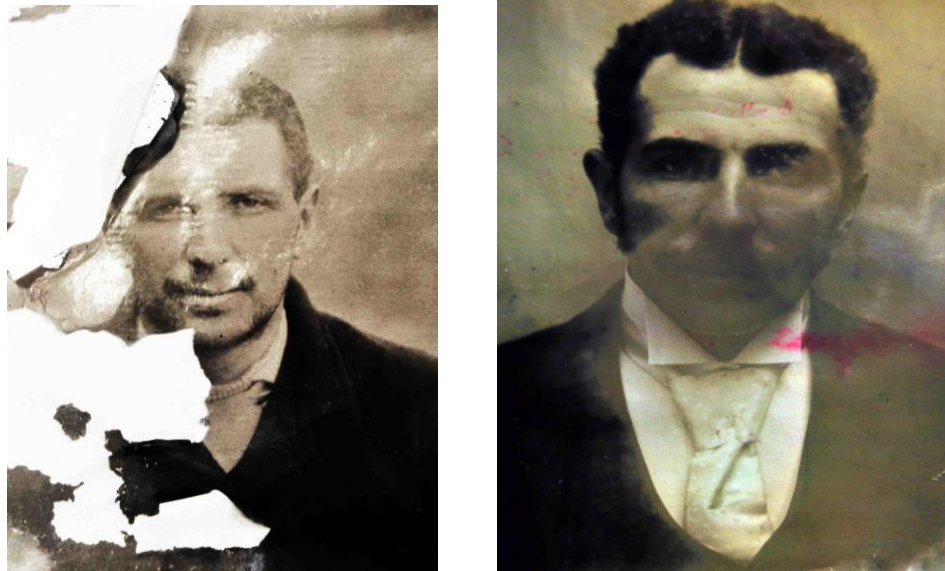


Fig. 45 Tom Ambrose on admission and 'recovered'¹⁶⁰

Our other example is rather different. He was Lewis Bullock, a 16-year-old errand boy whose family could not control him. He arrived at the asylum 'noisy, restless, kicking and spitting'. His speech was unintelligible and he began to regularly harm himself by hitting his head against a wall and on one occasion tried to strangle himself. He gradually calmed and was discharged six months after admission. In most respects he looks no different in his discharge photograph; he is

¹⁵⁸ Admission book BRO 40513/C/2/10, 133. Admitted 4/6/1895, discharged (recovered) 5/8/1895.

¹⁵⁹ '1901 England Census,' Ancestry, accessed June 11, 2016, <http://search.ancestry.co.uk/search/db.aspx?dbid=7814>.

¹⁶⁰ Admission book BRO 40513/C/2/10, 133.

wearing the same coat and his facial expression does not seem to have changed. What is different is that in the first photograph there is a hand on his shoulder, probably to ensure he stayed still. In the later photograph, no hand is needed. The message is clear: we have controlled him and now he can be sent back to his parents.¹⁶¹ He seems to have remained well and six years later in 1901 he was living with his parents and his occupation was listed as a painter.¹⁶²

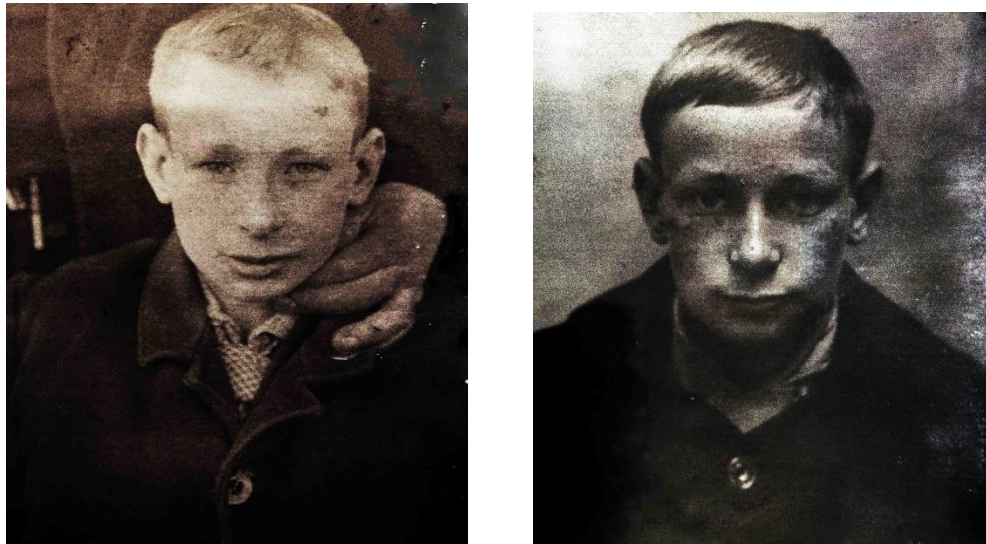


Fig. 46 Lewis Bullock on admission and 'recovered'¹⁶³

Discussion and Conclusions

In evaluating these photographs, the nature of their audience seems vital. The audience, who were the doctors, Commissioners and Visitors, comprised a privileged group. If the audience had been widened to the patients, their family or the public, these photographs would have been different. They would have been more censored, both in terms of not upsetting Victorian sensibilities and of promoting the asylum. Fig. 24 of Ellen Richman would have been too emotionally raw for the public and too upsetting for her relatives. Because of the audience, they could allow the patients a degree of autonomy, because that would show how unwell they were

¹⁶¹ Admission book BRO 40513/C/2/10, 114. Admitted 21/1/1895, discharged (recovered) 5/8/1895.

¹⁶² '1901 England Census,' Ancestry, accessed June 11, 2016, <http://search.ancestry.co.uk/search/db.aspx?dbid=7814>.

¹⁶³ Admission book BRO 40513/C/2/10, 114.

and thus what a difficult job the doctors had. If the audience was the public, they might have used some of the admission and recovery pictures but only ones like the last picture in Fig. 38, which looks like a 'normal' Victorian portrait.

The nature of the audience may have also influenced the decision to stop taking these photographs. With most of the long-stay patients a combination of ageing, institutionalisation and their illnesses would have meant that in person they looked worse than in their photographs. This would give the impression that the asylum had made them worse and thus these pictures were in some ways not an advert for its excellence; they became a reminder of its failures.

The intention of the photographs was to signify that it was a progressive establishment and in this they can be compared not only to institutions such as prisons but also to schools. Burke and Ribeiro de Castro's study of photographs of Portuguese schoolchildren suggested they 'convey a message to the onlooker of progress'.¹⁶⁴ To achieve this they used children whose looks embodied the idea of 'the perfect child'. These photographs, however, were aimed at the public. In contrast, the asylum was not looking for the 'perfect patient'; they wanted to categorise, they wanted pathology to be visible.

Much of our evidence does seem to support the contention that the photographs were a form of control.¹⁶⁵ Certainly the authorities controlled a number of the elements. They chose where and when the photograph could be taken. The photographer chose the moment when the photograph was taken and he had control over development and printing. From the admission books it looks as if during certain periods nearly all the patients had their picture taken, which indicates it was not voluntary.¹⁶⁶ The patients also had no control over the uses of the photographs, though the photographs taken on discharge may have pleased them. The patients

¹⁶⁴ Catherine Burke and Helena Ribeiro de Castro, 'The School Photograph: Portraiture and the Art of Assembling the Body of the Schoolchild,' *History of Education* 36(2): 217.

¹⁶⁵ Tagg, *The Burden of Representation*, 66–102.

¹⁶⁶ See admission books BRO 40513/C/2/11, 40513/C/2/12, 40513/C/3/12 and 40513/C/3/13.

can be seen as being, in what Cook has suggested (paraphrasing Foucault), 'caught in the centralised and unrelenting stare of modern disciplinary regimes'.¹⁶⁷

This view, however, takes a very one-sided view of the nature of photography in general and asylum photography in particular. Although the asylums were centralised, in the sense that the state made them obligatory and produced a very vigorous set of rules and requirements which they had to follow (and a regulatory system which enforced this), lumping together criminal and asylum photography is understandable but simplistic. Although both institutions were controlling, the motives of the institutions which produced the photographs were not the same. The prisons' need to control was greater and photography can be seen as part of that. With the asylums, photography was a temporary and half-hearted affair. Francis Galton may have been a biological determinist but the institution where he took his photographs had a different view. The asylum's regulations stated that 'all persons of unsound mind deemed to be curable, are eligible for admission'.¹⁶⁸ The Bristol Asylum also hoped to cure their patients, even if the later years saw the rise of a therapeutic pessimism. Secondly, the technical features of photography mean that aspects of the finished photograph were determined by the nature of the process, rather than by the photographer. Shutter speeds were relatively long so the photographs had to be taken outdoors. The photographer had no control over focal length and therefore of depth of field (the depth of the image which is in focus). Also, the development processes produced a particular fixed effect. They were also in black and white, which makes them more 'dramatic'.¹⁶⁹ Lastly, although they had some control over the posing of the photograph, the character of the subject is, at least partially, visible. A photograph is not an exact representation of its subject but it has

¹⁶⁷ James W. Cook, 'Seeing the Visual in US History,' *The Journal of American History* 95(2) (September 2008): 436.

¹⁶⁸ Colin Gale and Robert Howard, *Presumed curable: an illustrated casebook of Victorian psychiatric patients in Bethlem Hospital* (Petersfield: Wrightson Biomedical Publishing, 2003), 4.

¹⁶⁹ Beaumont Newhall, *The History of Photography from 1839 to the Present Day* (New York: The Museum of Modern Art, 1984). It is not possible to definitely assert whether the Victorians thought monotone was more 'dramatic' as they did not have colour to compare it with. A monotone image does, though, inevitably dramatise as it emphasises form.

some relationship to it and probably more so in the Victorian age when they had less control over technical aspects. Our modern digital manipulation software enables us to make almost any image from an original subject. In the Victorian age they did not have that ability.

Writers such as Tagg, Cross and Gilman have very effectively shown that the objectivity of photography, which the Victorians assumed, was ill-founded.¹⁷⁰ With our admission and recovery photographs, we have shown how the photographs were, in many respects, a male 'gaze'. This however, does not mean that the resultant images were completely subjective.

Lastly, although some of the photographs were misleading and the photographic situation heavily controlled, the personality of the subject and often their suffering does shine through. They are thus a useful addition to other evidence about the patients. Sidlauskas and Doyle have both suggested the elements of agency which can occur in such photographs.¹⁷¹ The individuality of the patients is very apparent in viewing these photographs and to suggest these patients were mere pawns of the system is to devalue them. Dolly Mackinnon and Catharine Coleborne in their recent book on the visual culture of psychiatry have concluded, 'we contend that psychiatric practices, as well as those who have been made subject to its regimes, become more visible when we consider both the material and visual cultures produced through and by psychiatric institutions'.¹⁷²

The past is conceptualised in words but we imagine the past through pictures. It can be argued that the photographs tell us more about the institution than about the patients; however, they help us to imagine both.

¹⁷⁰ Tagg, *The Burden of Representation*; Cross, *Mediating Madness*; Gilman, *Seeing the Insane*.

¹⁷¹ Sidlauskas, 'Inventing the Medical Portrait'; Doyle, 'Public eye, private eye'.

¹⁷² Dolly MacKinnon and Catharine Coleborne, *Exhibiting Madness in Museums: Remembering Psychiatry through Collections* (New York: Routledge, 2011), 3.

Conclusions

This study has produced a vast amount of information about the patients of the Bristol Lunatic Asylum. From this information, it is necessary to ascertain whether it was a typical asylum. The evidence where it seems typical can be used for and against arguments about the asylums in general. Untypicality might be evidence of the diversity of asylums. Comparing our evidence to other studies should suggest the degree of specificity, as well as answers to our original questions.

