

SUICIDE, LUNACY AND THE ASYLUM IN NINETEENTH-CENTURY ENGLAND

by

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ABSTRACT

Suicidal patients constituted a significant proportion of the annual admissions to nineteenth-century public lunatic asylums. They formed a distinct patient category that required treatment and management strategies that were capable of frustrating their suicidal propensity and alleviating their mental affliction. Yet despite being relatively large in number, the suicidal population of public asylums has received only nominal attention in the history of nineteenth-century psychiatry. This thesis examines the admission, discharge, treatment and management of suicidal lunatics over the course of the nineteenth century. It locates suicide and suicidal behaviour within the context of the asylum and uncovers the experiences of patients, their families and asylum staff. There is a distinct appreciation of the broader social and political context in which the asylum operated and how this affected suicide prevention and management.

This thesis argues that suicidal behaviour, because of the danger associated with it, triggered admission to the asylum and, once admitted, dangerousness and risk continued to dictate the asylum's handling of suicidal patients. Rather than cure and custody, it was protection and prevention versus control that dominated the asylum's treatment of suicidal lunatics. Conclusions are drawn based on evidence from five asylum case studies and contemporary publications.

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LIST OF CONTENTS

LIST OF CONTENTS	i
ACKNOWLEDGEMENTS	ii
ABSTRACT	iii
INTRODUCTION	1
CHAPTER ONE SUICIDAL BEHAVIOUR	47
The 'Standard view'	50
The 'Psychiatric view'	56
Melancholia	63
Mania	70
Puerperal Insanity	77
Other Diagnostic Categories	82
The Favoured Means of Suicide	86
CHAPTER TWO THE INCIPIENT PSYCHIATRIC PROFESSION AND SUICIDE	94
The Medical Profession and Insanity	96
The Psychiatric Profession	99
Changing Attitudes to Asylum Care and Treatment	111
Changing Attitudes to Risk and Suicide	128
CHAPTER THREE THE ADMISSION AND DISCHARGE OF SUICIDAL LUNATICS	140
The Admission Process	141
'Facts indicating insanity'	152
'Other facts indicating insanity'	157
Recovery and Discharge	160
Leaving the Asylum	169

CHAPTER FOUR THE MANAGEMENT OF SUICIDE IN THE ASYLUM	180
Asylum Architecture	182
Classification	196
Constant Watching	201
Mechanical Restraint	215
Seclusion	231
 CHAPTER FIVE THE STRUGGLE BETWEEN CONTROL AND THERAPY	245
Moral Treatment	246
Moral Management	261
The Challenge of Non-Restraint	264
Chemical Restraint	278
 CHAPTER SIX THE COMMISSIONERS IN LUNACY AND SUICIDE PREVENTION	296
The Lunacy Commission and Suicide Prevention	300
The Process of Investigation	311
The Commission and Private Asylums	318
 CONCLUSION	329
 APPENDICES	
1 Favoured Means of Suicide used Prior to Admission (male patients)	344
2 Favoured Means of Suicide used Prior to Admission (female patients)	345
 BIBLIOGRAPHY	346

ABBREVIATIONS

BCA	Birmingham City Archives
GA	Gloucestershire Archives
JMS	Journal of Mental Science
LCRO	Leicestershire County Record Office
LRO	Liverpool Record Office
NA	National Archives
NCA	Nottinghamshire County Archives
StaCRO	Staffordshire County Record Office
SCRO	Suffolk County Record Office
SRO	Shropshire Record Office
WCRO	Warwickshire County Record Office
WRO	Worcestershire County Record Office

INTRODUCTION

The history of psychiatry and institutional care has attracted considerable attention during recent decades from both social historians¹ and psychiatrists.² Each group has contributed to the narrative of the rise of the lunatic asylum and the professionalisation of 'psychiatry'. The historical inquiries and the methodological approaches adopted by the two fields have led to interpretations that often question, and conflict with, each other. Social historians have emphasised the need to place 'alienists'³ and the asylum in their social context. This enables changes in social structures and relationships to be determined and their influence on professional interests to be assessed. Psychiatrists, or amateur historians as they are sometimes

¹ A. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (London, 1979); D.J. Mellett, *The Prerogative of Asylumdom: Social, Cultural and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth Century Britain* (London, 1982); A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge, 1985); R. Porter, *Mind Forged Manacles: A History of Madness in England from the Restoration to the Regency* (Cambridge, 1987); J. Busfield, *Managing Madness: Changing Ideas and Practice* (1986); C. MacKenzie, *Psychiatry for the Rich. A History of Ticehurst Private Asylum, 1792-1917* (London, 1992); P. Bartlett and D. Wright (eds.), *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000* (London, 1999); J. Andrews and A. Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam & New York, 2004); L. Smith, *Lunatic Hospitals in Georgian England, 1750-1830* (London, 2007); R. Houston, *Madness and Society in Eighteenth Century Scotland* (Oxford, 2000).

² R. Hunter and I. Macalpine, *Three Hundred Years of Psychiatry; 1535-1860* (Oxford, 1963); R. Hunter and I. Macalpine, *Psychiatry for the Poor. 1851 Colney Hatch Asylum: Friern Hospital 1973* (London, 1974); G.E. Berrios and H. Freeman (eds.), *150 Years of Psychiatry, 1841-1991* (London, 1991); G.E. Berrios and H. Freeman (eds.), *150 Years of British Psychiatry, 1841-1991*, vol.II, *The Aftermath* (London, 1996); A. Walk, 'Some Aspects of the "Moral Treatment" of the Insane up to 1845', *Journal of Mental Science*, vol.C (1954), pp.807-838; T. Turner, '"Not worth powder and shot": The Public Profile of the Medico-Psychological Association, c.1851-1914', in G. Berrios and H. Freeman (eds.), *150 Years of British Psychiatry*, vol.I (London, 1991), pp.3-16.; T. Turner, 'A Diagnostic Analysis of the Case Books of Ticehurst House Asylum, 1845-1890', *Psychological Medicine Supplements*, no.21 (1992); J. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylums – St John's* (London, 1990); W. Parry-Jones, *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London, 1972).

³ Alienist was the nineteenth century term for psychiatrist. Medical men specialising in the treatment of mental illness preferred this title as it disassociated them from the negative connotations of the 'mad-doctor'. Throughout this study the term alienist will refer to the medical men who cared for and treated insane persons.

labelled, have tended to construct their work within a medical model that attempts to legitimise the activities of present day psychiatry. Psychiatric history written from this perspective is consequently dogged by questions of partiality and concerns that the narrative may be compromised and distorted. Despite these potential shortcomings, psychiatrists possess an important attribute that can strengthen their historical writing. The medical knowledge they hold means they tend to understand mental illness and its treatment in greater depth than social historians. John Crammer describes Andrew Scull's application of the terms madness, insanity and mental illness, in his sociological account of institutionalisation, as 'confused'. Scull's confusion about the difference between lay, legal and medical concepts is attributed to his 'little or no first-hand experience of people regarded as mad or insane, and how their behaviour impinges on others'.⁴

The assumption that psychiatrists were amateur historians was challenged by the ground breaking work of Richard Hunter and Ida Macalpine in the 1960s and 1970s. *Three Hundred Years of Psychiatry* and *Psychiatry for the Poor* broke decisively with the uncritical 'whig' accounts that had preceded them.⁵ The whiggish interpretation suggests psychiatric history was a story of morality in which reform was inevitably victorious. The history of psychiatry is presented as a march of progress from savagery and ignorance to institutional humanitarianism and medical science. It is

⁴ J.L. Crammer, 'English Asylums and English Doctors: where Scull is wrong', *History of Psychiatry*, vol.5 (1994), p104. Scull gave a response to Crammer's critique in which he agreed that he did not have direct experience with the mentally ill. However, he retorted that 'My qualifications on matters psychiatric are in this sense analogous to Dr Crammer's qualifications as a historian'. A. Scull, 'Psychiatrists and Historical 'facts''. Part Two: Re-Writing the History of Asylums', *History of Psychiatry*, vol.6 (1995), p.387.

⁵ The 'whig' interpretation presents the past as an inevitable progression towards greater liberty and enlightenment. It stresses the rise of constitutional government, personal freedoms and scientific progress. H. Butterfield, *The Whig Interpretation of History* (London, 1931).

argued that progress towards humane treatment resulted from 'the steady application of rational-scientific principles by people of good will'.⁶ 'Whig' interpretations aggrandise the contribution of nineteenth-century reformers, like John Conolly and Samuel Tuke, in order to denigrate much of what had gone before and contrast the dark days with the progress made since.

Hunter and Macalpine's work did not rely upon the established texts of major theorists. Instead, they delved into source material that had previously been overlooked or hardly used. Although their assessment of the development of psychiatry still retained elements of the 'whig' approach, their contribution to the advancement and re-shaping of psychiatry's historiography should not be doubted. Hunter and Macalpine's work strengthened the historical narrative of psychiatrists because their 'scholarship is fully contextualised, remarkably unjudgmental, and extraordinarily free of psychiatric triumphalism'.⁷ Despite the different perspectives held by psychiatrists and social historians, the work of both disciplines has cultivated a diverse and rich body of literature that has stimulated continued and extensive research on the subject of mental health provision.

Scull's *Museums of Madness*, published in 1979, challenged the traditional 'whiggish' interpretation of the rise and development of the asylum system and generated new debates among medical and social historians. The uncritical account of reform

⁶ A. Scull, 'Psychiatry and its historians', *History of Psychiatry*, vol.2 (1991), p.240.

⁷ R. Porter, 'Ida Macalpine and Richard Hunter: History between Psychoanalysis and Psychiatry', in R. Porter and M. Micale (eds.), *Discovering the History of Psychiatry* (Oxford, 1994), p.86.

offered by the 'whig' histories of Kathleen Jones and Hunter and Macalpine⁸ were displaced by a sociological paradigm that examined the impact of economics and a shifting social order. Jones' work is primarily concerned with lunacy reform on a parliamentary and legislative level. Her account is constrained by the exclusion of a sociological analysis of the rise of the public asylum. Jones does draw attention to the principal reformists of the period and their humanitarian motivations.⁹ Unfortunately, she does not take sufficient account of the cultural and economic forces that operated in society and facilitated an important change in what Scull terms 'a profound shift in the cultural understanding of madness'.¹⁰ The loosening of kinship ties, growing public tolerance and emerging professional interests are overlooked as catalysts for reform. Jones presents a narrative of humanitarianism that was stimulated and fuelled by revelations of abuse in the private and public asylums of the late eighteenth and early nineteenth centuries. She describes the 1845 Lunatics Act as 'the culmination of a slow process of social revolution', which infers that progress towards enlightenment was a straightforward task.¹¹

The emphasis Jones places on the inevitability of progress could compromise her work as it leads to the mistaken belief that the progressive sequence of events she charts becomes the sole line of causation for reform. Jones' work has obvious limitations, especially when compared to the later work of revisionist historians.

⁸ K. Jones, *A History of Mental Health Services* (London, 1972); R. Hunter and I. Macalpine, *Psychiatry for the Poor*.

⁹ Jones charts the work of (Benthamite) Sir George Onisephorus Paul and Lord Ashley. Both were concerned with pauper lunacy reform and were actively engaged in the select committee investigations that preceded respectively the passage of Wynn's Act (1808) and the Lunatics Act (1845).

¹⁰ A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (London, 1993), p.91.

¹¹ Jones, *A History of Mental Health Services*, p.149.

However, if her work is to be judged fairly it should be placed in historiographical context and understood within the tradition of the 'liberal fifties' and not the 'strident seventies'.¹² Importantly, Jones did at least open up the subject of the social and political history of provision for the insane. Her books, *Lunacy, Law and Conscience* and *Mental Health and Social Policy*¹³ were written in 1955 and 1960 respectively, which was a very different era for social history. Jones' adherence to the chronological approach of social history was reflective of the practices of the time. Social history was still dominated by the legacy of the Webbs¹⁴, whose approach to charting the progress of reform was not dissimilar to that of Jones. Radical historians, particularly Scull, criticise Jones but they do so from the sanctity of their own, distinctly different, historiographical context. As a sociologist who 'developed his trade' in the seventies, Scull writes in a different tradition and has been able to look 'over many of the same sources, but of course he has access to more up-to-date ones as well'.¹⁵

The simplistic view that reform was an inevitable consequence of growing humanitarianism, scientific advances and government inspection was in time disputed by radical and revisionist historians.¹⁶ Revisionist studies presented a more

¹² K. Jones, 'Scull's Dilemma', *British Journal of Psychiatry*, vol.141 (1982), p.221.