There is no easy answer to the question of whether the Bristol Asylum was typical. Firstly, our asylum was subject to very specific regulations concerning the admission process and the documentation was regulated by the state in the form of the Commissioners.¹ Also it was subject to the standards of the age. As we saw in chapter 2, the political, social, cultural and medical ideas about lunacy and its treatment would have influenced this and other asylums. Dr Stephens was influenced by the ideas of Moral Treatment and the design of the asylum was similar to many other asylums, particularly with its fairly extensive grounds.² In chapter 2 our findings on the composition of the asylum patients was similar to other asylums except that places such as Exminster had more patients from an agricultural background. Private asylums such as Ticehurst had patients from a very different social class and, as Mackenzie shows, were subject to market forces which did not affect the county asylums.³ The Bristol Asylum was also typical in its provision of employment and leisure activities. There were small differences, however: the Bristol Asylum, unlike the Denbigh asylum, did not employ fifteen patients to pump water from their well; however, studies by Michael and Hide show very similar provision.⁴

¹ Bartlett, *The Poor Law of Lunacy*, for regulation, 72-111 for the Commissioners, 197-237.

² Early, *Pauper Palace*, 10, Clare Hickman, 'The Picturesque at Brislington House, Bristol: The Role of Landscape in Relation to the Treatment of Mental Illness in the Early Nineteenth Century Asylum,' *Garden History* 33(1) (2005): 47-60.

³ Mackenzie, *Psychiatry for the Rich*, 216.

⁴ Michael *Care and Treatment*, 62. Hide, *Gender and Class*, 91-120.

With the treatment and diagnosis of patients, Bristol's typicality seems less certain. When Dr Thompson was in charge both his diagnostic criteria and his treatments seem out of step both with his predecessor and other asylums. His diagnosis of dementia was far higher than other asylums and his diagnosis of puerperal conditions far less (see chapter 5). His extensive use of hyoscine was also highly unusual. It is therefore difficult to compare the mental conditions from which the Bristol Asylum's patients suffered with other asylums. They were probably similar, and it was the diagnoses that were variable. Thus, we should not expect that the Bristol Asylum would be comparable to the private asylums, but, in many aspects - though not all - it was typical of most county asylums.

The first of our questions asked whether our patients represented a cross-section of Bristol society. We had evidence from where the patients lived, their occupations and level of education. From these sources it can be asserted that there was a slight preponderance of the very poor and a few occupational groups, such as domestic servants, were over-represented. There were, however, a wide variety of occupations and the addresses of the patients showed that they came from different parishes of Bristol roughly in line with their populations. There were some methodological difficulties, with the occupations noted by the asylum not always being compatible with the census categories. Also, as with the census, the results for female employment are very unreliable.⁵ Other writers, including Walton and Michael, have agreed that there was a much wider class distribution in the asylums than was suggested by Scull.⁶ Another interesting comparison is with Susan Burt's thesis on the Hampshire Asylum. She produced fairly extensive statistics based on a database and asserted that, although the asylum did not have a large proportion of the lowest class, the asylum 'community cannot be said to have been a

⁵ Richard Lawton, *The census and social structure: an interpretative guide to nineteenth century censuses for England and Wales* (London: Cass, 1978).

⁶ John Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50,' *Journal of Social History* 13(1) (1979); Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cardiff: University of Wales Press, 2003), 103; Andrew T. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993), 354-355.

microcosm of the wider community'.⁷ This seems to be at odds with our findings. The main reason for her conclusion compared to ours would seem to lie in the areas from which the patients came. Hampshire was a largely rural area, whereas Bristol was a prosperous city. Those who might be termed lower-middle or upper-working class amounted to quite a high proportion of the Bristol population. These groups would not have been wealthy enough for the fees of an asylum such as Brislington and so had to accept being admitted to the Bristol Asylum. Conversely, the area of Hampshire was more starkly divided between rich and poor; the rich went to the private asylums and the poor to the Hampshire Asylum.

From the above evidence it could be claimed that the Bristol Asylum contained a cross-section of Bristol society but only with a considerable proviso. The rich, the capitalists, the landowners and the upper echelons of the professions were rarely admitted to the asylum. They, however, would have made up a small percentage of the population but carried a large degree of influence. A view of a city's population that omits its leaders would seem unbalanced. Our original question can therefore only be answered in the affirmative if it is changed to 'Did the asylum's population represent a cross-section of Bristol's *working* population?'

Our second question asks how the asylum changed. There were a number of obvious changes which can easily be quantified. Most obviously, like virtually all asylums of this period, the size soon proved inadequate and by 1867 there was overcrowding with patients housed in corridors and demands for the asylum to be extended.⁸ The asylum did grow bigger and by the end of our period housed nearly 1000 patients.⁹ There were more admissions and more chronic cases. This was not helped by a fall in the recovery rate from 45 per cent in the 1860s to 34 per cent in the 1890s, and the death rate from 13 per cent in 1862 to 8.9 per cent in 1898.¹⁰

⁷ Susan Burt, "'Fit Objects for an Asylum' The Hampshire County Lunatic Asylum and its Patients, 1852–1899' (PhD thesis, University of Southampton, 2003), accessed June 21, 2015, <http://eprints.soton.ac.uk/194555/1.hasCoversheetVersion/00250119.pdf>.

⁸ Commissioner's Report 1868, Wellcome Library: WLM28.BE5B86, 1862–1868.

⁹ Medical Superintendent's Report 1898, Wellcome Library: WLM28.BE5B86, 1880–1898.

¹⁰ Figures calculated from database. The first few years of the 1860s are omitted because they inherited a large number of chronic cases from St Peter's.

Nationally the dominant view as to how to care for the mentally unwell was beginning to change. The high hopes of the humanitarian Moral Treatment movement were seen as being unfulfilled as the number of psychiatric cases continued to rise. This was being replaced by a more mechanistic view based on the medical model and influenced by the eugenics movement (see Chapter 2). The influence of these changes are apparent in the changes at the Bristol Asylum which were brought about by the change of Medical Superintendent. Dr Stephens was an advocate of Moral Treatment with its therapeutic optimism and disavowal of restraint. His replacement, Dr Thompson, was a much sterner character; Early characterised him as 'pompous' and 'imperious'.¹¹ In Chapter 5 we saw how the diagnosis of mania and dementia varied enormously between these two men. They also seemed to have differing ideas and values on a variety of issues, including using the seclusion room and the beer ration, which Dr Thompson ended in 1883.¹² These men certainly had different characters but they were also products of their time. Dr Stephens was a humanitarian whilst Dr Thompson was a man of science, and by the late nineteenth century the scientific paradigm had become the dominant philosophy for the treatment of the insane. It is difficult to determine how much these changes affected the patients but having a diagnosis which was thought to be untreatable (dementia) or being denied your pint of beer or being placed in seclusion were the practical effects of these changes. It should be noted that by cataloguing the changes we ignore what did not change. Throughout our period the patients experienced a combination of care and control by the authorities in admittedly varying proportions. What certainly did not change was the suffering from their mental conditions.

Our third question asked how these mental conditions affected them and our evidence suggests their chances of recovery were greatly influenced by the nature and type of these conditions. We saw in Chapter 5 how the diagnoses, particularly of mania and dementia, were influenced by the views of the doctors. Despite this, the recovery rates for the different conditions

¹¹ Donal Early, *'The Lunatic Pauper Palace' Glenside Hospital Bristol 1861 – 1994* (Bristol: Friends of Glenside Hospital Museum, 2003), 19–20.

¹² *Ibid.*

varied wildly from 2 per cent for General Paralysis of the Insane (GPI) to 81 per cent for puerperal mania (see Chapter 5). Other factors, particularly age and gender, certainly influenced recovery but to a lesser extent (see Chapter 5, Fig. 3). In terms of the patients' experiences whilst in the asylum, the symptoms often dominated their lives. This has been shown most extremely for those with epilepsy or GPI. Fig. 5 in Chapter 5 shows that on average a patient with epilepsy would suffer about twenty fits a month. As there was no treatment, these fits might be prolonged and would severely affect them for several hours postictal. Most patients with GPI were confused, physically frail and died not long after admission. Little could be done for these patients and it was only in the twentieth century that treatments became available for these conditions. The most common psychiatric symptom affecting at least half the patients was some sort of delusion. In our introduction we saw how George Silman thought he had a battery in his brain and how this delusion had ruined his life. It tended to be not the delusion itself that affected people but the actions that resulted from such beliefs. If, like Emily Minty, you believed you were a member of the royal family you almost certainly would soon lose your job as a domestic servant because you would not act like a servant.¹³ For most of the patients in the asylum, whether they were depressed, deluded or epileptic, their symptoms dominated their lives. The high level of delusional ideas is a subject which needs further research. Other studies, most notably the work of Renvoize and Beveridge, shows a similar high level of delusional thought. In their study of the York Asylum in the 1880s they found that 72.9 per cent of the patients had delusional thoughts.¹⁴ Myers has shown that psychotic thinking is at least partially culturally dependant, so further studies should examine what it was about the Victorian culture that made such delusions so numerous.¹⁵

¹³ Admission book BRO 40513/C/3/12, 90.

¹⁴ Edward Renvoize and Allan Beveridge, 'Mental illness and the late Victorians: a study of patients admitted to three asylums in York, 1880–1884,' *Psychological Medicine* 19 (1989): 19–28.

¹⁵ Neely Laurenzo Myers, 'Update: Schizophrenia Across Cultures,' *Current Psychiatry Report* 13 (2011): 305–311.

The asylum provided a very controlling structure that may have helped or hindered any recovery. Some of the staff, as John Weston observed, could be very harsh. Other staff were certainly caring, as Weston also observed, but for most patients it was their symptoms which caused them to be admitted and, if they continued, it was their symptoms that kept them there.¹⁶

The different strands of methodology used in this study are not unique in themselves but their combination creates possibilities which hopefully have created something of great utility. The range of methods from statistical analysis, using several variables, to studying the photographs of the patients produces a range of evidence, each with different strengths and weaknesses. Our database and its analysis using pivot tables is, I believe, unique with its ability to compare a number of variables simultaneously, for all the patients of the nineteenth century. Several writers have used statistics effectively in their studies of particular asylums. Melling and Forsythe in their work on Devon asylums have used them to increase our understanding of the nature of the asylum's population.¹⁷ As it was shown in chapter 2, several asylum studies have used databases however, by using 36 different categories and using pivot tables for analysis and comparison our study was able to provide information on a more sophisticated level. Although we have by no means exhausted the possibilities of this method, we have been able to combine variables to produce some interesting results. For instance, we used the variables 'sex', 'employment category' and 'result' to examine the number of patients of the professional classes admitted to the asylum, how that varied by gender and their relative recovery rates. Further research could, for instance, investigate the numbers of patients of differing religious faiths and whether there was a positive relationship between specific faiths and particular diagnoses.

¹⁶ John Weston, *Life in a Lunatic Asylum* (London: Houlston and Wright, 1867).

¹⁷ Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845–1914* (London: Routledge, 2006).

The photographs are sometimes difficult to 'read' and can often be interpreted in several ways but, as Burke suggests, they do provide a brilliant asset for the 'historical imagination'.¹⁸ Viewing all the photographs, which can be found in Appendix 2, one does get a sense of what the patients were like even if it is problematic to describe what that sense is. Rather than evidence of the patients' mental conditions, the photographs are also evidence of the problematic nature of the diagnoses made at the asylum.

Our quantitative analysis has the merits and defects of all quantitative methods. It has been possible to show how various categories relate to each other. We can analyse the relationship between diagnosis and recovery or gender and length of admission. These methods are limited by what information can be put into categories. It is easy to input age, sex or diagnosis into a database, however, sadness or anger are more problematic. Also, it is easy to over-emphasise that which can be categorised. One benefit of our eclectic methodology is that there is an interaction between the different methodologies. Fig. 1 in Chapter 5, detailing the Superintendents' differing diagnoses, is a quantitative report but is also about individuals. Knowledge of their backgrounds and interests helps inform us on their diagnostic preferences. The database and pivot tables show the extent of these different ideas. Following on from this, the results can be tested. Dr Stephens diagnosed many more people with mania and many fewer with dementia. It is likely that more of his mania diagnoses would be inaccurate whilst his dementia diagnoses would be more accurate than those of Dr Thompson. As people are much more likely to recover from mania than dementia (see chapter 5, Fig. 2), Dr Stephens should have a lower rate for both conditions. This was tested using our database and Fig. 1 below shows that his rates were lower, though for dementia it was a fairly small difference. It should be noted that, although his rates for each condition were lower, his overall recovery rate was slightly higher because so many more of his patients were diagnosed with mania.

¹⁸ Peter Burke, *Eyewitnessing: The Uses of Images as Historical Evidence* (London: Reaktion Books, 2001), 13.

	Recovery rate, dementia	Recovery rate, mania
Dr Stephens	22%	38%
Dr Thompson	25%	54%

Fig. 1 Recovery rates for Dr Stephens and Dr Thompson¹⁹

This study was blessed with a wide variety of sources, the most important being the asylum admission books. As with all historical evidence we have the problem of what the philosopher Raymond Aron has called ‘the blind selection of time’, meaning the evidence left to us has not been chosen for an historical analysis; it’s just what we have available.²⁰ Thus we might have a letter from a patient which describes an altercation with another patient, however, the other patient would probably have a different view on the matter but we do not have their view.

Most of our evidence is written by the asylum doctors and is infused by the ideas and biases of that set of people during that period. This is undoubtedly a weakness in this and virtually all other studies of asylums. We know very little about what the nurses thought and only a few fragments of evidence from the patients. This can be seen as a particular problem for this study as it is mostly about the patients; however, most history is based on evidence about the subject rather than by the subject. Hopefully this study has differentiated between evidence that can be deemed reliable, such as the address or marital status of a patient, and that which must be more carefully considered. When a doctor describes the patient Alice Birth as ‘silly’ we have to question that assertion which could mean a number of things or could just be a reflection of the doctor’s irritation.²¹ The doctors’ and the Visitors’ attitudes and views on a number of issues are in interesting contrast with the views expressed by John Weston. If Weston seems to have little insight into his own problems and how they might affect his judgement, the doctors often have

¹⁹ Figures from pivot tables using the categories ‘admission year’, ‘diagnosis’ and ‘result’.

²⁰ Raymond Aron, ‘Evidence and Inference in History,’ *Daedalus* 87(4) (Fall 1958): 12.

²¹ Admission book BRO 40513/C/3/12, 165.

little insight into the patients who were mostly of a different class and this particularly applies to those of a different sex.

What then is original about this study and in what ways does it add to existing research? Much of our evidence confirms the findings of other similar studies such as those by Hide, Michael and Melling and Forsythe.²² In terms of the composition of the asylum population our results are similar but the extensive database devised here does add to the certainty of our conclusions. This is the only study of the Bristol Asylum which has used extensive quantitative data. The only other major study of Bristol by Early is largely about the institution and the staff and so this study's emphasis on the lives of the patients at Bristol is also original.

More importantly there are aspects of our study which are original and have national implications. Our work on the influence of the Medical Superintendents shows an influence that both surprised the present author and has not been previously suggested in the academic literature. These individuals were products of their time, but the differences between their methods and beliefs were far reaching. This is also an example of how the use of pivot tables to analyse the database can produce information that would otherwise not be obtained. These findings also show how many of the statistics which the Victorian asylums produced must be carefully analysed. In particular, our results show that Victorian psychiatric diagnoses probably tell us more about the diagnostic views of the doctors than the nature of the patients' conditions. Generally this study shows the limitations of Victorian psychiatric diagnoses. Both our findings on the Superintendents and the photographs show that the Victorian need to categorize and the psychiatrists' desire for medical and scientific respectability produced deeply flawed results.

This study describes the patients' experiences of the asylum, their mental conditions and perhaps most importantly, it shows their humanity through their photographs, through the

²² Michael *Care and Treatment*, Hide, *Gender and Class*, Melling and Forsythe, *The Politics of Madness*.

writings of John Longman or John Weston and through some of the doctors' reports. They emerge as people and not merely as categories of a medical assessment or a sociological analysis.

List of Illustrations and Tables

Introduction

Fig. 1 George Joseph Silman in about 1905

Source: Admission book BRO 40513/C/2/8, 161.

Fig. 2 Areas of Bristol by population, disease, violent death and infant mortality in 1881.

Source: 'History of Bristol in Gloucestershire | Map and description, *A Vision of Britain through Time*,' Great Britain Historical Geographical Information System (GBHGIS), University of Portsmouth, accessed March 24, 2015, <http://www.visionofbritain.org.uk/place/843>.

Copyright access under Creative Commons agreement for students within the UK Access Management Federation for Education and Research.

Fig. 3 The Northwoods Asylum

Source: 'Northwoods Asylum BS36,' Paul Townsend, accessed September 16, 2013, <https://www.flickr.com/photos/brizzlebornandbred/10097423535/>.

Copyrighted work available under Creative Commons Attribution only licence CC BY 4.0 <http://creativecommons.org/licenses/by/4.0/>

Chapter 3

Fig. 1 Age of patients on admission by decade

Source: Pivot table from database using categories 'decade' and 'sex'.

Fig. 2 John Chapple, 1897

Source: Admission book BRO 40513/C/2/11, 89.

Fig. 3 Results of admissions by age in decades

Source: Pivot table from database using categories 'age' and 'result'.

Fig. 4 Results and duration of admissions in months by gender

Source: Pivot table from database using categories, 'sex', 'result' and 'duration category'.

Fig. 5 Deaths and recoveries of admissions by age and marital status

Source: Pivot table from database using category 'sex', and examples from the categories 'marital status' and 'result'.

Fig. 6 Duration of admission in months by marital status

Source: Pivot table from database using categories 'sex', 'marital status' and 'duration category'.

Fig. 7 Harriet Palmer, 1896

Source: Admission book BRO 40513/C/3/13, 53.

Fig. 8 Comparison of asylum population's occupations with Bristol and Wolverhampton based on 1881 census

Source: Pivot table compiled from 1881 census and database categories 'occupational category' and 'sex'.

Fig. 9 Asylum occupation categories by percentage for 1861–1899

Source: Pivot table from database using categories 'sex' and 'occupational category'.

Fig. 10 Occupations and the results of their admissions

Source: The figures for Bristol and Wolverhampton are based on the 1881 census, '1881 England Census,' Ancestry, accessed March 19, 2014,

<http://search.ancestry.co.uk/search/db.aspx?dbid=7572>. The figures for the asylum are from the database using the categories 'revised occupation' and 'sex'.

Fig. 11 Occupation categories and their results by percentage

Source: Percentages from pivot tables using the categories 'sex', 'occupational category' and 'result'.

Fig. 12 Admissions by area and their results

Source: Pivot table from database using categories 'result' and 'parish/workhouse'.

Fig. 13 Comparison of asylum population with areas of Bristol

Source: Table from database using examples from the category 'parish' and figures from the 1881 census, UK Census Online, accessed May 23, 2016,

<http://www.ukcensusonline.com/census/1881.php>.

Fig. 14 Occupational categories by area

Source: Pivot table from database using the category 'occupational category' and examples from category 'parish'.

Fig. 15 Ann Holmes

Source: Admission book BRO 40513/C/3/12, 88.

Fig. 16 Patients' literacy in percentages

Source: Pivot table from database using categories 'sex' and 'education'.

Fig. 17 Adjusted patients' literacy in percentages

Source: Pivot table from database using categories 'sex' and 'education' with figures adjusted to exclude those defined as 'idiots' or 'imbeciles'.

Fig. 18 Literacy for patients in selected areas

Source: Pivot table from database using the category 'education' and selected areas from the category 'parish'.

Fig. 19 Results for differing literacy levels

Source: Pivot table from database using the categories 'education' and 'results'.

Fig. 20 Results of admissions at various intervals (in months)

Source: Pivot table from database using categories 'results' and 'duration category'.

Fig. 21 Causes of death, 1870

Source: Figures for causes of death from Superintendent's Report 1870, Wellcome Library: WLM28.BE5B86.

Fig. 22 Results of admission of patients from workhouse compared to non-workhouse

Source: Figures from database using categories 'results of admission' and 'workhouse'.

Fig. 23 Comparisons of workhouse patients with general asylum population

Source: Figures from database using categories 'workhouse', 'education', 'marital status', 'diagnosis' and 'physical problems'.

Fig. 24 Occupational categories of private patients, the general asylum population and those from the workhouse

Source: Pivot table from database using the categories 'workhouse', 'private' and 'occupational category'.

Fig. 25 Residence of private patients and general population, selected areas

Source: Pivot table from database using examples from the category 'parish' and the category 'private'.

Chapter 4

Fig. 1 Number of patients employed on 31 December 1894

Source: Figures from 1894 Superintendent's Report, BRO 35510.

Fig. 2 Mentally ill patients dancing at a ball at Somerset County Asylum

Source: Process print after a lithograph by K. Drake, 'Wellcome Images', accessed January 29, 2015,

https://commons.wikimedia.org/wiki/File:Mentally_ill_patients_dancing_at_a_ball_at_Somerset_County_A_Wellcome_L0000508.jpg.

Copyrighted work available under Creative Commons Attribution only licence CC BY 4.0

<http://creativecommons.org/licenses/by/4.0/>

Fig. 3 A Ball at Colney Hatch Asylum

Source: 'Entertainment for the patients at the Middlesex County Lunatic Asylum, Colney Hatch, 1853,' Wellcome Images, accessed May 26, 2015,

Copyrighted Work available under Creative Commons by-nc 2.0 UK

Fig. 4 Number of patients visited each month, 1864

Source: Figures from Wellcome Library: WLM28.BE5B86, 1862–1868.

Fig. 5 Painting of unknown body part by Arthur Nichols

Source: Admission book BRO 40513/C/2/7, 33.

Fig. 6 Numbers of patients placed in seclusion

Source: Figures taken from medical journals BRO 40513/J/1–8. Figures for some years are missing.

Fig. 7 Moral causes of admission

Source: Figures obtained from pivot table using categories 'marital status' and 'moral causes'.

Fig. 8 Charlotte Long on admission

Source: Admission book BRO 40513/C/3/12, 62.

Fig. 9 Assessment of bodily health of admissions

Source: 'Report of the Committee of Visitors of the Lunatic Asylum for the City and County of Bristol, together with the reports of the medical superintendent & chaplain,' Wellcome Library: WLM28.BE5B86, 1869–1880 and 1881–1898.

Fig. 10 Patients' diet, 1894

Source: Medical Superintendent's Report 1894, BRO 35510.

Fig. 11 The asylum in 1904

Source: Bristol Plans, BRO Bristolplans/arranged/41.

Fig. 12 The Drive at the asylum, 1916

Source: 'Beaufort War Hospital, Fishponds, Bristol,' Paul Townsend, accessed February 24, 2013, <https://www.flickr.com/photos/brizzlebornandbred/6608655987>. Permission for use of image from Glenside Museum.

Fig. 13 One of the wards, 1916

Source: 'Help sought to build history of war hospital,' *Bristol Post*, accessed March 17, 2012, <http://www.bristolpost.co.uk/Help-sought-build-history-war-hospital/story-20221093-detail/story.html>. Permission for use of image from Glenside Museum

Chapter 5

Fig. 1 Percentages of patients given diagnosis of mania or dementia by year

Source: Figures from database using pivot table yearly figures for category 'diagnosis'.

Fig. 2 Diagnoses and results

Source: Figures calculated using pivot tables using categories 'diagnosis' and 'result'. Some minor categories have been omitted from this table to make it more readable.

Fig. 3 Comparison of recovery rates

Source: Figures obtained from database using categories 'diagnosis' and 'result'.

Fig. 4 Diagnoses of patients with epilepsy

Source: Figures obtained from pivot table comparing categories 'diagnosis' and 'physical problems'.

Fig. 5 No. of fits during the year 1881

Source: Figures from Wellcome Library: WLM28.BE5B86, 1870–1889.