¹³ K. Jones, *Lunacy, Law and Conscience, 1744-1845: the Social History of the Care of the Insane* (London, 1955); K. Jones, *Mental Health and Social Policy 1845-1959* (London, 1960).

¹⁴ Beatrice and Sidney Webb were social reformers, founding members of the Fabian Society, prolific writers and founders of the London School of Economics. The Webbs wrote on trade unionism, labour history, local government and the poor law. S. Webb and B. Webb, *English Poor Law Policy* (London, 1910); S. Webb and B. Webb, *English Local Government*, vol.I-X (London, 1906-1929); S. Webb and B. Webb, *The Break-Up of the Poor Law: being part one of the Minority Report of the Poor Law Commission* (London, 1909).

¹⁵ Jones, 'Scull's dilemma', p.221.

¹⁶ Scull argues strongly against this traditional interpretation of reform, which in his opinion 'functions as an intellectual straitjacket'. A. Scull, 'Humanitarianism or Control? Some Observations on the Historiography of Anglo-American Psychiatry', in A. Scull (ed.), *Social Order/Mental Disorder. Anglo-American Psychiatry in Historical Perspective* (London, 1989), p.35.

nuanced portrait of the patient experience and the cultural and professional context of psychiatric treatment. Discourse began to focus on the societal forces that created changes in the intellectual and social structure of English society in the early nineteenth century. The context for reform was widened to include economic, political and social factors. Consequently, the emergence and growth of public asylums in the nineteenth century has been defined and discussed in relation to deviance, segregation, social control, and the rise of the medical profession. Revisionist studies have acknowledged that boundaries, definitions and meanings of madness are influenced by social structures and fluctuate over periods of time as social responses to the insane change. Social organisation of deviant groups and clearer distinction between the criminal, poor, socially disruptive and insane members of the community have become the focus, so that madness can be placed and understood within the social order of nineteenth-century society.

Steven Cherry, in his work on the Norfolk Lunatic Asylum, suggests the importance of context and locality for understanding changes in mental health provision. He acknowledges that 'Different perceptions of madness and of appropriate responses to it exist within any era and have altered radically over time'.¹⁷ Lunacy reform is considered a feature of broader humanitarian concern with prison conditions, hospital provision and society's handling of the poor. Reformist concerns were then increased by the 'rapidity of population growth and economic change associated with the growth of market production'.¹⁸ A revisionist examination of nineteenth-century lunacy provision has taken place in a re-defined paradigm that recognises responses

¹⁷ S. Cherry, *Mental Health Care in Modern England: the Norfolk Lunatic Asylum/St. Andrew's Hospital c. 1810-1998* (Suffolk, 2003), p.6.

¹⁸ Ibid., p.8.

to madness were culture bound and heavily influenced by social tolerance and values.

The edited volumes, *The Anatomy of Madness*, are constructed within this new paradigm.¹⁹ Its editors acknowledge that the history of psychiatry is being written with a commitment to viewing the asylum and society from below. Each article addresses not only the history of mental illness but also 'the story of power relationships – paternalistic, legal, institutional, therapeutic, commercial'.²⁰ Searching for deeper meanings and interpretations of madness, the volumes probe the distinctions between public and private asylums, eighteenth and nineteenth-century practice, and English and international experiences. By exploring key issues about insanity and asylum care, the volumes develop many of the problems and questions raised by 'anti-psychiatry' and revisionist histories.²¹ A more recent reappraisal of the social history of insanity has appeared in the edited volume, *Insanity, Institutions and Society*.²² The collection of essays endeavours to 'uncover the institutional politics of madness and the historical conditions under which asylums came to be defined as necessary to the welfare of the body politic itself'.²³ The authors reconstruct the context of the politics of insanity and the workings of individual institutions. They

¹⁹ W.F. Bynum, R. Porter and M. Shepherd (eds.), *The Anatomy of Madness. Essays in the History of Psychiatry*, vol.1-2 (London, 1985); vol.3 (London, 1988)

²⁰ Bynum, Porter and Shepherd (eds.), *The Anatomy of Madness*, vol.1, p.2.

²¹ The term 'anti-psychiatry' was first used by David Cooper in 1967. The anti-psychiatry movement challenged common practices and conventional theories of psychiatry. Its members questioned the concept of mental illness as a medical entity and the power wielded by the psychiatric profession over the mentally ill and society as a whole. Leading figures in the anti-psychiatry movement included David Cooper, R.D. Laing and Thomas Szasz. D. Cooper, *Psychiatry and Anti-Psychiatry* (London, 1967); R.D. Laing, *The Divided-Self; a Study of Sanity and Madness* (London, 1960); T. Szasz, *The Manufacture of Madness: a Comparative Study of the Inquisition and Mental Health Movement* (New York, 1970).

²² J. Melling and B. Forsythe (eds.), *Insanity, Institutions and Society, 1800-1914. A Social History of Madness in Comparative Perspective* (London, 1999).

²³ *Ibid.*, p.23.

explore the domestic household, economics and demographic factors alongside cultural and political references.²⁴ The essays in this collection continue to develop the historical construction of insanity and encourage empirically detailed historical research that investigates insanity and the asylum within the social and political landscape of the nineteenth century.

Methodological approaches and historical questions have also changed over the course of three generations of asylum and psychiatry histories. The three generations might be defined as 'whigs', 'radicals', and revisionists.²⁵ As already suggested, 'whig' histories were based on a narrow field of inquiry that produced accounts which served to legitimate the current activities of the profession. In Scull's opinion, these histories were 'a harmless form of antiquarianism but largely fail to satisfy the elementary canons of good historiography'.²⁶ The generation of radical histories was led by Foucault's seminal work *Madness and Civilization*,²⁷ which broke away from the narrowly circumscribed historical monograph. Foucault's 'anti-psychiatry' study marked a watershed in the historiography of psychiatry and

²⁴ Examples of this analysis are, L.D. Smith, 'The County Asylum in the Mixed Economy of Care, 1808-1845', pp.33-47; P.Bartlett, 'The Asylum and the Poor Law: the Productive Alliance', pp.48-67; J. Andrews, "Raising the tone of asylumdom": Maintaining and Expelling Pauper Lunatics at the Glasgow Royal Asylum in the Nineteenth Century', pp.200-222.

²⁵ Andrew Scull's work exemplifies the radical history of the 1970s. His account of the rise of the public asylum offers a more cynical view of incarceration, stressing the economic, social and political forces that influenced and facilitated the birth of the public asylum system. Scull also grounds his work within the context of the emerging psychiatric profession. Other radical historians include M. Foucault, *Madness and Civilization*; K. Doerner, *Madmen and the Bourgeoisie* (Oxford, 1981); D. Rothman, *The Discovery of the Asylum* (Boston, 1971); R. Castel, *The Regulation of Madness: Origins of Incarceration in France* (Oxford, 1988).

Revisionist historians continue to view the asylum within its broader social context. Building on Scull's work, they focus on institutional studies and draw extensively on archive material. Historians of this generation have also been influenced by the emergence of a new approach within the history of medicine, 'history from below'. Institutional studies and histories of the asylum have, more recently, attempted to incorporate the patient's world and the role played by patient families.

²⁶ A. Scull, 'Psychiatry and its Historians', *History of Psychiatry*, vol.2 (1991), p.239.

²⁷ M. Foucault, *Madness and Civilization. A History of Insanity in the Age of Reason* (London, 1971).

institutional care. His polemical stance against the Enlightenment stimulated a reappraisal of the asylum. Foucault's interpretation has been criticised extensively by revisionist historians, but the powerful influence it has over their accounts and that of future studies make it worthy of evaluation. Throughout his works Foucault is concerned with how power and knowledge interact to produce the human subject, or, the self. In *Madness and Civilization* he analyses the mechanisms by which madness was established as a distinct category of human behaviour, and the detention of insane persons in institutions was legitimised. By distinguishing and separating people on the basis of behavioural distinctions such as sane and insane, specific categories are constructed that provide human subjects with the identities through which they are recognised by themselves and others. Foucault's analysis demonstrates how power can operate to create human subjects and populations which are all in various ways categorised, disciplined and controlled.

Foucault's interpretation challenges the idea that madness and mental illness are natural categories. He suggests instead, that madness existed when various institutional, social and political forces intersected. This suggested that power and control dictated responses to madness in the Classical age.²⁸ Foucault is pre-occupied with how madness was set apart and feared as a new mode of unreason. This position rules out the possibility of any genuinely benevolent intervention on the part of government authorities and medical men. To perceive the growth of asylums as a technique of alienation completely unaffected by reform is to limit the history of psychiatry to a one dimensional narrative of the politics of power and the human

²⁸ Foucault classifies the Classical age as the period 1650-1800.

subject. The omissions made by Foucault receive considerable criticism from Scull. He stresses that Foucault's analysis 'failed to present either a systematic discussion of politics or a serious dissection of economic structures'.²⁹ His work also neglected to provide a coherent or persuasive account of how medical men secured professional control over the care of the insane.

Foucault's depiction of eighteenth-century confinement emphasises the use of moral responsibility as a psychological form of control. 'Moral managers', particularly Samuel Tuke, are portrayed in a negative light as the creators of a moral world that imprisoned the mad.³⁰ Foucault claims that the restrictions of physical restraint were replaced by the bonds of self-discipline. In his opinion, the responsibility of work possessed 'a constraining power superior to all forms of physical coercion'.³¹ Foucault concludes that 'in the asylum, work is deprived of any productive value; it is imposed as a moral rule...an engagement of responsibility'.³² By imposing his own schematic arguments, Foucault does not recognise that work often assisted the patient's rehabilitation, distracted the minds of lunatics, and fostered self-control, all of which were vital prerequisites for the patient's recovery. Foucault retains the assumption that in any period the treatment of madness is intended to contain and control patients by means of surveillance and judgement. He is resolute that 'No

²⁹ A. Scull, 'Reflections on the Historical Sociology of Psychiatry', in *Social Order/Mental Disorder*, p.19.

³⁰ The term 'moral manager' describes asylum medical superintendents who employed psychological and organisational techniques to manage patient behaviour and begin a process of rehabilitation. They focused on occupying patients' minds by means of exercise, occupation, recreation and religion.

³¹ Ibid.

³² Ibid.

medical advance, no humanitarian approach was responsible for the fact that the mad were gradually isolated'.³³

Foucault's description of a 'great confinement' that swept across Europe in the seventeenth and eighteenth centuries is treated sceptically by Roy Porter. Foucault's cavalier generalisation does not apply to the developments that took place in England during this period. The English experience of confinement was 'gradual, localized and piecemeal'.³⁴ The establishment of early madhouses and asylums was prompted by individual initiative and humanitarian impulse rather than central policy and absolutist rule. Porter concludes that the age of 'great confinement' in England was not the Georgian era but its successor'.³⁵

Radical histories continued to share Foucault's interest in a broader assessment of social responses to madness, although they did not engage so explicitly with the ideas of fear, power and unreason.³⁶ Scull's *Museums of Madness* sparked a reactionary response similar to that which greeted Foucault's work. His provocative account of the growth of public asylums and the political economy of madness re-directed the historiography of psychiatry. Drawing on a much wider base of empirical evidence, Scull favoured the study of institutions and social responses to madness rather than the orthodox longitudinal study of reform. Scull's work is deeply rooted in a sociological analysis of psychiatry in the nineteenth century that in many ways tries

³³ Foucault, *Madness and Civilization*, p.224.

³⁴ R. Porter, 'Foucault's Great Confinement', *History of the Human Sciences*, vol.3 (1990), pp.47-54, quote p.4.

³⁵ Porter, *Mind Forg'd Manacles*, p.8.