Fig. 6 Edward Colston Hale

Source: Photograph from admission book BRO 40513/C/12, 102.

Fig. 7 Deaths of patients with GPI in months

Source: Chart produced from pivot table using categories 'duration calc', 'physical problems' and 'result'.

Fig. 8 Number of patients described as having delusions for the years 1885 and 1892

Source: Figures in table from admission books for 1885 and 1892 BRO 40513/C/2/7 and BRO 40513/C/3/10.

Fig. 9 Sarah Wright's letter to husband, 1897

Source: Letter from admission book BRO 40513/C/3/13, 72.

Fig. 10 Sarah Wright in 1896

Source: Photograph from admission book BRO 40513/C/3/13, 72.

Fig. 11 Margaret Walsh in 1892

Source: Photograph in admission book BRO 40513/C/3/12, 7.

Fig. 12 Walter Stanley Crocker, 1894

Source: Photograph in admission book BRO 40513/C/2/10, 70.

Fig. 13 Annie Smart, 1892

Source: Photograph in admission book BRO 40513/C/3/12, 4.

Fig. 14 Alice Jane Wells, 1892

Source: Photograph in admission book BRO 40513/C/3/12, 2.

Fig. 15 Robert Ellis Dudgeon's 'pocket sphygmograph'

Source: 'Welcome Images' <https://wellcomeimages.org/> Wellcome.

Images reproduced here courtesy of Wellcome Library, London; under Creative Commons

Attribution 4.0, only licence CC BY 4.0

Chapter 6

Fig. 1 Alice Kate Birth, 1894

Source: Photo from admission book BRO 40513/C/3/12, 165.

Fig. 2 Ship of Fools (c. 1490–1500) Louvre, Paris

Source: 'Ship of Fools,' Luke Mastin, accessed October 1, 2014,

http://www.lukemastin.com/testing/hieronymus/magnify_ship.html.

Image in Public domain.

Fig. 3 'The Rake's Progress', William Hogarth

Source: 'William Hogarth 019,' Wikimedia Commons, accessed June 10, 2016,

https://commons.wikimedia.org/wiki/File:William_Hogarth_019.jpg.

Image in public domain

Fig. 4 Charles Bell's 'Madness'

Source: Photograph in Sander Gilman, *Seeing the Insane* (Lincoln: University of Nebraska Press, 1982), 91. Permission for use given by Echo Books

Fig. 5 Original Photograph

Source: Photograph in Sander Gilman, *Seeing the Insane* (Lincoln: University of Nebraska Press, 1982), 91. Permission for use given by Echo Books

Fig. 6 Engraving of 'Religious Melancholy'

Source: Photograph in Sander Gilman, *Seeing the Insane* (Lincoln: University of Nebraska Press, 1982), 91. Permission for use given by Echo Books

Fig. 7 'Seated Woman with Bird'

Source: Photograph in Sander Gilman, *Seeing the Insane* (Lincoln: University of Nebraska Press, 1982), 91. Permission for use given by Echo Books

Fig. 8 Augustine as hysteric, photo by Charcot

Source: Freud Museum London, accessed January 9, 2013, http://www.freud.org.uk/file-uploads/small/hysteric_2_2.jpg. Image in public domain.

Fig. 9 'At the Medicine School', André Brouillet 1887

Source: 'Andre Brouillet,' Cultured, accessed October 18, 2013, http://wiki.cultured.com/people/Andre_Brouillet/. Image in public domain.

Fig. 10 Emily Sessions, 1894

Source: Admission book BRO 40513/C/3/12, 129.

Fig. 11 Ada Vissell, 1897

Source: Admission book BRO 40513/C/3/13, 143.

Fig. 12, Fig. 13, Fig. 14 [all untitled]

Source: Admission book BRO 40513/C/2/10, 96.

Fig. 15 [untitled]

Source: Admission book 40513/C/3/13, 95.

Fig. 16 Maria Eastman

Source: Admission book BRO 40513/C/3/12, 96.

Fig. 17 Simon Long

Source: Admission book BRO 40513/C/3/2/10, 171.

Fig. 18 Florence Louisa Harding

Source: Admission book BRO 40513/C/3/13, 51.

Fig. 19 Sarah Say

Source: Admission book BRO 40513/C/3/13, 18.

Fig. 20 Eliza Hill

Source: Admission book BRO 40513/C/3/12, 215.

Fig. 21 Emily Neale

Source: Admission book BRO 40513/C/3/13, 139.

Fig. 22 Edward Case

Source: Admission book BRO 40513/C/2/10, 177.

Fig. 23 Emily Shepherd

Source: Admission book BRO 40513/C/3/13, 165.

Fig. 24 Ellen Richman

Source: Admission book BRO 40513/C/3/13, 149.

Fig. 25 Mary Ann Gale

Source: Admission book BRO 40513/C/3/13, 165.

Fig. 26 'Mania'

Source 'Wikimedia Commons', accessed 20.7.16

https://commons.wikimedia.org/wiki/File:A._Morison_%22Physiognomy_of_mental_diseases%22,_cases_Wellcome_L0022719.jpg.

File under Creative Commons agreement Attribution 4.0 International

Fig. 27 Grace Attwood Biggs

Source: Admission book BRO 40513/C/2/12, 160.

Fig. 28 Charles West

Source: Admission book BRO 40513/C/3/11, 80.

Fig. 29 Annie Button

Source: Admission book BRO 40513/C/3/12, 229.

Fig. 30 Christina Pike

Source: Admission book BRO 40513/C/3/12, 166.

Fig. 31 James Davis

Source: Admission book BRO 40513/C/2/11, 95.

Fig. 32 Charles Davis

Source: Admission book BRO 40513/C/2/11, 79.

Fig. 33 Sarah Ann Tovey

Source: Admission book BRO 40513/C/3/12, 70.

Fig. 34 Sidney Albert Edgell

Source: Admission book BRO 40513/C/2/1, 65.

Fig. 35 Harriett Abbott

Source: Admission book 40513/C/3/11, 14.

Fig. 36 Frank Willoughby Jones

Source: Admission book BRO 40513/C/2/11, 14.

Fig. 37 Margaret Bowden

Source: Admission book BRO 40513/C/14, 41.

Fig. 38 Patients of the asylum chosen randomly from the admission books

Source: Appendix 2. These photographs were consecutive admissions from the same year.

Fig. 39 Grace Attwood Biggs on admission and 'recovered'

Source: Admission book BRO 40513/C/12, 19.

Fig. 40 Rosina Rayment: studio portrait, on admission and two 'recovered' photographs

Source: Admission book BRO 40513/C/3/12, 56 and 199.

Fig. 41 Louisa Anne Murray

Source: Admission book BRO 40513/C/12, 83.

Fig. 42 Ada Brooks on admission, with skin infection and 'recovered'

Source: Admission book BRO 40513/C/3/12, 116.

Fig. 43 Emma Eginton on admission and 'recovered'

Source: Admission book BRO 40513/C/3/12, 138.

Fig. 44 Emma Cottrell on admission and 'recovered'

Source: Admission book BRO 40513/C/12, 145.

Fig. 45 Tom Ambrose on admission and 'recovered'

Source: Admission book BRO 40513/C/2/10, 133.

Fig. 46 Lewis Bullock on admission and 'recovered'

Source: Admission book BRO 40513/C/2/10, 114.

Conclusions

Fig. 1 Recovery rates for Dr Stephens and Dr Thompson

Source: Figures from pivot tables using the categories 'admission year', 'diagnosis' and 'result'

Bibliography

Primary Sources

Records of the Bristol Lunatic Asylum held at the Bristol Record Office

Admission books

Male admissions BRO 40513/C/2/3 – C/2/21

Female admissions BRO 40513/C/3/3 – C/3/20

Admission certificates BRO 40513/R/2/3

Admission warrants BRO 40513/R/4

Chronic Case books BRO 40513/C/4/1 & 2

Doctors' Special reports BRO 40513/C/11/1 – C/11/3

Medical journals BRO 40513/J/1–8

Plans of Bristol Lunatic Asylum BRO Bristolplans/arranged/41

The Metropolitan Commissioners in Lunacy. *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor : presented to both houses of Parliament by command of Her Majesty.*

London: Bradbury and Evans, 1844.

Post-mortem records BRO 40513/C/18

Register of Mechanical Restraint BRO 40513/C/14/1

Visiting Committee Reports M/BCC/MEH/3/1-6

Visiting Committee Report 1894 BRO 35510/HS/1/1/1

Reports of the Asylum held by the Wellcome Library

WLM28.BE5B86: 1860–1869, 1870–1880 & 1881–1898

Other Sources

Davis, J.L., ed. *Glenside Hospital Reports 1861–1961*. Bristol: Friends of Glenside Hospital Museum

Bristol Mercury

Bristol Mercury and Daily Post

Bristol Mirror

Bristol Post

Bristol Times and Mirror

Morning Post (London)

Western Daily Press

Contemporary Articles

Chance, W. 'Indoor v. Outdoor Relief.' *National Review* (July 1895): 667–689.

Conolly, John. "Description and Treatment of Puerperal Insanity'. Lecture XIII. Clinical Lectures on the Principal Forms of Insanity, Delivered in the Middlesex Lunatic-Asylum at Hanwell.' *Lancet* 1(1178) (March 28, 1846): 349–354.

Hopkins, Ellice. 'The moral treatment of insanity: a sketch of its rise and progress.' *Fraser's magazine* 15(88) (April 1877): 444–459.

Ritto, Robert. 'Ovariectomy as a Prophylaxis and Cure for Insanity.' *Journal of the American Medical Association* XVI(15) (April 11, 1891): 516–517.

Thompson, George. 'On the use of the Hydrobromate of Hyoscine in the Treatment of Recurrent and Acute Mania,' *Lancet*, 1(3362) (February 4, 1888): 218–219.

———. 'The Sphygmograph in Lunatic Asylum Practice.' *West Riding Lunatic Asylum Medical Reports* 1 (London: J. & A. Churchill, 1871): 58–70.

Contemporary Books

Booth, Charles. *Life and Labour of the People in London*. London: Macmillan, 1902.

Browne, W.A.F. *What Asylums Were, Are and Ought To Be*. Edinburgh: A. & C. Black, 1837.

Bucknill, J.C., and D.H. Tuke, eds. *A Manual of Psychological Medicine*. London: John Churchill, 1862.

Clark, George T. *Report to the General Board of Health on a preliminary inquiry into the sewerage, drainage, and supply of water, and the sanitary condition of the inhabitants of the city and county of Bristol*. London: HMSO, 1850.

Clouston, Thomas. *Clinical lectures on mental diseases*. London: J. & A. Churchill, 1896.

Conolly, John. *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*. London: John Churchill, 1847.

De la Beche, Sir Henry T. *Health of Towns Commission – Report on the State of Bristol, and other Large Towns*. London: HMSO, 1845.

Latimer, John. *The Annals of Bristol in the Nineteenth Century*. Bristol: W. & F. Morgan, 1887.

The Medico-Psychological Association. *Handbook for the Attendants on the Insane*. Memphis, Tennessee: General Books, 2014. First published by Chicago: Chicago Medical Book Co., 1909

Mitford, John. 'Part second of the crimes and horrors in the interior of Warburton's private mad-houses at Hoxton and Bethnal Green; and of these establishments in general, with reasons for their total abolition.' *Hume Tracts*, 1820.

Morison, Alexander. *The Physiognomy of Mental Diseases*. London: Longman, 1843.

Rowntree, B.S. *Poverty: A Study of Town Life*. London: Macmillan, 1901.

Weston, John. *Life in a Lunatic Asylum: An Autobiographical Sketch*. Bristol: Houlston & Wright, 1867.

Secondary Sources

Articles

Adair, Richard, Joseph Melling, and Bill Forsythe. 'Migration, family structure and pauper lunacy in Victorian England: admissions to the Devon County Pauper Lunatic Asylum, 1845–1900.'