³⁶ Doerner, *Madmen and the Bourgeoisie*; Rothman, *The Discovery of the Asylum*; Castel, *The Regulation of Madness*.

to correct Foucault's imprecision.³⁷ He argues that the genesis and development of 'segregative techniques for handling the mad was neither fortuitous nor the product of the mere piling up of a series of incremental, *ad hoc* decisions'.³⁸ The reform process should instead be:

seen as intimately linked to a whole series of historically specific and closely interrelated changes in English society's political, economic, and social structure, and to the associated shifts in the intellectual and cultural horizons of the English bourgeoisie.³⁹

Scull argues that a mature capitalist economy heralded the growing commercialisation of existence and ultimately broke the social bonds that kept the structure of society in check. If family members were unable to contribute economically then they became a drain on the family's resources.⁴⁰ Economic and social changes enabled the asylum to absorb those who could not function effectively in the market economy. Scull's critical account of lunacy reform engages with the economics of madness, something which had previously been omitted or rejected. He instigated a re-examination of the social ideas of madness and the practices of the nineteenth-century asylum as they responded to changes in the meaning of madness and the interests of the emerging psychiatric profession.

³⁷ Scull, *Museums of Madness; Mad-Houses, Mad-Doctors and Madmen: A Social History of Psychiatry in the Victorian Era* (London, 1981).

³⁸ *Ibid.*, pp.42-43.

³⁹ *Ibid.*, p.43.

⁴⁰ Scull, *The Most Solitary of Afflictions*, pp29-36; Scull, *Social Order/Mental Disorder*, pp.216-218.

Detailed institutional studies, based on administrative and medical documentation, have become the favoured form of historical research among the generation of 'revisionist' historians that have followed Scull.⁴¹ Their work adopts an anti-establishment approach that accepts neither Scull's line of argument nor the 'whig' interpretation. The works of Andrews, Melling, Forsythe, Porter, Walton and Wright⁴² have broadened the scope of historical inquiry and placed greater emphasis on 'the experiences of the people whose lives intersected in the asylum world'⁴³ – patients, families, attendants, and medical men. Jonathan Andrews acknowledges that 'new emphases within social history on "history from below"' has prompted medical history to pay more attention to the patient's experience of illness.⁴⁴ Case notes and individual case histories are an extensive resource in the reconstruction of the patient experience. Medical historians utilise these sources extensively in their work as they

⁴¹S. Cherry, *Mental Healthcare in Modern England*; J. Crammer, *Asylum History: Buckinghamshire County*; C. MacKenzie, *Psychiatry for the Rich*; N. Tames, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping* (Cambridge, 1984); J. Melling & B. Forsythe, *The Politics of Madness. The state, insanity and society in England, 1845-1914* (London, 2006); A. Digby, *From York Lunatic Asylum to Bootham Park Hospital*, (York, 1986); P. Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000* (Cardiff, 2003); J. Walton, 'The Treatment of Pauper Lunatics in Victorian England: the Case of Lancaster Asylum, 1816-70, in A. Scull (ed.), *Madhouse, Mad-Doctors and Madmen*, pp.166-197; L. Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England*, (London, 1999).

⁴² J. Andrews, 'Case Notes, Care Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, vol. 11 (1998), pp.255-281; J. Melling and B. Forsythe, *The Politics of Madness*; R. Porter, 'The Patient's View: Doing History from Below', *Theory and Society*, vol.14 (1985), pp.175-198; D. Wright, *Mental Disability in Victorian England. The Earlswood Asylum, 1847-1901* (Oxford, 2001); J. Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-1870' in Bynum, Porter & Shepherd (eds.) *The Anatomy of Madness*, pp.132-146.

⁴³ Wright, *Mental Disability in Victorian England*, p.1.

⁴⁴ Andrews, 'Case Notes, Case Histories and Patient's Experience', p.255; Allan Beveridge, Louise Wannell, Catharine Colebourne and Leonard Smith have produced more recent work on patient experiences and correspondence with the asylum. A. Beveridge, 'Life in the Asylum: Patients' Letters from Morningside, 1873-1908', *History of Psychiatry*, vol.9 (1998), pp.431-469; C. Colebourne, 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880-1910', *Social History of Medicine*, vol.19 (2006), pp.426-442; L. Smith, "'Your Very Thankful Inmate': Discovering the Patients of an Early County Lunatic Asylum", *Social History of Medicine*, vol.21 (2008), pp.237-252; L. Wannell, 'Patients' Relatives and Psychiatric Disorders: Letter Writing in the York Retreat, 1875-1910', *Social History of Medicine*, vol.20 (2007), pp.297-313.

‘may provide the surest basis we have for understanding the changing nature of the experience of the insane in asylums since 1800’.⁴⁵

Recent historians of insanity and the asylum have become increasingly concerned with the interplay that existed between the agencies involved in the committal, treatment, and discharge of lunatics. What constitutes madness and the appropriate response to it fluctuates over time as the rules that bind society and determine ‘normal’ behaviour are affected by the cultural and intellectual context of any given period. The experiences of all persons involved in the process of institutionalisation need to be considered so that the social context and relations that influence the decision-making process can be understood. David Wright has adopted this approach in his work on nineteenth-century asylums, particularly his monograph on the Earlswood Asylum.⁴⁶ Wright’s work focuses on patterns of confinement so that the diversity of the insane population and the complexities of committal are understood as consequences of social interaction rather than the imposition of medical authority. John Walton’s study of admissions to the Lancaster Asylum follows a similar line of argument. Concentrating on family involvement in the committal process, he concludes that ‘the invocation of the asylum brought relief from impossible circumstances to many families’.⁴⁷

Walton and Wright’s detailed analysis of admission documents and case notes has encouraged historians to perceive and study the workings of the asylum as an on-going collaboration between families, medical men, patients and official authority.

⁴⁵ Andrews, ‘Case Notes, Case Histories and the Patient’s Experience’, p.255.

⁴⁶ Wright, *Mental Disability in Victorian England*.

⁴⁷ Walton, ‘Casting Out and Bringing Back’, p.141.

Akihito Suzuki applied this concept to his recent study of *Madness at Home*.⁴⁸ His research focuses on the relationship and interaction between the psychiatrist, patient and family during the early to mid-nineteenth century. He emphasises medical men's reliance on lay narratives when forming a diagnosis and making other medical decisions. On their own neither the family's account nor the psychiatrist's personal examination offered a solid, infallible, assessment. A relatively accurate and reliable diagnosis could however be made when lay and medical interpretations were brought together.

The administration of pauper lunacy also involved co-operation between asylum and Poor Law officials. In his study, *The Poor Law of Lunacy*, Peter Bartlett veers away from the traditional history of confinement set in the context of the rise of the medical profession and the power exerted by alienists. He convincingly argues that county asylums were poor law institutions that should be understood in the context of the nineteenth-century Poor Law. His analysis of the administrative structures involved in the construction and operation of county asylums shows that 'asylum doctors had little role in deciding how asylum construction would occur, and who would be placed in or removed from county asylums'.⁴⁹ Poor Law officials and Justices of the Peace were charged with making decisions about the construction of asylums and who was to be admitted and discharged. Under the 1834 Poor Law Amendment Act, Poor Law relieving officers were made responsible for organising the applications for admission to the local asylum.

⁴⁸ A. Suzuki, *Madness at Home. The Psychiatrist, The Patient, and the Family in England, 1820-1860* (Berkeley, 2006).

⁴⁹ P. Bartlett, *The Poor Law of Lunacy. The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London, 1999), p.2.

After 1853 Poor Law medical officers were given the authority to sign the statutory medical certificate required for the admission of pauper lunatics.⁵⁰ Bartlett contrasts this with the asylum medical superintendent who played no role in admission and patient certification. Despite being the medical professional and lunacy expert, he was exempt from signing medical certificates and admitted patients based on an outsider's authority. Justices of the Peace and Poor Law officials effectively controlled the admission process which, in Bartlett's opinion, made county asylums 'an institution legally based in the Poor Law'.⁵¹ Bartlett concludes that it 'was only with the introduction of...Poor Law relieving officers and medical officers...that the intensive administrative provisions of the Asylum Acts became remotely realisable, and the asylum system could flourish'.⁵²

The construction of madness is an amalgamation of social forces and medical opinion, but it is also affected by contemporary concepts of disruptive behaviour. Visible signs of insanity often manifested themselves in the form of disturbed, destructive, suicidal and violent behaviour. Evidence from admission documents has indicated that these behavioural traits acted as a trigger for admission.⁵³ Hilary Marland's examination of patient case notes at the Royal Edinburgh Asylum reveals that dangerous behaviour or infanticide were often recorded on admission

⁵⁰ Bartlett, 'The Asylum and the Poor Law: the Productive Alliance', p.51.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Wright, 'Getting Out of the Asylum', *Social History of Medicine* (1997), p.151; Walton, 'Casting Out and Bringing Back', p.140.

documents in cases of puerperal insanity.⁵⁴ Puerperal mania and melancholia prompted threatening or unpredictable behaviour that contravened social norms and, perhaps more shockingly, contemporary notions of domesticity and femininity. Suicidal patients flouted the rules governing life and self-preservation whilst women 'flouted the ideals of maternal conduct and feeling'.⁵⁵

Dangerousness dominated contemporary concerns about suicidal lunatics and it remains a prominent theme in historians' discussion of suicide and the asylum. Suicidal patients constituted a significant proportion of the annual admissions to public asylums.⁵⁶ They formed a distinct patient category that required treatment and management strategies that were capable of frustrating their suicidal propensity and alleviating their mental affliction. Yet despite being relatively large in number, the suicidal population of public asylums has received only nominal attention in the history of nineteenth-century psychiatry. Suicidal lunatics are commonly discussed in the context of admission, discharge, dangerousness and the use of restraint, but the attention they receive is relatively brief.⁵⁷ Institutional studies acknowledge the dangers of suicide and cite examples of suicidal behaviour, but this is usually as a constituent part of broader discussions on general patient management and

⁵⁴ H. Marland, *Dangerous Motherhood. Insanity and Childbirth in Victorian Britain* (Hampshire, 2004), p.4, 129-130.

⁵⁵ *Ibid.*, p.5.

⁵⁶ Shepherd and Wright's quantitative research on the patient population of Brookwood and Buckinghamshire Asylums revealed that suicidal admissions were considerable. In Buckinghamshire, 17 per cent of male first admissions and 22 per cent of female first admissions were labelled as suicidal. The rate at Brookwood was higher, approaching one-third of all patients. A. Shepherd and D. Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint', *Medical History*, vol.46 (2002), p.183.

⁵⁷ Melling and Forsythe, *The Politics of Madness*, pp.189-190; Smith, *Cure, Comfort and Safe Custody*, pp.97-99; MacKenzie, *Psychiatry for the Rich*, pp.179-180.

treatment.⁵⁸ By engaging with the issue of suicide, even in a moderate fashion, they raise important questions that have stimulated interest in the subject and require further investigation in a detailed study of suicide and the asylum.

Anne Shepherd and David Wright's article 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint' deals directly with the asylum's suicidal population. Their article is important and influential because it tackles the uncharted territory of attempted suicide in the asylum. They were aware that within the history of psychiatry there 'have been, as yet no histories specifically devoted to how asylums responded to suicidality'.⁵⁹ Shepherd and Wright's research began the process of redressing this omission and provided the impetus for the present study. Their article investigates the identification, incarceration and treatment of suicidal lunatics during a period of important transition in the treatment and management of the insane. As a counter balance to the use of coroners' reports by historians of suicide, Shepherd and Wright embark on a comparative study of the Buckinghamshire and Brookwood Asylums. They draw extensively on certificates of insanity, admission registers and patient casebooks to document the asylum's response to suicide. Their methodology demonstrates the value of analysing asylum documents for the purposes of quantitative and qualitative research in the history of suicide.

⁵⁸ Cherry, *Mental Healthcare in Modern England*, p.97; Mackenzie, *Psychiatry for the Rich*, pp.179-180; Digby, *Madness, Morality and Medicine*, pp.198-199; Smith, *Cure, Comfort and Safe Custody*, pp.97-98, 250-251.

⁵⁹ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p.179.