Continuity and Change 12(03) (December 1997): 373–401.

Andrews, Jonathan. 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century.' *Social History of Medicine* 11(2) (1998): 255–281.

Aron, Raymond. 'Evidence and Inference in History.' *Daedalus* 87(4) (Fall, 1958): 11–39.

Bartlett, Peter. 'The Asylum, the Workhouse and the Voice of the Insane Poor in 19th-Century England.' *International Journal of Law and Psychiatry* 21(4) (1998): 421–432.

Berkenkotter, Carol. 'A Patient's Tale of Incarceration in a Victorian Lunatic Asylum.' *International Journal of English Studies* 11(1) (2011): 1–14.

Berkenkotter, Carol, and Cristina Hanganu-Bresch. 'Occult Genres and the Certification of Madness in a 19th-Century Lunatic Asylum.' *Written Communication* 28(2) (2011): 220–250.

Berrios, G.E. 'Classifications in psychiatry: a conceptual history.' *Australian and New Zealand Journal of Psychiatry* 33(2) (1999): 145–160.

———. '“Depressive pseudodementia” or “Melancholic dementia”: a 19th century view.' *Journal of Neurology, Neurosurgery, and Psychiatry* 48 (1985): 393–400.

———. 'Historical aspects of psychoses: 19th century issues.' *British Medical Bulletin* 43(3) (1987): 484–498.

———. 'Of Mania: Introduction.' *History of Psychiatry* 15(1) (2004): 105–124.

———. 'Retrospective diagnosis and its vicissitudes.' *History of Psychiatry* 24 (March 2013): 126–128.

Beveridge, Allan. 'Life in the Asylum: patient's letters from Morningside, 1873–1908.' *History of Psychiatry* 9(36) (1998): 431–469.

———. 'Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873–1908.' *History of Psychiatry* 6(22) (1995): 133–156.

———. 'Voices of the mad: patients' letters from the Royal Edinburgh Asylum, 1873–1908.' *Psychological Medicine* 27(4) (1997): 899–908.

Bortolotti, Lisa, and Kengo Miyazono. 'Recent Work on the Nature and Development of Delusions.' *Philosophy Compass* 10(9) (September 2015): 636–645.

Bridge, Thomas, Eleanor Cannon, and Richard Wyatt. 'Burned-out Schizophrenia: Evidence for Age Effects on Schizophrenic Symptomatology.' *Journal of Gerontology* 33(6) (1978): 835–839.

Brown, J.F. 'Epistemological differences within psychological science: A philosophical perspective on the validity of psychiatric diagnoses.' *Psychology and Psychotherapy: Theory, Research and Practice* 75(3) (2002): 239–250.

Brown, P.S. 'The Providers of Medical Treatment in Mid-Nineteenth Century Bristol.' *Medical History* 24(3) (1980): 297–314.

Burke, Catherine, and Helena Ribeiro de Castro. 'The School Photograph: Portraiture and the Art of Assembling the Body of the Schoolchild.' *History of Education* 36(2) (2007): 213–226.

Carus, A.W., and Sheilagh Ogilvie. 'Turning qualitative into quantitative evidence: a well-used method made explicit.' *Economic History Review* 62(4) (2009): 893–925.

Charland, Louis. 'Benevolent theory: moral treatment at the York Retreat.' *History of Psychiatry* 18(1) (2007): 61–80.

Clayton, Paul, and Judith Rowbotham. 'An unsuitable and degraded diet? Part one: public health lessons from the mid-Victorian working class diet.' *Journal of the Royal Society of Medicine* 101(6) (2008): 282–289.

———. 'An unsuitable and degraded diet? Part two: realities of the mid-Victorian diet.' *Journal of the Royal Society of Medicine* 101(7) (2008): 350–357.

Cook, James W. 'Seeing the Visual in U.S. History.' *Journal of American History* 95(2) (September 2008): 432–441.

Coser, Rose Laub. 'Suicide and the Relational System: A Case Study in a Mental Hospital.' *Journal of Health and Social Behaviour* 17(4) (1976): 318–327.

Dallenbach, Karl M. 'Tables vs. Graphs as Means of Presenting Experimental Results.' *The American Journal of Psychology* 76(4) (December 1963): 700–702.

Davis, G. 'The most deadly disease of asylumdom: general paralysis of the insane and Scottish psychiatry, c.1840–1940.' *Journal of the Royal College of Physicians of Edinburgh* 42 (2012): 266–273.

Dowdall, George, and Janet Golden. 'Photographs as Data; An Analysis of Images from a Mental Hospital.' *Qualitative Sociology* 12(2) (1989): 183–213.

Du Plessis, Rory. 'Beyond a clinical narrative: casebook photographs from the Grahamstown Lunatic Asylum, c. 1890s.' In 'Archival addresses: photographies, practices, positionalities,' edited by Leora Farber, special issue, *Critical Arts* 29(Supplement 1) (2015): 88–103.

Edginton, Barry. 'Moral architecture: the influence of the York Retreat on asylum design.' *Health & Place* 3(2) (1997): 91–99.

Ellis, Robert. 'The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the county Asylums of Yorkshire in the Nineteenth Century.' *Social History of Medicine* 19(1): 55–71.

- Enzmann, Dieter, and Barton Lane. 'Cranial Computed Tomography Findings in Anorexia Nervosa.' *Journal of Computer Assisted Tomography* 1(4) (1977): 410–414.
- Everitt, B.S. 'Statistics in Psychiatry.' *Statistical Science* 2(2) (May 1987): 107–116.
- Felton, Gideon, and Suheib Abu-Kmeil. 'Was the introduction of single-sex wards a mistake?' *Mental Health Practice* 15(5) (2012): 21–24.
- Ferguson, T. 'Public Health in Britain in the Climate of the Nineteenth Century.' *Population Studies* 17(3) (1964): 213–224.
- Bernard A Fischer, 'Maltreatment of People With Serious Mental Illness in the Early 20th Century: A Focus on Nazi Germany and Eugenics in America' *The Journal of Nervous and Mental Disease*, 12/2012, Vol. 200, Is. 12, 1096-1100.
- Fogel, Robert William. 'The Limits of Quantitative Methods in History.' *The American Historical Review* 80(2) (1975): 329–350.
- Fox, Stephen. 'The Panopticon: From Bentham's Obsession to the Revolution in Management Learning.' *Human Relations* 42(8) (1989): 717–739.
- Freeman, Daniel H., Jr., María Elena González, David C. Hoaglin, and Beth A. Kilss. 'Presenting Statistical Papers.' *The American Statistician* 37(2) (1983): 106–110.
- Gambino, Matthew. 'Erving Goffman's Asylums and Institutional Culture in the Mid-twentieth-century United States.' *Harvard Review of Psychiatry* 21(1) (2013): 52–57.
- Garety, Philippa A., Matthew Gittins, Suzanne Jolley, Paul Bebbington, Graham Dunn, Elizabeth Kuipers, David Fowler, and Daniel Freeman. 'Differences in Cognitive and Emotional Processes Between Persecutory and Grandiose Delusions.' *Schizophrenia Bulletin* 39(3) (2013): 629–639.
- Gilbert, Arthur. 'Masturbation and Insanity: Henry Maudsley and the Ideology of Sexual Repression.' *Albion: A Quarterly Journal Concerned with British Studies* 12(3) (1980): 268–282.

Goffman, Erving. 'The Insanity of Place.' *Psychiatry: Interpersonal and Biological Processes* 32(4) (1969): 357–388.

Gomory, Tomi, David Cohen, and Stuart A. Kirk. 'Madness or Mental Illness? Revisiting Historians of Psychiatry.' *Current Psychology* 32(2) (2013): 119–135.

Haines, Robin, and Ralph Shlomowitz. 'Explaining the mortality decline in the eighteenth-century British slave trade.' *Economic History Review* L111(2) (2000): 262–283.

Hall, Lesley. 'Does Madness have a Gender?' *History of Psychiatry* 20(4) (2009): 497–501.

Hare, E.H., J.S. Price, and E. Slater. 'Parental Social Class in Psychiatric Patients.' *British Journal of Psychiatry* 121(564) (1972): 515–524.

Harris, Margaret, Fiona Farquhar, David Healy, Joanna Le Noury, Darren Baker, Christopher Whitaker, Stefanie Linden, Paul Green, and Antony P. Roberts. 'The incidence and prevalence of admissions for melancholia in two cohorts (1875–1924 and 1995–2005).' *Journal of Affective Disorders* 134(1–3) (2011): 45–51.

Hickman, Clare. 'The Picturesque at Brislington House, Bristol: The Role of Landscape in Relation to the Treatment of Mental Illness in the Early Nineteenth-Century Asylum.' *Garden History* 33(1) (2005): 47–60.

Hide, Louise. 'Making Sense of Pain: Delusions, Syphilis and Somatic Pain in London County Council Asylums c. 1900.' *19: Interdisciplinary Studies in the Long Nineteenth Century* 15 (2012): 1–20.

Hill, Bridget. 'Women, Work and the Census: a Problem for Historians of Women.' *History Workshop* 35(1) (1993): 78–94.

Hill, Simon, and Richard Laugharne. 'Mania, dementia and melancholia in the 1870s: admissions to a Cornwall Asylum.' *Journal of the Royal Society of Medicine* 96(7) (2003): 361–363.

- Hitchcock, Tim. 'A New History from Below.' *History Workshop Journal* 57(1) (Spring 2004): 294–298.
- Hodgkinson, R.G. 'Provision for pauper lunatics 1834–1871.' *Medical History* 10(2) (1966): 138–154.
- Holmes, Gordon. 'Evolution of Clinical Medicine Illustrated by the History of Epilepsy.' *British Medical Journal* 2(4461) (July 6, 1946): 1–4.
- Horley, James. 'On the Tyranny of Professional Labelling.' *Psychotherapy and Politics International* 9(2) (2011): 127–133.
- Horwitz, Allan, and Gerald Grob. 'The Checkered History of American Psychiatric Epidemiology.' *The Milbank Quarterly* 89(4) (2011): 628–657.
- Kanemoto, Kousuke, Yukari Tadokoro, and Tomohiro Oshima. 'Violence and postictal psychosis: a comparison of postictal psychosis, interictal psychosis, and postictal confusion.' *Epilepsy and Behaviour* 19(2) (2010): 162–166.
- Kanner, Andres. 'Psychiatric issues in epilepsy: the complex relation of mood, anxiety disorders, and epilepsy.' *Epilepsy and Behaviour* 15(1) (2009): 83–87.
- Kendler, K.S., and A. Jablensky. 'Kraepelin's concept of psychiatric illness.' *Psychological Medicine* 41(6) (2011): 1119–1126.
- Kiran, Chandra, and Suprakash Chaudhury. 'Understanding Delusions.' *Industrial Psychiatry Journal* 18(1) (2009): 3–18.
- Kosslyn, Stephen M. 'Graphics and Human Information Processing: A Review of Five Books.' *Journal of the American Statistical Association* 80(391) (1985): 499–512.
- Kromm, Jane E. 'The Feminization of Madness in Visual Representation.' *Feminist Studies* 20(3) (1994): 507–535.