Shepherd and Wright's investigation focuses on a specific period of the nineteenth century, but they identify important patterns and reach conclusions that can be applied and tested in a broader investigation of suicide and the nineteenth-century asylum. Their examination of the committal process shows that attempted suicide and threats of suicide were common precursors in the identification and classification of insanity and often prompted the decision to seek confinement. Evidence from these records also suggests that 'families sought asylum control and participated in the confinement of household members'.⁶⁰ By outlining the context of committal for suicidal admissions, Shepherd and Wright emphasise the importance of pre-admission behaviour and the role of the family. Their research suggests that 'dangerousness' and 'risk' predominated and were common triggers for the admission of suicidal patients. This conclusion provides a starting point for the work of the study currently being undertaken. It directs attention to the question of lay involvement and social tolerance of dangerous behaviour.

The final section of Shepherd and Wright's article focuses on the surveillance of patients and identifies the 'culture of prevention' that 'revolved around the diligence of the asylum staff'.⁶¹ Although surveillance constituted the primary method of suicide prevention, it was frequently supplemented by other measures. The sedation of suicidal patients was one such alternative. The use of sedation at Buckinghamshire and Brookwood is attributed to a lack of human resources that stemmed from 'the burgeoning size of the inmate population and, thus, the patient to staff ratio'.⁶² This argument stimulates questions about the rising patient population and its impact on

⁶⁰ Ibid., p.185.

⁶¹ Ibid., p.192.

⁶² Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p.192.

the work of asylum attendants. Shepherd and Wright restrict most of their discussion of prevention techniques to surveillance and sedation. An examination of seclusion, restraint, moral and physical treatments is therefore covered within the remit of this study.

Histories of the asylum have drawn attention to suicide in the context of an institutional setting. However, it is in wider historical and sociological studies that suicide has been dealt with comprehensively as a cultural and social phenomenon. Olive Anderson's substantial contribution, *Suicide in Victorian and Edwardian England* can be seen as the first monographic, historical study of the subject in post nineteenth-century Britain. By Anderson's own admission 'very little sustained research has been done on the history of suicide apart from its role in literature and ethical debate'.⁶³ As an historical rather than sociological study, Anderson's work provides a new understanding of suicidal behaviour and nineteenth century social attitudes towards it. The book is divided into four sections: suicide rates and demographic distributions, individual case histories, cultural backgrounds and social attitudes, and efforts to prevent suicide. As an historian's book each part 'offers a historical dimension for one particular aspect of suicidology; yet each has its *raison d'être* in a distinctive set of historical issues, each is primarily based upon a particular sort of historical evidence'.⁶⁴

The first part of the book is concerned with suicide statistics and what they can reveal about the experience of suicide. Anderson acknowledges the faults implicit in official

⁶³ O. Anderson, *Suicide in Victorian and Edwardian England* (Oxford, 1987), p.1.

⁶⁴ Ibid.

statistics and recognises that to overcome or compensate for them, statistical evidence needs to be 'continually appraised in the light of as much contextual knowledge as possible and used with cautious discrimination'.⁶⁵ Statistics are only able to establish the bare bones about attempted or completed suicides. They allow historians or sociologists to determine and compare suicide rates for each gender and different age groups. They also reveal how commonly suicide occurred in a particular place and what method was used most frequently by different genders and age-groups. Anderson's study shows that there existed important age, gender, geographical, and occupational variations in the suicide rate and that these fluctuated over time. The general trend in Victorian and Edwardian England saw men become increasingly more prone to suicide than women.⁶⁶

To reconstruct the experience of suicide and social attitudes of the day Anderson makes considerable use of the case papers kept by coroners and their verbatim notes of evidence given at inquests. Coroner's reports and witness depositions are employed to 'illuminate the ways in which place and time, gender, age, and occupation affected individual experiences of suicide'.⁶⁷ Anderson argues that coroner's reports are 'more vivid than clinical case notes can ever be, and their purport can often be made clearer still with the aid of local press reports'.⁶⁸ In the context of Anderson's own work, this assertion may be true but the evidence that can be drawn from medical journals, treatises and asylum case records is of immense

⁶⁵ Ibid., p.3.

⁶⁶ Anderson does acknowledge that historical understanding only extends outwards when researchers look behind averages and generalizations. Although statistics show that men committed suicide more often than women 'the reality behind this generalization was divergent trends between men and women in certain age-groups and in certain sorts of places'. Ibid, p.418.

⁶⁷ Ibid., p.3.

⁶⁸ Ibid., p.108.

value to historians studying suicide in the asylum. To understand responses to suicide in the asylum and the experience of the patient, it is more appropriate to utilise medical case books, admission documents, and annual reports. These sources reveal how patients were treated, how suicide was prevented, the manner in which suicidal behaviour manifested itself, and the methods by which suicide was attempted.

In the fourth part of the book, Anderson discusses the role of medical men in preventing suicide and it is this section which is most pertinent to the interests of the present study. The efforts of general practitioners, medical officers of prisons and asylum doctors are considered. Anderson concludes that, of the three groups, it was asylum doctors who endured the heavy end of the task of suicide prevention.⁶⁹ According to Anderson, death rates for county and borough asylums reveal that 'only a dozen or so successful suicide attempts...were made within asylum walls' despite the fact that thousands of patients were admitted as suicidal.⁷⁰ The low figures that were recorded suggest that asylum staff made a significant and substantial contribution to the prevention of suicide. Despite this evidence, Anderson expresses signs of scepticism and questions whether this achievement was quite as impressive as asylum figures indicate. She adopts a critical approach and re-assesses just how formidable the task of suicide prevention was for asylum staff.⁷¹

⁶⁹ Ibid., p.402.

⁷⁰ Ibid., p.405. Anderson does not refer to a specific time period over which these figures were collated. It can only be assumed that she is discussing the entire Victorian and Edwardian period.

⁷¹ Ibid., p.408.

The first point of contention lies with admission and the labelling of patients as suicidal. Contemporary evidence leads Anderson to conclude that in many cases slight suicidal tendencies were sufficient for a person to be committed.⁷² This would mean that in reality fewer patients were actively and dangerously suicidal than admission records suggested. The success that asylums achieved also seems less impressive when the statistical profile of suicidal patients is considered. This was because the majority of suicidal patients admitted to asylums were suffering from melancholia. In Anderson's opinion this had substantial practical implications since melancholia was the most curable form of insanity.⁷³ However, Anderson claims it would be 'ungenerous to deny that the contribution to suicide prevention made by asylum staff was more tangible and direct' than that of prison medical officers or general practitioners.⁷⁴

Anderson's discussion of suicide prevention raises, and attempts to answer, important questions about the role of asylum staff. The conclusions that are reached depend to a great extent on statistical evidence and, although a quantitative study does not produce inaccurate findings, it may lead to a skewed interpretation. The present study is based more extensively on patient case books, which will provide a

⁷² Anderson draws on comments made by John Charles Bucknill and George Savage. In 1880, Bucknill commented that the 1845 Lunatics Act had been made to cover a motley crowd of people including 'persons said to have suicidal tendencies if they are not always under supervision'. Savage also questioned the accuracy of suicide rates. In 1884, he reported that during his twelve years as resident physician at Bethlem, although between 20 and 30 per cent were always classified as suicidal 'there is much more cry than wolf'. J.C. Bucknill, *The Care of the Insane and their Legal Control* (London, 1880), pp.3-4; G.H. Savage, *Insanity and Allied Neuroses: Practical and Clinical* (London, 1884), p.169.

⁷³ Anderson's argument that melancholia was most common amongst suicidal patients is based on evidence from returns published in the Lunacy Commissioners' annual reports. Statistics are taken from 1879 to 1888. Although Anderson states that 'one Victorian specialist after another pointed out' that melancholia was curable, she only references G. Fielding Blandford as supporting evidence.

⁷⁴ *Ibid.*, p.417.

qualitative counter-balance to Anderson's work. Medical documents provide textual evidence which can reveal more detailed information than figures and statistics. This evidence may help to confirm Anderson's conclusions about the genuine risk posed by those labelled suicidal and the prevalence of melancholia. Conversely, a close examination of asylum and patient documents might present an alternative interpretation that challenges or, at least questions, Anderson's argument.

Building on Anderson's work, Victor Bailey uses a case study of Kingston upon Hull to assess 'suicide across the life cycle'.⁷⁵ He adopts the framework of the "life cycle" to evaluate individual cases and determine the circumstances and causes of suicide. Bailey draws on evidence from 604 inquests held in Hull between 1837 and 1879. These documents are greater in number than those used by Anderson and allow him to get closer to the experience of suicide and its social construction. Bailey's framework is built around several pressure points in 'the life course transitions of the nineteenth century urban population'.⁷⁶ The pressure of working life was most influential between 15 and 24, whilst the pressures of the poverty cycle struck during the prime of life and de-skilling, illness and widowhood dominated in old age.

Bailey's survey reveals that physical and mental illness were most significant among male and female suicides between the ages 15 and 24. During the prime of life economic hardship and unemployment were the main factors that motivated men to commit suicide. Bailey concludes that suicide in the prime of life was, regardless of gender, caused by the things that mattered to people such as family and home. His

⁷⁵ V. Bailey, *"This Rash Act". Suicide Across the Life Cycle in the Victorian City* (Stanford, 1998).

⁷⁶ *Ibid.*, p.99.

study demonstrates that 'the barriers between public and private life were more permeable, the links between home and work more fluid' than previously conceived.⁷⁷ The importance of Bailey's work lies in his conclusion that men and women are equally susceptible to romantic disappointment, the loss of loved ones, economic hardship and the difficulties of working life. Both sexes experienced physical and mental illness that related in part to contemporary urban life and the different stages of the 'life course'.

Michael MacDonald and Terence Murphy made a significant contribution to the history of suicide with their in-depth study of self-destruction in the early modern period. *Sleepless Souls* provides a social and cultural history that analyses suicide at every stratum of society between 1500 and 1800.⁷⁸ They acknowledge that in Western culture suicide has been commonly viewed as 'the negation of the good death',⁷⁹. However, as socio-economic and cultural changes have taken place the circumstances of individual lives and the criteria that determine states of happiness and misery have been reshaped. MacDonald and Murphy's study is concerned with describing cultural and social changes and tracing their origins in the political events, religious shifts, social transformations, and intellectual developments that took place during the early modern period. This approach separates MacDonald and Murphy's work from other histories of suicide that trace its legal history or try to reconstruct suicide rates based on statistical analysis.⁸⁰

⁷⁷ Ibid., p.256.

⁷⁸ M. MacDonald and T. Murphy, *Sleepless Souls. Suicide in Early in Modern England* (Oxford, 1990).

⁷⁹ Ibid., p.2.

⁸⁰ See G. Seabourne and A. Seabourne, 'The Law of Suicide in Medieval England', *The Journal of Legal History*, vol.21 (2007), pp.21-48; S.J. Stevenson, 'The Rise of Suicide Verdicts in South-East England, 1530-1590: the Legal Process', *Continuity and Change*, vol.2 (1987), pp.37-75; C. Jennings

Constructing a social and cultural history of suicide enables MacDonald and Murphy to promote the idea that suicide is an individual act, but it is inevitably influenced and encouraged by external circumstances. Treating suicide as a social phenomenon means they have to engage with documents that reveal people's opinion of suicide and how they responded to death by suicide. This methodology runs counter to the Durkheimian fixation with suicide rates and statistics. MacDonald and Murphy reject the use of statistics in favour of a study that focuses on the social meaning of suicide, its production and how it changed. They are keen to demonstrate that severity towards suicide declined as secularization penetrated social attitudes in the late seventeenth and eighteenth centuries. Secularization is defined as 'the rejection of belief in the frequent and potent intervention of the supernatural world'.⁸¹ The rise of science and secular psychology provided alternative ways of understanding suicide. MacDonald and Murphy are not implying that religion became unimportant or that suicide was not considered a sin after 1700. Instead, they suggest that suicide lost its supernatural connotations as pressure from above and below encouraged the demystification of self-destruction.

Changes in the societal reaction to suicide were closely connected to coroners and their juries. According to MacDonald and Murphy, the decisions made by juries were influenced by the attitudes of the ruling classes 'as well as by the moral conservatism of local communities'.⁸² The rise of the *non compos mentis* verdict is considered to

and B. Barraclough, 'Legal and Administrative Influences on the English Suicide Rate Since 1900', *Psychological Medicine*, vol.10 (1980), pp.407-418.

⁸¹ Ibid., p.6.

⁸² Ibid., p.110.

be a strategy deployed by juries to avoid forfeiture for the family of suicides.⁸³ However, over time it came to embody the profound change that was taking place in beliefs about suicide. MacDonald and Murphy claim that 'it was the tangible expression of the secularization of suicide, of the opinion that self-destruction was in itself an act of insanity, an end more to be pitied than to be scorned'.⁸⁴ MacDonald and Murphy also argue that the process of secularization was assisted by the growth of the periodical press and the spread of literacy after 1700. Newspaper stories tended to steer clear of supernatural depictions and often adopted a sympathetic tone towards suicide. They persuaded the public to interpret suicide as a consequence of social, economic and psychological pressures rather than supernatural or demonic possession. The use of literary realism in newspaper reports meant readers could identify with the thoughts and actions of individuals they had never met. The public were able to evaluate the person's motive and decide for themselves whether they were worthy of pity or scorn.⁸⁵

MacDonald and Murphy's study is specific to the early modern period, but its findings are an important precursor to the history of suicide in the nineteenth century. To assess and understand nineteenth-century attitudes and responses to suicide it is necessary to consider the changes that occurred in previous centuries. The history of suicide in early modern England reveals how cultural and social changes shaped attitudes and responses to self-destruction. It demonstrates the influence of political events, religious reform, and the periodical press on cultural change. The work of MacDonald and Murphy directs historians of suicide towards a broader consideration

⁸³ Ibid., pp.110-114.

⁸⁴ Ibid., p.114.

⁸⁵ Ibid., p.335.

of their subject matter. It suggests that suicide should be understood in a socio-cultural and economic context. If beliefs and opinions are influenced by a wide range of factors, then a study of nineteenth-century suicide will need to consider how growing medical intervention, psychiatric diagnosis and the confinement of suicidal lunatics affected contemporary interpretations of suicide.

The history of suicide is a field of study in its own right that attracts scholars from across the academic disciplines; it is not exclusive to historians. Sociologists and those researching legal history have all engaged with some aspect of the history of suicide. Their work often contributes to ethical debates on the subject or tries to reconstruct suicide rates in relation to age, gender, class, and nationality. Statistical analysis enables the creation of indices of health in a specific country or society, but it does not shed light on attitudes and responses to suicide as they react to cultural and social changes. Statistical and sociological studies of suicide are not shaped by historical concerns. Emile Durkheim's seminal theoretical examination of suicide was first published in 1897.⁸⁶ His work is rooted in the concept of social facts and social currents which were external to, and coercive of, the individual. He argues that the causes of suicide were not individual because suicide was structural in origin. As well as an individual inclination, Durkheim asserts that each society has a collective inclination towards suicide. The individual inclination to suicide 'is explicable scientifically only by relation to the collective inclination, and this collective inclination is itself a determined reflection of the structure of the society in which the individual lies'.⁸⁷

⁸⁶ E. Durkheim, *Suicide. A Study in Sociology*, trans. J.A. Spalding and G. Simpson (London, 1970).

⁸⁷ *Ibid.*, p.16.

Durkheim begins his study by attempting to define suicides as a homogenous group that can be designated by a special term. He reaches a conclusive definition in which the term 'suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result'.⁸⁸ A suicide attempt retains the same definition, but does not achieve actual death. The causes of suicide are divided into two categories - extra-social and social causes. Durkheim classifies 'psychopathic states'⁸⁹, or insanity, as an extra-social cause. His discussion of 'psychopathic states' focuses on whether suicidal insanity existed. If manifestations of insanity were presumed to be present in every suicide, the problem of social factors would be solved because suicide would be a purely individual affliction. Durkheim is reluctant to accept alienists' claims that in most instances suicide was a consequence of insanity. He declares their conclusion as hasty because 'from the suicides they [alienists] have known, who were, of course insane, no conclusion can be drawn as to those not observed, who, moreover, are much more numerous'.⁹⁰ To achieve an accurate assessment, Durkheim advocates a methodical procedure of classification according to the essential characteristics of the suicides committed by the insane. Expressed more simply, Durkheim believed 'to learn whether suicide is an act peculiar to the insane one must fix the forms it assumes in mental alienation [insanity] and discover whether these are the only ones assumed by it'.⁹¹

⁸⁸ Ibid., p.44.

⁸⁹ In the context of Durkheim's work, psychopathic states is used to define mental alienation or non-normal psychological states.

⁹⁰ Ibid., p.62.

⁹¹ Ibid., p.63.

Durkheim chooses to classify maniacal suicide according to the presence of hallucinations or delirious conceptions. He characterises suicide as the patient's desire to escape an imaginary danger or feeling of dishonour, or as a response to orders from a mysterious 'order from on high'.⁹² By contrast, melancholy suicide is connected with a state of extreme depression and sadness. Ideas of suicide tend to be fixed and the patient shows determination in achieving their objective. Regardless of the mental affliction, Durkheim argues that all suicides committed by the insane are either devoid of any motive or result from purely imaginary motives. However, many deaths by suicide fall into neither category because the majority have motives not unfounded in reality. This leads Durkheim to conclude that not 'every suicide can therefore be considered insane, without doing violence to language'.⁹³ This is a valid conclusion which parallels the opinion expressed by a number of nineteenth-century alienists.⁹⁴

His argument that insane suicides are devoid of any motive does not resonate so convincingly. Determining an individual's precise motive for committing suicide is difficult to achieve because the thoughts and feelings of the person are usually internalised. Even when the person verbalises his or her wish to die he or she does not always refer directly to the reason (s) why they want to end their life. Although motives are hard to clarify, it is a little far-reaching for Durkheim to claim that all insane suicides are devoid of motive. Patient case notes, particularly details of their

⁹² Ibid.

⁹³ Ibid., p.66.

⁹⁴ W. Wynn Westcott, *A Social Science Treatise* p.141; George Man Burrows, *Commentaries on the Causes, Forms, Symptoms, and Treatments of Insanity* (London, 1828), p.413; J.C. Bucknill and D.H. Tuke, *A Manual of Psychological Medicine* (Philadelphia, 1858), p.201; J.N. Radcliffe, 'The English Suicide – Fields, and the Restraint of Suicide', *Medical Critic & Psychological Journal*, Vol. II (1862), p.708.

background, give inferences about the causes of the patient's suicidal tendency. Economic hardship, shame, guilt, despair, bereavement and disappointment are frequently cited reasons for a patient's propensity to suicide. These may be contributory causes rather than the direct motive but, nonetheless, they provide some indication of the circumstances and feelings that prompted a person to self-destruction.

Durkheim's work relies on statistics to promote a sociological interpretation of suicide that emphasised social rather than psychological factors. Its publication at the close of the nineteenth century stimulated a debate about the validity of statistical methods as opposed to detailed case studies. Maurice Halbwachs' book, *The Causes of Suicide*, attempts to resolve the acrimony between the 'sociological thesis' and the 'psychiatric thesis'.⁹⁵ Halbwachs argues that it is a mistake to 'maintain a clear-cut separation between social and psychological causes...It seems likely that mental disorders are themselves in substantial part the product of social influences'.⁹⁶ Halbwachs considers suicide to be an intentional or motivated act. He also argues that assumptions about suicide and its relationship with insanity would be unnecessary if two distinct categories of suicide could be established. The first would be explained by social conditions and the second by mental illness. Unfortunately, Halbwachs concludes that these two categories cannot be established because of the conflicting interests and arguments held by psychiatrists and sociologists.

⁹⁵ M. Halbwachs, *The Causes of Suicide* (1930; London, English translation published 1978).

⁹⁶ *Ibid.*, preface xix-xx.

Psychiatrists are criticised by Halbwachs for their inability to decide which social factors do or do not influence their patients. Observation of insane suicides skewed psychiatrists' opinions and led them to conclude that social influences had no effect at all. Although social influences may be 'weak and barely perceptible', in Halbwachs opinion, that 'does not prevent them from playing a decisive role'.⁹⁷ Suicide statistics that distinguish age, gender, religion and marital status allow sociologists to measure the influence of social factors on the insane. Reaching the same overall conclusion as Durkheim, Halbwachs argues that suicide is caused by a fusion of internal emotion and external influences. When an individual commits suicide, according to Halbwachs, he experiences the feeling of being carried along in a 'current of thought in which he is no longer capable of distinguishing what comes from himself and what from elsewhere'.⁹⁸

The history of asylums and the history of suicide exist for the most part as separate fields of enquiry. The two territories occasionally overlap as suicide and insanity have a natural association, but there has not previously been a study that concentrates specifically on the links between suicide, lunacy and the asylum in nineteenth-century England. Suicidal lunatics are not missing from the history of lunacy provision, but in previous studies they have not been given centre stage. Historians are not the only academics to have paid limited attention to the suicidal lunatic. Sociologists commonly choose to explore suicide as a cultural and social phenomenon that is affected by changes in the structure of society. The contributions made by historians and sociologists to the history of suicide have nonetheless opened the door for

⁹⁷ Ibid., p.283.

⁹⁸ Ibid., p.304.

further, more detailed, research on suicide in an institutional setting. Previous studies provide a reference point and assist in the contextualisation of suicide in nineteenth-century society. Their strengths have helped in the development of this study, which focuses on institutional provision for the suicidal insane in the nineteenth-century, public asylum system.

In this study, suicide and lunacy are framed within an institutional setting, but the asylum neither defined nor determined the relationship that existed between the two. Secular concepts had begun to penetrate social attitudes from the second half of the eighteenth century, whilst medical explanations increasingly pointed to individual pathology as the root cause of suicide. Insanity and suicide were often seen as bi-products of modernity, poverty, and the stresses of industrial society. However, medical men were keen to dispel these perceptions by defining self-destruction in medical and psychological terms. Nineteenth-century alienists contested and debated how far insanity was responsible for suicide. Their opinions were informed by observations in the asylum and the medical knowledge they had acquired outside the confines of the institution. This is borne out in chapter one, where suicidal behaviour is discussed in relation to the main diagnostic categories of the period. The general characteristics of insanity in its common forms, and the manner in which suicide manifested itself alongside mental illness, require examination so that the relationship between the two 'abnormal' states can be understood. This discussion will reveal a good deal about how alienists interpreted suicidal behaviour and how their understanding informed and shaped the asylum's response to the risk of suicide.

In light of recent scholarship and current debates on the history of insanity, the present study will consider the admission, discharge, treatment and management of suicidal lunatics over the course of the nineteenth century. Changes in practice will be assessed in the context of the changing nature of the asylum, the transition from 'mad-doctors' to psychiatrists, and the secularisation of suicide. Scull has argued that the rise of the asylum was intrinsically connected to the professional advancement of psychiatry and bourgeois pretensions of social control.⁹⁹ Whilst this argument has merit, it fails to give sufficient acknowledgement to the influence that was exerted by the various agencies who participated in lunacy provision. In their recent work, Melling and Forsythe criticise Scull for overstating the extent to which the asylum represented modern bourgeois values. In contrast, they construe the asylum as a 'locus for social conflict'.¹⁰⁰ This argument will be developed for the committal and treatment of suicidal lunatics. The input of each agency either contributed to the identification of suicide, the formulation of prevention techniques or the monitoring of patient welfare. It will be contended that the asylum's function as a protective environment for suicidal lunatics was not solely determined by medical men.

The reasons underlying the rise in the number of insane persons committed to public asylums during the nineteenth century have been the subject of considerable debate in the history of psychiatry. Historians share divided opinions as to why this increase

⁹⁹ Scull, *The Most Solitary of Afflictions*, pp.41-42; A. Scull, C. MacKenzie and N. Hervey, *Masters of Bedlam. The Transformation of the Mad-Doctoring Trade* (Princeton, 1996).

¹⁰⁰ Melling and Forsythe, *The Politics of Madness*, p.6.

occurred.¹⁰¹ Aside from questions of causation, there has been considerable discussion about the impact rising patient numbers had on institutional care. The rapid growth of the patient population marked a notable transition away from curative care. The sheer growth of numbers, when combined with the increased number and size of asylum buildings and facilities, and the rise in staffing levels, magnified the organisational problems and management issues that naturally occur in the running of an institution. The therapeutic optimism that surrounded the asylum in its early years slowly ebbed away as medical superintendents accepted the reality of asylum management and resigned themselves to the task of custodial containment. Large scale institutions required greater classification, discipline and routine to deal with large numbers of disturbed and insane people.