- Laffey, Paul. 'John Wesley on insanity.' *History of Psychiatry* 12(48) (2001): 467–479.
- Lanzoni, Susan. 'The Asylum in Context: An Essay Review.' *Journal of the History of Medicine and Allied Sciences* 60(4) (October 2005): 499–505.
- Laws, Jennifer. 'Crackpots and basket-cases: a history of therapeutic work and occupation.' *History of the Human Sciences* 24(2) (2011): 65–81.
- Layton-Jones, Katy. 'Introduction: Visual Collections as Historical Evidence.' *Visual Resources* 24(2) (2008): 105–107.
- Loudon, D.M. 'Puerperal insanity in the 19th century.' *Journal of the Royal Society of Medicine* 81(2) (February 1988): 76–79.
- Maglogiannis, Ilias, Demosthenes Vouyioukas, and Chris Aggelopoulos. 'Face detection and recognition of natural human emotion using Markov random fields.' *Personal and Ubiquitous Computing* 13(1) (2009): 95–101.
- Mahé, V., and A. Dumaine. 'Oestrogen withdrawal associated psychoses.' *Acta Psychiatrica Scandinavica* 104(5) (2001): 323–331.
- Martin, Moira. 'Single Women and Philanthropy: a case study of women's associational life in Bristol, 1880–1914.' *Women's History Review* 17(3) (2008): 395–417.
- Masia, Shawn, and Orrin Devinsky. 'Epilepsy and Behavior: A Brief History.' *Epilepsy and Behavior* 1(1) (2000): 27–36.
- McCrae, Niall. 'The Beer Ration in Victorian Asylums.' *History of Psychiatry* 15(2) (2004): 155–175.
- Mellet, D.J. 'Bureaucracy and Mental Illness: The Commissioners in Lunacy 1845–90.' *Medical History* 25 (1981): 221–250.
- Miller, E. "'Pauper Lunatics and their Treatment' by Joshua Harrison Stallard." *History of Psychiatry* 24(3) (2013): 356–368.

———. 'Variations in the official prevalence and disposal of the insane in England under the poor law, 1850–1900.' *History of Psychiatry* 18(1) (2007): 25–38.

Miller, Jacques-Alain, and Richard Miller. 'Jeremy Bentham's Panoptic Device.' *October* 41 (Summer, 1987): 3–29.

Misbach, Judith, and Henderikus Stam. 'Medicalizing Melancholia: Exploring Profiles of Psychiatric Professionalization.' *Journal of the History of the Behavioral Sciences* 42(1) (Winter 2006): 41–59.

Morris R.J. 'Computers and the Subversion of British History.' *Journal of British Studies* 34(4) (October 1995): 503–528.

Murphy, Elaine. 'The Lunacy Commissioners and the East London Guardians, 1845–1867.' *Medical History* 46(4) (2002): 495–524.

Myers, E.D. 'Workhouse or asylum: the nineteenth century battle for the care of the pauper insane.' *BJPsych Bulletin* 22(9) (1998): 575–577.

Myers, Neely Laurenzo. 'Culture, Stress and Recovery from Schizophrenia: Lessons from the Field for Global Mental Health.' *Culture, Medicine, and Psychiatry* 34(3) (2010): 500–528.

———. 'Update: Schizophrenia Across Cultures.' *Current Psychiatry Report* 13 (2011): 305–311.

Nazoz, Fatma, Kaye Alvarez, and Christine L. Lisetti. 'Emotion Recognition from Physiological Signals for Presence Technologies.' *International Journal of Cognition, Technology, and Work – Special Issue on Presence* 6(1) (2003): 1–32.

Newman, Charlotte. 'To Punish or Protect: The New Poor Law and the English Workhouse.' *International Journal of Historical Archaeology* 18(1) (2014): 122–145.

Nowers, Mike, and David Gunnell. 'Suicide from the Clifton Suspension Bridge in England.' *Journal of Epidemiology and Community Health* 50(1) (February 1996): 30–32.

Oddy, D.J. 'Working-Class Diets in Late Nineteenth-Century Britain.' *The Economic History Review* 23(2) (1970): 314–322.

Patil, Tejas, and James Giordano. 'On the ontological assumptions of the medical model of psychiatry: philosophical considerations and pragmatic tasks.' *Philosophy, Ethics, and Humanities in Medicine* 5(3) (2010): 1–8.

Perlmutter, David. 'Visual Historical Methods: Problems, Prospects, Applications.' *Historical Methods* 27(4) (1994): 167–184.

Phillips, A.D.M., and J.R. Walton. 'The distribution of personal wealth in English towns in the mid-nineteenth century.' *Transactions of the Institute of British Geographers* 64 (1975): 35–48.

Porter, Roy. 'The Patient's View: Doing Medical History from Below.' *Theory and Society* 14(2) (1985): 175–198.

———. 'Seeing the Past.' *Past and Present* 118(1) (1988): 186–205.

Pozo Andrés, María del Mar, del and Jacques F.A. Braster. 'Bridging the Gap between Quantitative and Qualitative Historical Research: an application of multiple regression analysis and homogeneity analysis with alternating least squares.' *History and Computing* 8(3) (1996): 133–144.

Ray, Laurence. 'Models of madness in Victorian asylum practice.' *European Journal of Sociology* 22(02) (1981): 229–264.

Renvoize, Edward, and Allan Beveridge. 'Mental illness and the late Victorians: a study of patients admitted to three asylums in York, 1880–1884.' *Psychological Medicine* 19(1) (1989): 19–28.

Roberts, David. 'How Cruel Was the Victorian Poor Law?' *The Historical Journal* 6(1) (1963): 97–107.

- Robinson, A.D.T. 'A century of delusions in south west Scotland.' *The British Journal of Psychiatry* 153(2) (1988): 163–167.
- Rowbotham, Judith, and Paul Clayton. 'An unsuitable and degraded diet? Part three: Victorian consumption patterns and their health benefits.' *Journal of the Royal Society of Medicine* 101(9) (2008): 454–462.
- Rutherford, Sarah. 'Landscapers for the Mind: English Asylum Designers, 1845–1914.' *Garden History* 33(1) (2005): 61–86.
- Salloum, I.M., J.R. Cornelius, J.E. Mezzich, and L. Kirisci. 'Impact of concurrent alcohol misuse on symptom presentation of acute mania at initial evaluation.' *Bipolar Disorders* 4(6) (2002): 418–421.
- Sandall, Roger. 'Sir Francis Galton and the Roots of Eugenics.' *Society* 45(2) (200): 170–176.
- Scott, Francis. 'English County Asylums.' *Fortnightly Review* (July 1879): 114–143.
- Scull, Andrew T. 'The Insanity of Place.' *History of Psychiatry* 15(4) (2004): 417–436.
- . 'Madness and Segregative Control: The Rise of the Insane Asylum.' *Social Problems* 24(3) (1977): 337–351.
- Sekula, Allan. 'The Traffic in Photographs.' *Art Journal* 41(1) (1981): 15–25.
- Shepherd, Anne, and David Wright. 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint.' *Medical History* 46(2) (2002): 175–196.
- Sidlauskas, Susan. 'Inventing the Medical Portrait: Photography at the 'Benevolent Asylum' of Holloway, c. 1885–1889.' *Medical Humanities* 39 (2013): 29–37.
- Smith, Cathy. 'Family, community and the Victorian asylum: a case study of the Northampton General Lunatic Asylum and its pauper lunatics.' *Family & Community History* 9(2) (2006): 109–124.

- . ‘Visitation by God’: Rationalizing Death in the Victorian Asylum.’ *History of Psychiatry* 23(1) (2012): 104–116.
- Smith, Leonard. ‘A Gentleman’s mad-doctor in Georgian England: Edward Long Fox and Brislington House.’ *History of Psychiatry* 19(74) (2008): 163–184.
- . ‘Welcome release: perspectives on death in the early county lunatic asylums, 1810–50.’ *History of Psychiatry* 23(1) (2012): 117–128.
- . ‘Your Very Thankful Inmate’: Discovering the Patients of an Early County Lunatic Asylum.’ *Social History of Medicine* 21(2) (2008): 237–252.
- Sprafkin, Robert. ‘The Rebirth of Moral Treatment.’ *Professional Psychology: Research and Practice* 8(2) (1977): 161–169.
- Stokes, Peter M. ‘Bentham, Dickens, and the Uses of the Workhouse.’ *Studies in English Literature, 1500–1900* 41(4) (Autumn 2001): 711–727.
- Stone, Lawrence. ‘Literacy and Education in England 1640–1900.’ *Past and Present* 42(1) (February 1969): 69–139.
- . ‘The Revival of Narrative: Reflections on a New Old History.’ *Past and Present* 85 (1979): 3–24.
- Suzuki, Akihito. ‘The Politics and Ideology of Non-Restraint: The Case of the Hanwell Asylum.’ *Medical History* 39(1) (1995): 1–17.
- Taylor, Barbara. ‘The Demise of the Asylum in Late Twentieth-Century Britain: A Personal History.’ *Transactions of the Royal Historical Society (Sixth Series)* 21 (December 2011): 193–215.
- Thompson, E.P. ‘History from Below.’ *Times Literary Supplement*, April 7, 1966.
- Tschinkel, S., M. Harris, J. Le Noury, and D. Healy. ‘Postpartum psychosis: two cohorts compared, 1875–1924 and 1994–2005.’ *Psychological Medicine* 37(4) (2007): 529–536.

Tuke, John. 'Lunatics as patients, not prisoners.' *The Nineteenth Century* 25 (April 1889): 595–607.

Walton, John. 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848–50.' *Journal of Social History* 13(1) (1979): 1–22.

Wannell, Louise. 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875–1910.' *Social History of Medicine* 20(2) (2007): 297–313.

Widdess-Walsh, P., and O. Devinsky. 'Historical perspectives and definitions of the postictal state.' *Epilepsy and Behavior* 19(2) (2010): 96–99.

Wright, David. 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century.' *Social History of Medicine* 10(1) (1997): 137–155.

Yanni, Carla. 'The Linear Plan for Insane Asylums in the United States before 1866.' *Journal of the Society of Architectural Historians* 62(1) (2003): 24–49.

Yorston, Graeme, and Camilla Haw. 'Old and mad in Victorian Oxford: a study of patients aged 60 and over admitted to the Warneford and Littlemore Asylums in the nineteenth century.' *History of Psychiatry* 16(4) (2005): 395–421.

Theses

Burt, Susan. 'Fit Objects for an Asylum': The Hampshire County Lunatic Asylum and its Patients, 1852–1899.' PhD thesis, University of Southampton, 2003.

Rawling, Katherine Dorothy Berry. 'Visualising Mental Illness: Gender, Medicine and Visual Media, c.1850–1910.' PhD thesis, Royal Holloway, University of London, September 2011.

York, Sarah. 'Suicide, lunacy and the asylum in nineteenth-century England.' PhD thesis, University of Birmingham, 2010.

Pamphlets

Penny, John, *All the news that's fit to print: A short history of Bristol's newspapers since 1702* (Bristol: Bristol Historical Association, 2001).

Books

Anderson, Michael. *Family Structure in 19th Century Lancashire*. Cambridge: Cambridge University Press, 1971.

Andrews, Jonathan, and Digby, Anne, eds. *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*. New York: Rodopi, 2004.

Archer, Ian, Spencer Jordan, and Keith Ramsey. *Abstract of Bristol historical statistics. Part 1: Poor law statistics 1835–1948*. Bristol: Bristol Historical Databases Project, Faculty of Humanities, University of the West of England, 1997.

Arendt, Hannah, ed. *Illuminations: Essays and Reflections*. Translated by Harry Zohn. New York: Schocken Books, 1998.

Arieno, Marlene. *Victorian Lunatics: A Social Epidemiology of Mental Illness in Mid-Nineteenth-Century England*. Cranbury, NJ: Associated University Presses, 1989.

Arnold, Catharine. *Bedlam: London and its Mad*. London: Simon and Schuster, 2008.

Barry, J., and C. Jones, eds. *Medicine and Charity Before the Welfare State*. London: Routledge, 1991.

Barthes, Roland. *Camera Lucida: Reflections on Photography*. Translated by Richard Howard. New York: Farrar, Straus and Giroux, 1981.

Bartlett, Peter. *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England*. London: Leicester University Press, 1999.