The changing nature of the asylum also had implications for the conduct of treatment methods. Remedial benefits were at odds with medical superintendents' growing need for patient control and efficient management. Balancing curative treatment with security was on-going in the asylum, even before the expansion of institutions. The asylum had to operate with restorative and custodial intent so that problematic patients could be managed effectively. Custody was an implicit part of patient management and the organisational running of the asylum. The growth in patient numbers and expansion of asylum buildings that occurred from the mid-nineteenth century prompted a shift in the balance between custody and therapy. The asylum's custodial intent became more explicit as structural changes forced a reversal of priorities. Walton's work on the Lancaster Asylum demonstrates how practical

¹⁰¹ E. Hare, 'Was Insanity on the Increase?', *British Journal of Psychiatry*, no.142 (1983), pp.439-435; A. Scull, 'Was Insanity on the Increase? A Response to Edward Hare', *British Journal of Psychiatry*, no.144 (1984), pp.432-436.

problems inevitably undermined the institution's initial therapeutic principle. Similarly, Joan Busfield argues that the custodial nature of the asylum changed over time. In early asylums the custodial element of confinement was achieved by 'controlled and ordered conduct' of individual behaviour. However, institutions were gradually pushed towards a system that 'achieved control by regimentation and routine and the creation of passivity and dependence'.¹⁰² This study will contribute to that discussion by addressing the question, was control or therapeutic intervention the underlying rationale for the treatment and management techniques that were applied to suicidal lunatics? It will be argued that the transformation of asylum conditions placed inevitable constraints on the effectiveness of treatment methods.

Protection and prevention were the main objectives in the management of suicidal behaviour. The rigid enforcement of prevention strategies was a central theme in contemporary writing and the practical day-to-day running of the asylum.¹⁰³ Suicide prevention also assumes a central position in this study. Preventive action commenced when the decision was taken to commit a person deemed insane and unmanageable. Prevention and protection then permeated all aspects of institutional life. It influenced the organisation and workings of the institution, the conduct of treatment methods and formed an intrinsic part of the attendant's duties. The

¹⁰² Busfield, *Managing Madness*, p.260.

¹⁰³ Conolly, *Treatment of the Insane*, p.198; G.H. Savage, 'Constant Watching of Suicidal Cases', *Journal of Mental Science*, vol.30 (1884) pp.17-19; Wynn Westcott, *Suicide: Its History, Literature*, p.170.

asylum's regulating body, the Lunacy Commission, shared this pre-occupation with patient safety and security.¹⁰⁴

Original evidence drawn from five asylum case studies and contemporary publications underpins the discussion that unfolds in the following chapters. Patient case books, asylum annual reports, and admission documents have been consulted for the asylums of Birmingham, Leicestershire, Rainhill,¹⁰⁵ Warwickshire, and Worcestershire.¹⁰⁶ These five institutions constitute the main source of primary material for this study. However, for the purposes of comparative analysis additional material has been sourced from Gloucestershire, Lancashire,¹⁰⁷ Nottinghamshire, Shropshire and Staffordshire asylums.¹⁰⁸ The chosen case studies provide a rural-urban cross section that will allow for a comparative analysis of the commonalities and differences that existed between asylums' handling of suicidal patients. Each asylum was selected as a case study because of the quantity and quality of the records that are available. To reconstruct a particular situation or phenomenon as it occurred over a period of time requires continuity in the records that are consulted. A chronological run of administrative and patient documents was available for each of

¹⁰⁴ The Commissioners in Lunacy devoted a significant proportion of their time to matters concerning suicidal patients and the prevention of self-destruction. The Commission's role as an inspectorate is the subject of Chapter Six.

¹⁰⁵ Rainhill opened in January 1851 and was the second Lancashire County Asylum.

¹⁰⁶ Records were consulted from the year each institution opened until 1880. Leicestershire County asylum opened in July 1837, but patient case books were only available from January 1845. Worcestershire County asylum opened in August 1852, but patient case books are only held from 1858.

¹⁰⁷ Material for Lancashire refers to the records of the Lancaster Asylum that opened in July 1816.

¹⁰⁸ Patient case books and annual reports were consulted for each asylum. Records for the Lancashire, Gloucestershire and Nottinghamshire asylums were utilised because each institution opened before the 1845 Lunatics Act. Evidence from pre-1845 asylums will provide an insight into practices before the implementation of non-restraint and before overcrowding became a major problem. Contemporary treatise, articles and pamphlets published throughout the nineteenth century have also been consulted to supplement evidence found in case notes.

the asylums except Birmingham.¹⁰⁹ The completeness with which these records have survived enables practices in individual asylums to be documented and compared with developments on a national level.

The content of patient case books allows an understanding to develop of the treatment methods and prevention strategies that were prescribed for suicidal patients. Changing attitudes towards treatment methods and asylum practices are evident in the case notes recorded by medical superintendents. In most instances, case note entries are characterised by brief and periodic summaries of the patient's progress. The details recorded were subject to dilution and filtering by the medical superintendent, whose observations and viewpoint were being articulated. Although the detail of case notes varied between institutions, the completeness of the records for each case study still permits some reconstruction of the experience of patients and asylum staff. It is possible to delineate a relatively accurate picture of the asylum environment, its available resources and its response to the threat of suicide. The evidence drawn from case notes is valuable as a single documentary account of the patient's asylum stay. However, when it is supplemented by evidence from annual reports, admission documents and Lunacy Commission records it is possible to build a much clearer and more rounded impression of the asylum's function and day-to-day workings. Studying suicidal patients in an institutional setting is an attempt to make sense of, and interpret, the phenomena of insanity and self-destruction as they co-existed within the changing landscape of the nineteenth-century public asylum.

¹⁰⁹ Patient case books have survived for Birmingham Borough Asylum from 1855-1882, but, unfortunately, the male case book for 1873-1880 has suffered significant damage and cannot be viewed by the public.

The use of case studies as a form of qualitative research will provide sufficient detail for the reader to grasp the idiosyncrasies of suicidal behaviour and patient management in the asylum. Qualitative research has been the favoured approach in this study because it uses focused data samples that offer a unique perspective of a specific situation and certain category of people. The richness and depth that can be ascertained from textual sources allows the human experience to be understood, as well as the how and why of decision making. Patient cases are chosen based on the way they typify certain characteristics, in this instance insanity and suicidal behaviour. The evidence gained is concerned with the opinions, experiences, feelings and responses of those involved in lunacy provision, both lay and medical, patient and doctor. Case notes were of course written for medical staff, not for historians and the purposes of academic research. Their value as an historical source must therefore take account of the deficiencies they contain. The information recorded by the medical superintendent is variable from asylum to asylum because each individual determined what and how much detail to write. Practical issues such as deciphering handwriting and contemporary medical terms can also complicate or impede historian's use of case notes. This may slow down the research process, but more importantly it can lead to omissions in the information that is transcribed from original material. When historians decide to use case notes or medical records it is essential that they comprehend 'how they were generated and kept, how and why their format changed over time, and what functions they served'.¹¹⁰

¹¹⁰ Andrews, 'Case Notes, Case Histories, and the Patient's Experience', p.280.

Using people's accounts as the primary data source facilitates a naturalistic, interpretative approach of suicide and lunacy in the contextual setting of the asylum. However, statistical data collection is appropriate when admission and discharge patterns are being determined. Numbers, not words, allow suicidal admissions, forms of insanity and recovery rates to be quantified. These measurements supplement written evidence from admission and discharge documents with hard data that produces outcomes rather than subjective meanings. The validity of statistical material is largely dependent on the accuracy with which the original figures were generated and recorded. The construction of statistics raises several problems around the issue of data selection and sampling. Historians should consider precisely how the figures were collated and by whom, as issues of competency could affect the reliability of the data. The form in which the statistics were originally gathered also needs to be examined so that it can be established by what means the information was ascertained. The circumstances under which the statistics were compiled and tabulated require careful scrutiny by the historian to minimise any discrepancies that could undermine the accuracy of the data.

The first chapter of this thesis examines nineteenth-century theories and explanations of the relationship between insanity and suicide. By the close of the eighteenth century suicide was less of a religious pre-occupation and was viewed with increasing sympathy by a more secular society. However, a medical rationale was required to explain the cause of suicide in the absence of religious or supernatural explanations. The first part of chapter one focuses on the question, were all persons who committed suicide insane? Particular attention is paid to

developments in psychiatric understanding and the effect this had on the conceptual definitions of suicide and insanity. The chapter also outlines the general characteristics of contemporary diagnostic categories, together with a closer inspection of how suicidal behaviour manifested itself alongside each condition.¹¹¹. The chapter concludes by examining the favoured means of suicide employed by lunatics. It considers the extent to which the chosen method was influenced by the patient's mental affliction and the availability of potential weapons.

Chapter two explores the evolution of psychiatry during the nineteenth century and its eventual emergence as an organised profession. It begins by locating psychiatry within the broader context of nineteenth-century professionalisation. The main section of the chapter examines alienists' endeavours to elevate their status by means of education, practical experience and the creation of a professional identity. The development of knowledge, the cultivation of a medical model and the adoption of a physiological approach to insanity are also examined with the purpose of identifying whether they produced any notable changes in attitude and practice. The profession's attitude towards risk and suicide are described in the final part of the chapter. This discussion demonstrates that suicide prevention was a marketable skill that alienists purposely emphasised to enhance claims of expertise in the care of the insane. It also draws out their growing preoccupation with defining suicide as a derivative of cerebral disease, thereby strengthening their alliance with medical science.

¹¹¹ The diagnostic categories discussed are mania, melancholia, puerperal insanity, dementia and monomania.

The context of suicide management is considered in chapter three. Discussion focuses on the admission and discharge of suicidal lunatics. It explores the significance of dangerousness and risk in the decision to commit and discharge suicidal patients. Each decision was influenced by asylum authorities and families. The co-dependent relationship that formed between the two agencies is considered in the context of admission, recovery and discharge. Considerable emphasis is placed on the communication and exchange of information that occurred within this relationship. Attention is also paid to the behaviour that precipitated the committal of suicidal lunatics. Attempted suicide or threats of self-destruction are identified as direct triggers for admission to the asylum. The criteria for recovery and readiness for discharge is examined with a similar consideration of patient behaviour and an assessment of risk. This discussion considers the tests of fitness used to determine the patient's suitability for discharge. The decision to discharge patients was also based on the presence of adequate external support that was to be provided by family and friends. The negotiation and reassurances that preceded the patient's release into lay care is explored and reveals the apprehension and anxiety felt by asylum authorities and families.

Chapter four assesses the management of suicide in the asylum. It looks at the manner in which broadly accepted management techniques (constant watching, mechanical restraint and seclusion) were adopted and applied to suicidal patients. The chapter first focuses on the creation of a safe and secure therapeutic environment. Discussion focuses on the concept of treatment through environment, particularly the use of interior space to assert order and control over the patient's

mind and behaviour. It is suggested that asylum architecture supported the curative ethos of moral treatment and became a useful adjunct to the vigilance of attendants. The second part of the chapter tries to determine the meaning of 'management' when applied to suicidal lunatics and the extent to which protection, not control, was the main motivation for the use of surveillance, restraint and seclusion. How far patient welfare dominated the decision to restrain or seclude a suicidal patient is examined, with the intention of demonstrating that control was a subordinate concern. Throughout the chapter, consideration is given to the role asylum attendants played in the implementation of management techniques. Discipline and vigilance were essential skills for attendants but these were often undermined and threatened by inadequate training and staff numbers.

Chapter five focuses on the struggle between control and therapy. It considers the question, was control or therapeutic intervention the underlying intention of moral treatment, non-restraint and chemical restraint? The chapter explores the intended benefits and eventual conduct of each treatment, focusing on the implications for institutional organisation, asylum staff, and most importantly the care of suicidal patients. The chapter also considers how the transition from cure to custody placed constraints on the effectiveness of each treatment method. It is argued that the ascendancy of moral treatment gave suicidal patients an opportunity to re-assert control over their own behaviour. The non-restraint system placed a new found emphasis on the adoption of alternative, more proactive, methods of patient management. The move towards a comprehensive scheme of awareness, foresight and direct attendant involvement is examined and reveals a greater reliance on strict

surveillance and the removal of potential weapons. The discussion of chemical restraint focuses on whether drug treatment flourished as a means of re-asserting control and prevention over the suicidal, or rather was based upon a genuine rationale to provide medicinal and therapeutic benefit. To answer this question, contemporary opinion and knowledge on the medicinal value of drugs is examined. It is concluded that the justification of curative treatment was often a misleading, if plausible, argument as medicinal or therapeutic benefit remained secondary to institutional needs.

Chapter six is concerned with the asylums' regulating body, the Lunacy Commission and their attempts to monitor and raise standards in the area of suicide prevention. It looks at how the Commission utilised its powers of inspection and regulation to improve the standard of care for suicidal patients. An assessment of the Commission's work is intended to judge whether standards were significantly improved and if so, whether it was the result of a pragmatic or systematic approach to suicide prevention. It will be suggested that the Commission's innovation and strength as an authoritative organisation was curtailed by its lack of formal power. The chapter also examines the investigation process that followed all completed suicides. It outlines the formal procedure and documentation that asylums were required to submit for the Commission's perusal. Completed suicides in private asylums appear frequently in the Commissioner's minute book which, for comparative purposes, prompts a brief examination of the Commission's attitude and response to suicide prevention in private asylums. This section assesses whether a

different institutional environment created differences in practice and a change in the Commission's monitoring of suicide.

The intention of this thesis is to construct a history of the asylum's response to suicide and rectify the omission identified by Shepherd and Wright. The purpose of the following chapters is to investigate the identification, committal, treatment and discharge of suicidal lunatics in the nineteenth-century public asylum system. Major objectives for the study are to locate the act of suicide and suicidal behaviour within the context of the asylum and uncover the experiences of patients, their families and asylum staff. Exploring suicidal behaviour and its treatment and prevention, largely through case histories, reveals a great deal about the asylum's handling of patients and the relationships that existed between lunatics and attendants. This study continues the current trend for writing the history of madness as a social history that acknowledges the politics of insanity. Suicide is framed within the micro-politics of insanity and the asylum. There is a distinct appreciation of the broader social and political context in which the asylum operated and how this affected treatment practices, particularly suicide prevention and management. This provides an opportunity to explore nineteenth-century tolerance and understanding of insanity and suicide. Explorations of lay and medical interpretations provide indicators of how disturbed, dangerous and abnormal behaviour were viewed by Victorian society and the medical profession.

Dangerousness and risk appear as a constant theme throughout each of the chapters. The basic premise of this thesis is that suicidal behaviour, because of the

danger associated with it, triggered admission to the asylum and, once admitted, dangerousness and risk continued to dictate the asylum's handling of suicidal patients. Discussions of asylum care and treatment usually focus on the struggle and tension between custody and cure, but the management of suicidal patients was concerned with maintaining a different balance. Rather than cure and custody, it was protection and prevention versus control that dominated the asylum's treatment of suicidal lunatics. This study investigates suicide, lunacy and the asylum with an overt consideration of how asylum authorities and staff tried to maintain the correct balance. It intends to determine in which direction the balance swung and the implications this had for the prevention of suicide, patient recovery and the work of asylum attendants.

1

SUICIDAL BEHAVIOUR

In recent times, accompanying periods of decline of religious fervour, new symptoms of mental and moral philosophy have sprung up and become popular; and these, if not openly advocating the cause and permissibility of self-murder, have never associated themselves with Christianity in condemning it.¹¹²

By the second half of the eighteenth century, enlightened laymen and philosophers had cultivated a greater leniency and tolerance towards the act of suicide.¹¹³ The development of secular moral philosophy and the growing prestige of science helped to cultivate liberal attitudes among the intellectual elite and lay society. Philosophers argued in defence of the right to kill oneself whilst medical and scientific commentators blamed mental illness. The rational arguments proposed by eighteenth-century intellectual movements stimulated discussions about the legitimacy of suicide. In a bid to evoke sympathy and understanding, the public were encouraged to consider the causal events that motivated a person to commit suicide. The secularisation of social attitudes transformed the depiction of suicide from an evil and ungodly act, worthy of punishment, to one of heroism and tragedy.¹¹⁴

A more forgiving social attitude did not emerge in isolation, but rather in conjunction with an early foray into medical explanations. Enlightened laymen were increasingly

¹¹² Westcott, *Suicide its History*, p.3.

¹¹³ M. MacDonald, 'Suicidal Behaviour: social section', in R. Porter and G.E. Berrios (eds.) *A History of Clinical Psychiatry* (London, 1995), pp.627-628.

¹¹⁴ *Ibid.*, p.628.

of the opinion that 'suicide was the consequence of individual pathology'.¹¹⁵ By the end of the eighteenth century, suicide was relatively free from religious condemnation, but the act's shock value had not diminished. In consequence, 'psychiatry was invited to take charge of it [suicide], since society still regarded it as a threat to the established order'.¹¹⁶ Early nineteenth-century views represented an obvious continuation and development of the secular concepts created during the Enlightenment period. They did not represent a radical rupture from the religious and moral paradigm that had dictated social attitudes in the previous centuries. The act of self-destruction was separated from religion and recast as one of the many social problems that plagued nineteenth-century society. However, the stresses of contemporary urban life could not suffice as the sole explanation for the causation of suicide; the connection between modernity and suicide required medical credibility. The emerging psychiatric profession emphasised that suicide was caused by various states of mental disorder. In alienists' hands suicide was legitimized by a scientific vocabulary and medical theory that made suicide more palatable to society.

This chapter examines nineteenth-century psychiatric theories and explanations of the relationship between insanity and suicide. The first part focuses on the question, were all persons who committed suicide insane? This question stimulated extensive debate throughout the nineteenth century and divided alienists into two opposing sides. Each group tried to determine how far insanity was responsible for suicide. Particular attention is paid to developments in psychiatric understanding and the effect this had on the conceptual definitions of suicide and insanity. The chapter also

¹¹⁵ Ibid., p. 628.

¹¹⁶ G. Lanteri-Laura and L. Del Psitoia, 'Structural analysis of suicidal behaviour', *Social Research*, vol.37 (1970), pp.324-325.

outlines the general symptoms, behaviours and manifestations of contemporary diagnoses of melancholia, mania, puerperal insanity, dementia and monomania. The suicide risk associated with each condition is assessed in a bid to determine which patient category posed the greatest danger and demanded the most attention from asylum staff. The chapter concludes by examining the favoured means of suicide employed by lunatics. Discussion focuses on the importance of accessibility and environment. The intention is to identify whether there was a direct correlation between environment and the methods of suicide favoured by individuals.

The connection made between insanity and suicide raised a question that dominated medical debate and divided the opinion of alienists throughout the nineteenth century: 'How far insanity is responsible for the suicide which occurs among a people is, and must ever remain, a vexed question'.¹¹⁷ Alienists grappled with this question and provided a variety of opinions but, according to Strahan, professional consensus was hindered by two apparently insurmountable difficulties: 'The first of these is the difficulty of getting hold of any satisfactory definition of insanity, and the second, the impossibility in most cases of discovering the mental condition of the suicide immediately before his last act'.¹¹⁸ The struggle to establish a recognised and accepted definitional baseline was further complicated (during the nineteenth century) by the emergence of new concepts that pushed the debate in a multitude of directions. G.E. Berrios argues that the concept of partial insanities, such as Esquirol's monomania, offered a new way of explaining suicide and its relationship with insanity; no longer was a loss of all reason and rationality necessary to denote

¹¹⁷ S.A.K Strahan, *Suicide and Insanity. A Psychological and Sociological Study* (London, 1893), p.92. Strahan was a barrister-at-law and a member of the Medico-Psychological Association.

¹¹⁸ Ibid.

madness.¹¹⁹ Changes in psychological theory paved the way for a consideration of non-intellectual insanities that derived from the emotions and volition.

Professional division focused on the responsibility that insanity held for the commission of a suicidal desire. 'Some thinking that all who commit suicide are insane, others that delusion must be ascertained before we can pronounce any suicidal patient to be found of unsound mind'.¹²⁰ These opinions became representative of the two leading, contemporary schools of thought and have subsequently been classified by Berrios as the 'standard view' and the 'psychiatric view'. Prominent supporters of the 'standard view' included George Fielding Blandford, John Bucknill, Daniel Hack Tuke and William Wynn Westcott.¹²¹ The 'psychiatric view' was led by Forbes Winslow and enjoyed only marginal support among the profession.

The 'standard view'

French alienist Jean Etienne Esquirol believed that the origin of mental illness lay in the passions of the soul.¹²² He was convinced that madness did not fully and irremediably affect a patient's reason. The passions were considered as causes,

¹¹⁹ G.E. Berrios, *The History of Mental Symptoms. Descriptive Psychopathology since the Nineteenth Century*, (Cambridge, 1996), p.443.

¹²⁰ Blandford, *Insanity and its Treatment*, p.191.

¹²¹ George Fielding Blandford was a lecturer in psychological medicine at St Georges Hospital. John Bucknill was medical superintendent at Devon County Asylum from 1844 until 1862. In 1853, he founded the *Asylum Journal* which later became known as the *Journal of Mental Science*. Daniel Hack Tuke was the great-grandson of the founder of the York Retreat. He was assistant physician to the Retreat and physician to the York Dispensary. He co-wrote *A Manual of Psychological Medicine* with Bucknill and later became joint editor of the *Journal of Mental Science* in 1880. The following year he became president of the Medico-Psychological Association. William Wynn Westcott was the deputy coroner for Central Middlesex.

¹²² Esquirol assumed the position of physician in chief at the Salpêtrière Hospital in Paris in 1811. Esquirol's work emphasised the environmental and age factors that precipitated mental illness and the role of the emotions.

symptoms and a means of cure in cases of insanity. This paradigm allowed Esquirol to frame a broad analysis of suicide in 1821 when he stated that, 'this phenomenon is observed in the most varied circumstances...and shaped by the same uncertainties that affect mental illness; doubtless, suicide is idiopathic, but it can frequently be secondary'.¹²³ He explained that suicide could exist in two forms; as a *sui generis* disease, unique in its own characteristics, or, as an act secondary to mental illness. Esquirol's construction of suicide corresponded with the 'standard view' argument that only some suicides were caused by mental illness whilst others were a manifestation of emotional upheaval.

A disorder of the emotions could be precipitated by life events, social factors and the emotional tendencies of the individual. Esquirol inferred that during the act of suicide the individual was always in an altered state of mind, but it could be a short lived period of emotional upheaval and not insanity:

When the soul is strongly moved, by a violent and unexpected affection, organic functions are perverted, the reason is disturbed, the individual loses his self-consciousness...and commits acts the most thoughtless; those most opposed to his instinct, to his affections and interests'.¹²⁴

The emotional upheaval generated by a sudden and unexpected event such as disappointment in love, disappointed ambition, the loss of wealth or shame was powerful enough to unseat reason and deprive the individual of their power of

¹²³ J.E. Esquirol, 'Suicide' in Adelon, Alibert et al (eds.) *Dictionnaire des Sciences Medicales* (Paris, 1821), p.213.

¹²⁴ J.E. Esquirol, *Mental Maladies. A Treatise on Insanity* (1845, translated 1965), p.256.

reflection. Overwhelmed by intense emotional anguish, a consequence of temporary delirium, patients were overcome with an impulsive desire to escape their despair by committing suicide. It was the moral feelings of the mind rather than the intellectual faculties that were in a disordered state. The passions were capable of bringing happiness or adversity to an individual's mental state without the need for organic cerebral derangement to precede it. In all cases of suicide, there was an abnormal condition of the mental faculties, but there was no lunacy present where obvious moral and emotional causes existed that satisfactorily accounted for the deed.