- Beck, Aaron T., and Brad A. Alford. *Depression: Causes and Treatment*. Philadelphia: University of Pennsylvania, 1991.
- Berger, John. *Understanding a Photograph*. Edited by Geoff Dyer. London: Penguin, 2013.
- Berkenkotter, Carol. *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry*. Columbia: University of South Carolina Press, 2008.
- Berrios, German E. *The History of Mental Symptoms: Descriptive psychopathology since the nineteenth century*. Cambridge: Cambridge University Press, 1996.
- Borsay, Anne, and Peter Shapely, eds. *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c.1550–1950*. Burlington: Ashgate Publishing, 2007.
- Briggs, Asa. *A Victorian Portrait: Victorian Life and Values As Seen Through the Work of Studio Photographers*. New York: Harper and Row, 1989.
- Burke, Peter. *Eyewitnessing: The Uses of Images as Historical Evidence*. London: Reaktion Books, 2001.
- Busfield, Joan. *Men, Women and Madness: Understanding Gender and Mental Disorder*. Basingstoke: Palgrave Macmillan, 1996.
- Bynum, W.F., Roy Porter, and Michael Shepherd, eds. *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. II, Institutions and Society*. London: Tavistock, 1985.
- Cherry, Steven. *Mental Health Care in Modern England: The Norfolk Lunatic Asylum – St. Andrew's Hospital, c. 1810–1998*. Martlesham: Boydell & Brewer, 2003.
- Coleborne, Catharine, and Dolly MacKinnon, eds. *Exhibiting Madness in Museums: Remembering Psychiatry through Collection and Display*. New York: Routledge, 2011.
- Cooper, David. *The Death of the Family*. New York: Vintage Books, 1971.

- Cross, Simon. *Mediating Madness: Mental Distress and Cultural Representation*. Basingstoke: Palgrave Macmillan, 2010.
- Dale, Pamela, and Joseph Melling, eds. *Mental Illness and Learning Disability Since 1850: Finding a place for mental disorder in the United Kingdom*. London: Routledge, 2006.
- Davis, Mark. *Voices from the Asylum: West Riding Pauper Lunatic Asylum*. Stroud: Amberley Publishing, 2013.
- Didi-Huberman, Georges. *Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière*. Paris: Éditions Macula, 1982.
- Digby, Anne. *Madness, morality and medicine: A study of the York Retreat 1796–1914*. Cambridge: Cambridge University Press, 1985.
- . *Pauper Palaces*. London: Routledge & Kegan Paul, 1978.
- Dresser, Madge, and Philip Ollerenshaw, eds. *The Making of Modern Bristol*. Tiverton: Redcliffe Press, 1996.
- Dwyer, Ellen. *Homes for the Mad: Life inside two Nineteenth Century Asylums*. New Brunswick: Rutgers University Press, 1987.
- Early, Donal F. 'The Lunatic Pauper Palace' *Glenside Hospital Bristol 1861 – 1994*. Bristol: Friends of Glenside Hospital Museum, 2003.
- Falcone, John, and Louise Hide. *Points of View: Capturing the 19th Century in Photographs*. London: The British Library, 2009.
- Fissell, Mary E. *Patients, Power, and the Poor in Eighteenth-Century Bristol*. Cambridge: Cambridge University Press, 1991.
- Floud, Roderick. *An Introduction to Quantitative Methods for Historians*. London: Methuen, 1973.
- Foucault, Michel. *Madness and Civilization*. London: Random House, 1965.

- Gale, Colin, and Robert Howard. *Presumed Curable: An Illustrated Casebook of Victorian Psychiatric Patients in Bethlem Hospital*. Petersfield: Wrightson Biomedical Publishing, 2003.
- Gardner James. *Sweet Bells Jangled out of Tune: A History of the Sussex Lunatic Asylum (St Francis Hospital) Haywards Heath*. Brighton: Self-published, 1999.
- Gates, Barbara. *Victorian Suicide: Mad Crimes and Sad Histories*. Princetown: Princetown University Press, 1988.
- Gilman, Sander L., ed. *The Face of Madness: Hugh W. Diamond and the Origin of Psychiatric Photography*. New Jersey: Brunner-Mazel, 1976.
- . *Seeing the Insane*. Lincoln: University of Nebraska Press, 1982.
- Ginzburg, Carlo. *The Cheese and the Worms: The Cosmos of a Sixteenth-Century Miller*. Baltimore: John Hopkins University Press, 1976.
- Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*. London: Penguin, 1961.
- Gorsky, Martin. *Patterns of Philanthropy: Charity and Society in Nineteenth-Century Bristol*. Martlesham: Royal Historical Society, Boydell, 1999.
- Gough, Paul. *Stanley Spencer: Journey to Burghclere*. Bristol: Sansom, 2007.
- Gutting, Gary, ed. *The Cambridge Companion to Foucault*. Cambridge: Cambridge University Press, 1994.
- Hide, Louise. *Gender and Class in English Asylums, 1890–1914*. Basingstoke: Palgrave Macmillan, 2014.
- Higgs, Edward. *A Clearer Sense of the Census: the Victorian Census and Historical Research*. London: HMSO, 1996.
- . *Making Sense of the Census*. London: HMSO, 1989.

- Huppert, Felicia, Carol Brayne, and Daniel O'Connor, eds. *Dementia and Normal Aging*. Cambridge: Cambridge University Press, 1994.
- Jay, Mike. *The Influencing Machine: James Tilly Matthews and the Air Loom*. London: Strange Attractor Press, 2012.
- Jenkins, Keith, ed. *The Postmodern History Reader*. London and New York: Routledge, 1997.
- Jones, Kathleen. *Asylums and After: A Revised History of the Mental Health Services: From the Early Eighteenth Century to the 1990s*. London: Athlone Press, 1993.
- Koers, Diane. *Excel 2003 Just the Steps for Dummies*. Hoboken: Wiley, 2006.
- Laing, R.D. *The Politics of the Family and other Essays*. New York: Random House, 1972.
- Lambie, James. *The Story of Your Life: A History of "The Sporting Life" Newspaper (1859–1998)*. Leicester: Matador, 2010.
- Large, David. *The Municipal Government of Bristol 1851–1901*. Bristol: Bristol Record Society, 1999.
- Lawton, Richard, ed. *The Census and Social Structure: An Interpretative Guide to Nineteenth Century Censuses for England and Wales*. London: Cass, 1978.
- Linkman, Audrey. *The Victorians: Photographic Portraits*. New York: Tauris Parke, 1993.
- MacDonald, Michael. *Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth-Century England*. Cambridge: Cambridge University Press, 1981.
- Mackenzie, Charlotte. *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917*. London: Routledge and Keegan Paul, 1992.
- Malament, Barbara, ed. *After the Reformation: Essays in Honor of J.H. Hexter*. Philadelphia: University of Pennsylvania Press, 1980.

- Marland, Hilary. *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain*. New York: Palgrave Macmillan, 2004.
- Marshall, Susan. *Mendip Hospital: An Appreciation*. Ely: Melrose Books, 2006.
- Mechanic, David. *Mental Health and Social Policy*. Englewood Cliffs, New Jersey: Prentice Hall Inc., 1969.
- Meller, Helen. *Leisure and the Changing City 1870–1914*. Boston: Routledge & Kegan Paul, 1976.
- Mellet, David. *The Prerogative of Asyludom: Social, Cultural and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth-Century Britain*. London: Taylor and Francis, 1982.
- Melling, Joseph, and Bill Forsythe, eds. *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective*. London: Routledge, 1999.
- . *The Politics of Madness: The State, Insanity and Society in England, 1845–1914*. London: Routledge, 2006.
- Michael, Pamela. *Care and Treatment of the Mentally Ill in North Wales 1800–2000*. Cardiff: University of Wales Press, 2003.
- Mitch, David F. *The Rise of Popular Literacy in Victorian England: The Influence of Private Choice and Public Policy*. Philadelphia: University of Pennsylvania Press, 1992.
- Newhall, Beaumont. *The History of Photography: from 1839 to the Present*. 5th ed. New York: The Museum of Modern Art, 1984.
- Nolan, Peter. *A History of Mental Health Nursing*. London: Chapman & Hall, 1993.
- Parry-Jones, William L. *The Trade In Lunacy: A Study of Private Mad-Houses in England in the Eighteenth and Nineteenth Centuries*. London: Keegan Paul, 1972.

- Penny, John. *All the News that's Fit to Print: A Short History of Bristol's Newspapers since 1702*. Bristol: Bristol Branch of the Historical Association, 2001.
- Perceval, John. *Perceval's Narrative: A Patient's Account of His Psychosis, 1830–1832*. Stanford: Stanford University Press, 1961.
- Porter, Roy. *Madness: A Brief History*. Oxford: Oxford University Press, 2003.
- . *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency*. London: Athlone Press, 1987.
- . *A Social History of Madness: Stories of the Insane*. London: Weidenfeld & Nicolson, 1996.
- Putnam, Tim, Melinda Mash, Jon Bird, Barry Curtis, and George Robertson, eds. *The Block Reader in Visual Culture*. Abingdon: Routledge, 1996.
- Quétel, Claude. *History of Syphilis*. Cambridge: Polity Press, 1990.
- Richardson, Mike. *The Bristol Strike Wave of 1889–1890: Socialists, New Unionists and New Women – Part 2: Days of Doubt*. Bristol: Freedom Press, 2012.
- . *The Bristol Strike Wave of 1889–1890: Socialists, New Unionists and New Women – Part 1: Days of Hope*. Bristol: Freedom Press, 2012.
- Scull, Andrew T. *Hysteria: The disturbing history*. Oxford: Oxford University Press, 2009.
- . *The Most Solitary of Afflictions: Madness and Society in Britain 1700–1900*. New Haven and London: Yale University Press, 1993.
- . *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England*. London: Allen Lane, 1979.
- Selikowitz, Mark. *Down Syndrome: The Facts*. 2nd ed. Oxford: Oxford University Press, 1997.
- Showalter, Elaine. *The Female Malady: Women, Madness and English Culture, 1830–1980*. London: Virago, 1987.

Skultans, Vieda. *English Madness: Ideas on Insanity 1580–1890*. London: Routledge & Kegan Paul, 1979.

Smith, Leonard D. *'Cure, Comfort and Safe Custody': Public Lunatic Asylums in Early Nineteenth-Century England*. London: Leicester University Press, 1999.

Sontag, Susan. *On Photography*. London: Farrar, Straus & Giroux, 1977.

Stephens, W.B. *Education, Literacy and Society 1830–70: The Geography of Diversity in Provincial England*. Manchester: Manchester University Press, 1987.

———, ed. *Studies in the history of literacy: England and North America. Educational Administration and History Monographs 13*. Leeds: Museum of the History of Education, University of Leeds, 1983.

Still, Arthur and Irving Velody, eds. *Rewriting the History of Madness: Studies in Foucault's Histoire de la folie*. New York: Routledge, 1992.

Szasz, Thomas S. *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*. London: Routledge & Kegan Paul, 1971.

Tagg, John. *The Burden of Representation: Essays on Photographies and Histories*. Basingstoke: Macmillan Education, 1988.

Thompson, E.P. *The Making of the English Working Class*. London: Victor Gollancz, 1963. Reprint, London: Penguin, 1991.

Tuke, William. *Description of the Retreat, An Institution near York, for Insane Persons of the Society of Friends*. 1813. Reprint, London: Process Press, 1996.

Ussher, Jane. *Women's Madness: Misogyny or Mental Illness?* Hemel Hempstead: Harvester Wheatsheaf, 1991.

Wise, Sarah. *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England*.

London: Bodley Head, 2012.

Wittgenstein, Ludwig. *On Certainty*. New York: Harper and Row, 1969.

Wright, David. *Mental Disability in Victorian England: The Earlswood Asylum 1847–1901*. Oxford:

Oxford University Press, 2001.

Zizek, Slavoj. *Did Somebody Say Totalitarianism?: Five Interventions in the (Mis)Use of a Notion*.

London: Verso, 2001.

Web Sources

Ancestry. 'England & Wales, Death Index, 1916–2007.' Accessed June 9, 2016.

<http://search.ancestry.co.uk/search/db.aspx?dbid=7579>.

———. 'UK Census Collection.' Accessed June 9, 2016.

<http://search.ancestry.co.uk/search/group/ukicen>.

Are You Mental? (Yes I Am) (blog).

<http://areyoumental.tumblr.com/post/146097872/wingsandfins-higherhills-religious-melancholy>.

Asylum Science. 'Medical technology in the asylum.' Accessed February 25, 2014.

<http://asylumscience.com/tag/sphygmograph>.

Avon and Somerset Constabulary. 'Firearms Offences and Murders in Bristol 1999–2013.'

Accessed January 13, 2016. <https://www.avonandsomerset.police.uk/about-us/freedom-of-information/previous-foi-requests/firearmslicensingweapons/firearms-offences-and-murders-in-bristol-1999-2013/>.

Barton Hill History Group. 'William Herapath.' Accessed March 7, 2014.

<http://www.bhhg.co.uk/showfiles.php?files=williamherapath>.

Biomedical Ephemera (blog). <http://biomedicalephemera.tumblr.com/post/7775087538/ways-to-die-erysipelas>.

Bristol City Council. 'Conservation Area 5 – Clifton & Hotwells: Character Appraisal and Management Proposals.' Accessed May 23, 2016.

<https://www.bristol.gov.uk/documents/20182/33832/clifton-and-hotwells-character-appraisal.pdf>.

The Bristol Post. 'Help sought to build history of war hospital.' Accessed March 17, 2012.

<http://www.bristolpost.co.uk/Help-sought-build-history-war-hospital/story-20221093-detail/story.html>.

Burt, Susan. "Fit Objects for an Asylum": The Hampshire County Lunatic Asylum and its Patients, 1852–1899.' Doctoral thesis, University of Southampton, 2003. Accessed June 21, 2015.

<http://eprints.soton.ac.uk/194555/1.hasCoversheetVersion/00250119.pdf>.

Chandoo. 'Guide to Excel Pivot Tables.' Accessed May 28, 2014. <http://chandoo.org/wp/excel-pivot-tables/>.

Citizens Report. 'Murders in the UK – Location, Rate and Victim Profile of Murder, Homicide and Fatal Violence.' Accessed August 12, 2014. <http://www.citizensreportuk.org/reports/murders-fatal-violence-uk.html>.

Cultured. 'Andre Brouillet.' Accessed October 8, 2013.

http://wiki.cultured.com/people/Andre_Brouillet/.

The Daily Mail. 'Obese people lose IQ through 'Homer Simpson effect'.' Accessed August 24, 2014.

<http://www.dailymail.co.uk/news/article-410505/Obese-people-lose-IQ-Homer-Simpson-effect.html>.

Doyle, Peter. 'Public eye, private eye: Sydney police mug shots, 1912–1930.' *Scan – Journal of Media Arts and Culture* 2(3) (December 2005). Accessed April 6, 2014.

http://scan.net.au/scan/journal/display.php?journal_id=67.

Epilepsy Action. 'Treatment and care for seizures that last more than 5 minutes and for status epilepticus.' Last modified December 2015. <https://www.epilepsy.org.uk/info/treatment/status-epilepticus>.

Foust, John. 'Before-and-after advertising.' Accessed September 14, 2014.

http://www.scpres.org/eBulletin/foust_nov.pdf.

Freud Museum London. [untitled]. Accessed January 9, 2013. http://www.freud.org.uk/file-uploads/small/hysteric_2_2.jpg.

GENUKI. 'City of Exeter Police Charge Book Entries for 28 Aug 1856 – 23 Dec 1856.' Last modified April 10, 2004. <http://genuki.cs.ncl.ac.uk/DEV/Exeter/Police5/ChargeBook1856-2.html>.

Gilman, Sander L., Helen King, Roy Porter, G.S. Rousseau, and Elaine Showalter. *Hysteria Beyond Freud*. Berkeley: University of California Press, 1993. Accessed March 9, 2013.

<http://publishing.cdlib.org/ucpressebooks/view?docId=ft0p3003d3&chunk.id=d0e16276&toc.depth=1&toc.id=d0e16276&brand=ucpress;query=hugh%20diamond#1>.

Glenside Hospital Museum. 'Psychiatric Hospital 1861–1994.' Accessed June 10, 2016.

<http://www.glensidemuseum.org.uk/psychiatric-hospital-1861-1994/>.

Great Britain Historical Geographical Information System (GBHGIS), University of Portsmouth.

'History of Bristol in Gloucestershire | Map and description, *A Vision of Britain through Time*.'

Accessed March 24, 2015. <http://www.visionofbritain.org.uk/place/843>.

The Guardian. 'Repulsion – review.' Accessed March 12, 2014.

<http://www.theguardian.com/film/2013/jan/03/repulsion-review>.

Histpop: The Online Historical Population Reports Website. 'General report, England and Wales, Vol. IV, 1891: Page 112.' Accessed April 15, 2014.
[http://www.histpop.org/ohpr/servlet/PageBrowser?path=Browse/Census%20\(by%20date\)&active=yes&mno=68&tocstate=expandnew&tocseq=3900&display=sections&display=tables&display=pages&titles&pageseq=first-nonblank](http://www.histpop.org/ohpr/servlet/PageBrowser?path=Browse/Census%20(by%20date)&active=yes&mno=68&tocstate=expandnew&tocseq=3900&display=sections&display=tables&display=pages&titles&pageseq=first-nonblank).

Hughes, Kathryn. 'Inconvenient People by Sarah Wise – review.' Accessed June 15, 2014.
<http://www.theguardian.com/books/2012/nov/09/inconvenient-people-sarah-wise-review>.

Legislation.gov.uk. 'Public Records Act 1958.' Accessed April 11, 2016.
<http://www.legislation.gov.uk/ukpga/Eliz2/6-7/51>.

Living Easton. 'The Easton Workhouse.' Accessed May 8, 2013.
http://www.cems.uwe.ac.uk/~rstephen/livingeaston/local_history/eastvilleworkhouse.html.

Marland, Hilary. 'Maternity and Madness: Puerperal Insanity in the Nineteenth Century.' Paper presented at the UK Centre for the History of Nursing and Midwifery seminar, University of Manchester, April 2003. Accessed October 6, 2015.
<http://www.nursing.manchester.ac.uk/ukchnm/publications/seminarpapers/maternityandmadness.pdf>.

Mastin, Luke. 'Ship of Fools (c. 1490–1500).' Accessed October 1, 2014.
http://www.lukemastin.com/testing/hieronymus/magnify_ship.html.

Medical Protection Society. 'Access to health records.' Accessed November 12, 2014.
<http://www.medicalprotection.org/uk/england-factsheets/access-to-health-records>.

Medscape. 'Marasmus.' Last modified May 13, 2014.
<http://emedicine.medscape.com/article/984496-overview>.

Mental Health Foundation. 'Depression.' Accessed December 7, 2013.
<http://www.mentalhealth.org.uk/help-information/mental-health-a-z/D/depression/>.

Morison, Alexander. 'The physiognomy of mental diseases.' Accessed June 11, 2016.

<https://archive.org/stream/physiognomyofmen00mori#page/n13/mode/2up>.

Ontario Genealogy. 'Upper Canada (Ontario) Insane Asylum Inmates.' Last modified September

2012. http://www.ontariogenealogy.com/insaneasylum/insaneasylum_part1.html.

Oxford University Press. 'Oxford Dictionaries.' Accessed June 16, 2013.

<http://www.oxforddictionaries.com>.

———. 'Oxford English Dictionary.' Accessed March 7, 2014. <http://www.oed.com>.

Reinarz, Jonathan, and Leonard Schwarz, eds. *Medicine and the Workhouse*. Rochester, NY:

University of Rochester Press, 2013. Accessed March 14, 2014.

<http://universitypublishingonline.org.ezproxy.uwe.ac.uk/boydell/ebook.jsf?bid=CBO97815804680>

2.

Stone, Lawrence. 'Madness.' Accessed December 3, 2014.

<http://www.nybooks.com/articles/1982/12/16/madness/>.

Surkis, Judith. 'Fiction and Film for French Historians: A Cultural Bulletin – Alice Winocour's

Augustine.' Accessed June 10, 2016. <http://h-france.net/fffh/the-buzz/alice-winocours-augustine/>.

Townsend, Paul. 'Beaufort War Hospital, Fishponds, Bristol.' Accessed February 24, 2013.

<https://www.flickr.com/photos/brizzlebornandbred/6608655987>.

———. 'Northwoods Asylum BS36.' Accessed September 16, 2013.

<http://www.flickr.com/photos/brizzlebornandbred/10097423535/>.

Tucker, J. 'Diamond, Hugh Welch (1808–1886).' Accessed August 27, 2014.

[http://www.oxforddnb.com/templates/article.jsp?articleid=7583&back=.](http://www.oxforddnb.com/templates/article.jsp?articleid=7583&back=)

UK Census Online. 'Search UKCensusOnline.' Accessed June 9, 2016.

<http://www.ukcensusonline.com/search/index.php>.

Wellcome Trust – Life from a Wellcome Trust perspective (blog).

<http://blog.wellcome.ac.uk/2011/11/29/feature-tax-and-quacks-the-role-of-tax-in-the-development-of-modern-medicine/l0000641-colney-hatch-lunatic-asylum/>.

Wikimedia Commons. 'File:Hugh Welch Diamond (British – Seated Woman with Bird – Google Art Project.jpg.' Last modified March 28, 2016.

[http://commons.wikimedia.org/wiki/File:Hugh_Welch_Diamond_\(British_-_Seated_Woman_with_Bird_-_Google_Art_Project.jpg](http://commons.wikimedia.org/wiki/File:Hugh_Welch_Diamond_(British_-_Seated_Woman_with_Bird_-_Google_Art_Project.jpg).

———. 'File:Mentally ill patients dancing at a ball at Somerset County A Wellcome L0000508.jpg.' Last modified June 14, 2016.

https://commons.wikimedia.org/wiki/File:Mentally_ill_patients_dancing_at_a_ball_at_Somerset_County_A_Wellcome_L0000508.jpg.

———. 'File:William Hogarth 019.jpg.' Last modified November 26, 2015.

https://commons.wikimedia.org/wiki/File:William_Hogarth_019.jpg.

The Workhouse: The story of an institution. '1881 Census: Residents of Bristol City Workhouse, Stapleton, Gloucester, England.' Accessed March 17, 2014.

<http://www.workhouses.org.uk/Bristol/Bristol1881.shtml>.

Guide to Appendix 1: The Database of all Admissions to the Asylum in the Nineteenth Century

The database is digital and can be found on the attached memory stick but the following is a brief guide to its use.

The chart below gives a list of all the categories which are arranged in columns on the database (found on the tab marked 'Data', at the bottom of the workbook), together with a brief explanation of the categories which are not self-explanatory. The patients are listed in a chronological order of their admission from 1861 till the end of 1899. The data is mostly taken from the admission books but in a few cases these had been destroyed and the data was taken from admission forms. Researchers wanting more information on particular patients can use columns D and E to find their admission notes from the books held at the Bristol Record Office. Not all the categories are completed in every case, with some categories such as 'physical problems' being only rarely filled in. In row 3 the categories are named and there is a small arrow in the bottom right-hand corner of each cell, which if pressed shows all the possible entries which can then be arranged in a number of ways.

Sheets 1–5 show various workings and calculations. Also at the bottom is a tab marked 'Pivot Table', which was the main method used to analyse the data and complete tables or other statistical analyses. For a fairly simple guide to how to use these see: <http://www.excel-easy.com/data-analysis/pivot-tables.html>.

Appendix 2

The Photographs of the Asylum Patients

This appendix is included on the memory stick and consists of low resolution photographs of 700 of the patients that were taken in the 1890s. They include their name and are arranged alphabetically by their Christian names.

Appendix 3

This is also stored digitally and is to be used in conjunction with Appendices 1 and 2. It is a spreadsheet which has small versions of all the photographs from Appendix 2 arranged in the first column of the spreadsheet. For each of these photographs the other columns include all the information from Appendix 1. Thus researchers or anyone else interested can link the photographs to both the database information and the admission books at the Bristol Record Office.