The 'standard view', particularly Esquirol's explanation, focused on suicide that existed without the presence of insanity, but that did not mean that the co-existence of insanity and suicide escaped discussion. Among maniacs, melancholics and monomaniacs, suicide was considered a secondary phenomenon, rather than the primary symptom of insanity. Esquirol emphasised the presence and influence of false beliefs and delusion in the suicidal behaviour of the truly insane:

When maniacs commit self-murder, they do it without reflection. They usually throw themselves from a height; a circumstance which proves that they obey a blind impulse, by the employment of a means the most easy and accessible.¹²⁵

Hallucinations caused maniacs imperfectly to perceive the relation of things. The thoughts and judgment of the maniac were distorted and understanding was overthrown in place of a multiplicity of incoherent ideas that led to sudden and

¹²⁵ Ibid., p.259.

spontaneous actions; 'then it is, that maniacs destroy themselves...in consequence of the wandering of the reason, not knowing what they do; or by accident, in consequence of imprudences'.¹²⁶ Esquirol acknowledged that maniacs were driven to destroy themselves at the commencement of the disease. The patient was consciously aware of the condition that consumed his mind and plunged him into despair. Suicide in this situation appeared preferable to chronic 'cerebral affection'.

The 'standard view' found considerable support amongst the emerging psychiatric profession in nineteenth-century England. Leading alienists of the period were keen to acknowledge that insanity was not the cause of suicide *per se*.¹²⁷ Henry Maudsley wrote:

all the eminent men who have had practical knowledge of insanity, and whose authority we habitually accept, are entirely agreed as to the existence of a form of mental disorder in which, without hallucination, illusion, or delusion, the symptoms are exhibited in a perverted state of those mental faculties that are usually called the active and moral powers, or included under the feeling and volition.¹²⁸

The presence of delusions or hallucinations as a criterion for insanity was no longer considered essential. Alienists were prepared to consider the power of emotion and the temporary disturbance it brought to the individual's state of mind. Changing

¹²⁶ Ibid., p.383.

¹²⁷ Those who believed insanity was not always the cause of suicide included G. Fielding Blandford, John Bucknill, and J.N. Radcliffe.

¹²⁸ H. Maudsley, *The Pathology of Mind* (London, 1879), p.345.

concepts of mental illness, particularly James Prichard's work on moral insanity, encouraged alienists to recognise that the moral, as well as the intellectual faculties, could be disordered.¹²⁹ By making explicit what was implicit in Esquirol's work, Prichard provided the conceptual basis for a major extension of the range of human behaviour that could be considered medically insane. He asserted the existence of 'moral insanity', arguing that it was a:

morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination.¹³⁰

Moral insanity extended the parameters of the 'standard view' and introduced, into English psychiatry, a second model for explaining suicidal behaviour. Suicidal individuals could be called insane without the presence of delusions or hallucinations. *Tedium vitae*, or weariness of life, was prominent in alienists' discussion of the 'standard view'. Westcott described a disgust of life as 'either profound sorrow produced by a very real and serious loss, or else it is the effect of satiety following the abuse of pleasure'.¹³¹ When the mind was incapable of being healthily occupied, and all sources of pleasure were exhausted, the mental faculties became diseased. Westcott observed that:

¹²⁹ J.C. Prichard, *Treatise on Insanity and Other Disorders Affecting the Mind* (London, 1835).

¹³⁰ *Ibid.*, p.6.

¹³¹ Westcott, *Suicide its History*, p.141.

their difficulties may seem entirely beyond their power to surmount, and they calmly and deliberately arrange to leave behind them a life which has become unbearable; such an act may be unwise, and is certainly presumptuous, but it has no signs of disease.¹³²

An individual who was low spirited, but free from delusions, neither did nor said anything that warranted them being labelled insane. The only indication of their altered state of mind was a manifest inability to enjoy themselves and a visible change in spirits. Writing slightly earlier than Westcott, but sharing the same view, George Fielding Blandford classified this state of mind as pure suicidal melancholia; 'so he blows his brains out, or jumps from the top of the house...the whole feeling of the individual makes him look on life as not worth the keeping'.¹³³ In cases like this, the insanity of the man was seen in how he entirely changed from what he was previously; there was no pathological cause for his depression.

By the late nineteenth century, the majority of English alienists had subscribed to Esquirol's 'standard view'. The notion that all suicides were insane had been largely dispelled. In its place, the psychiatric profession favoured a broad definition of suicide. A multitude of social causes were acknowledged alongside the traditional model of insanity and the criterion that delusion and false beliefs denoted mental illness. Early nineteenth century understanding of the relationship between suicide and insanity had been impeded by adherence to an arbitrary standard of mental disorder. Winslow asserted that 'they [alienists] have disposed to consider no

¹³² Ibid., p.117.

¹³³ Blandford, *Insanity and its Treatment*, p.191.

deviation from mental soundness as insanity, unless it exhibited the symptoms which their preconceived ideas had led them to suppose necessary, in order to constitute that disease'.¹³⁴ Changes in psychiatric understanding and the definition of mental illness were a necessary prerequisite for the emergence of the 'standard view'. During the nineteenth century, alienists came to understand the protean nature of suicide and constructed a conceptual framework that acknowledged broader definitions of both insanity and suicide. The 'standard view' prevailed because it allowed psychiatry to define and take ownership of suicide as both a medical and social problem.

The 'psychiatric view'

Those opposed to the standard view chose to adopt the alternative theory that Berrios labels the 'psychiatric view'. Unwilling to accept that a temporary state of emotional upheaval could lead to suicide, the counter-argument was grounded in a firm belief that all suicides were in fact always due to the presence of insanity. In all cases, suicide was perceived as an impulse that was symptomatic of the existence of 'cerebro-mental' disease. Functional disturbance of the emotional and intellectual faculties was considered capable of generating an abnormal or insane condition in the individual's mind. Adherents to the psychiatric view were less inclined to accept moral and emotional upheaval as a short lived condition that existed separately from insanity:

We must bear in mind that insanity is often as much a disease of the moral as of the intellectual faculties, and that it is possible for

¹³⁴ Winslow, *The Anatomy of Suicide*, p.228.

the intellect to be perfectly sound, and yet for insanity to be present...moral derangement has not met with that consideration from the profession which its importance demands.¹³⁵

The emotions' influence over the bodily and mental functions of an individual was thought to give rise to serious functional disorder, actual organic disease and the commission of suicide. This model allowed the 'psychiatric view' to justify the existence of a suicidal tendency as confirmation that the patient was afflicted with insanity.

Supporters of the psychiatric view (were few in number and) included Dr J.G. Davey, proprietor of Northwoods licensed house near Bristol and Dr James Christie, medical assistant at the Glasgow Royal Lunatic Asylum. Its most vocal proponent was the eminent alienist and proprietor of two private asylums, Dr Forbes Winslow. As editor of the *Journal of Psychological Medicine and Mental Pathology*, Winslow was concerned with the interests of private asylums. He readily seized the opportunity to criticise public institutions and the medical men affiliated to them. Winslow claimed that, before his own publication, suicide appeared primarily as the subject of novels and the theatre. With the exception of a fleeting reference in works on medical jurisprudence, the pathological and physiological character of suicide had been neglected. The publication, in 1840, of Winslow's treatise *The Anatomy of Suicide* marked the first in England that was exclusively devoted to an inquiry on suicide.

¹³⁵ Ibid., p.232.

Winslow sought to establish a fact that he believed was of primary importance to contemporary theories:

that the disposition to commit self-destruction is, to a great extent, amenable to those principles which regulate our treatment of ordinary disease; and that, to a degree is more than generally supposed, it originates in derangement of the brain and abdominal viscera.¹³⁶

The unwillingness of some alienists to accept this argument was seen by Winslow as a major failure by the profession to grasp fully the connection between medical and moral science. By neglecting psychological medicine and mental philosophy, Winslow felt that the profession continued to view the subject of suicidal behaviour as belonging to the province of the moral philosopher rather than the asylum doctor. The extent to which this argument was truly reflective of contemporary attitudes to suicide and insanity is questionable. Earlier discussion of the standard view demonstrates that alienists were actively seeking ownership of suicide by defining it in medical terms. Winslow's comment appears misguided and reflective more of his hostility to the profession than any gaping omission in alienists' understanding of psychological medicine.

Assuming that a propensity to commit suicide was generated by derangement of the brain, the psychiatric view took as its leading doctrine the following: (1) that an attempt at self-destruction was often the first distinct overt act of insanity; (2) that

¹³⁶ Ibid., preface.

suicide could never be committed when the mind was perfectly healthy; (3) that it was safe always to presume the presence of insanity in those who exhibited a desire to commit suicide. Central to this doctrine was the concept of self-preservation, a law of nature to which suicide was diametrically opposed. To preserve one's existence was perceived as an instinctive feeling within human nature and subversion of this was taken as evidence of insanity. Dr James Christie stated that when both the motive and the act were suicidal, 'the instinct of self-preservation is either dormant to a greater or less extent, or completely overruled by the supremacy of powerfully exciting passions'.¹³⁷ Christie believed that insanity prevented the intellectual faculties from subduing the propensity for self-destruction and allowed a morbid desire for death to develop and be acted upon. To subvert the law of nature and seek self-destruction rather than self-preservation inferred, to the psychiatric view, that acts of suicide could not occur where there existed perfect sanity.

In contrast to Esquirol, the psychiatric view asserted that moral causes were capable of producing true mental derangement and not simply a heightened, temporary state of emotional upheaval. Winslow favoured this theory and afforded great attention to it in *The Anatomy of Suicide*. Believing that medical and moral science were closely allied, Winslow declared that 'science of the mind' should be properly investigated in order to understand the origins and habits of thought and feeling:

The passions are to be considered, in a medical point of view, as part of our constitution. They stimulate or depress the mind, as food and drink do the body. Employed occasionally, and in

¹³⁷ J. Christie, 'On Suicidal Impulse', *Glasgow Medical Journal*, vol. 11 (1864), p.283.

moderation, both may be of use to us, and are given to us by nature for this purpose; but when urged to excess, the system is thrown off its balance and disease is the result.¹³⁸

Winslow inferred that equilibrium of the mind and body could be dislodged by the passions exercising 'so despotic a tyranny over the physical economy'.¹³⁹ He believed that the disruptive influence of the passions and moral causes could also be traced to the advent of suicide. Winslow claimed that close examination of suicidal cases would reveal that the individual had suffered from depression of spirits or anxiety of mind either for a prolonged period of time or at the precise moment of the act. Regardless of the duration of such feelings, what remained significant was that they were borne from cerebral derangement. Winslow declared that suicide ought to be regarded and treated as insanity and not just its forerunner; 'we may always be assured, that if mental anxiety or perturbation be more than commensurate with the exciting cause, it may be presumed that the individual is labouring under the incipient indications of insanity'.¹⁴⁰

Remorse, guilt, disappointed love, despair and loss of pride constituted the passions of the mind that readily drove individuals to suicide. In each case insanity was deemed the consequence of the passion and the cause of suicide. When afflicted with remorse or guilt, the patient's mind was possessed by an intense desire to withdraw quickly from a state of mental torture. The sufferer felt overwhelmed by feelings that he was an outcast from God and fellow man for the crime or sins a

¹³⁸Winslow, *The Anatomy of Suicide*, p.48.

¹³⁹ Ibid., p.48.

¹⁴⁰ Ibid., p.229.

diseased imagination led him to believe was true. According to Winslow, fancy and conscience acted interchangeably in the form of 'melancholy notions'.¹⁴¹ These were manifested as moral and religious duty and 'lay hold on the faculties without opposition, because we are afraid to exclude or banish them'.¹⁴² The consuming anguish of a guilty conscience was expressed in a poem included in Winslow's treatise. The poem described the sleeplessness of a guilt-ridden mind:

Though thy slumber may be deep,
Yet thy spirit shall not sleep;
There are shades which will not vanish,
There are thoughts thou canst not banish;
By the power to thee unknown,
Thou canst never be alone;
Thou art wrapt as with a shroud,
Thou art gathered in a cloud;
And for ever shalt thou dwell
In the spirit of the spell.¹⁴³

The power of the passions was considered to be at its most dangerous and influential when love was involved. Love could constitute the height of human happiness but, when unrequited, it was subverted and replaced by 'the most baneful influence upon the system'.¹⁴⁴ Winslow believed that the most severe melancholy cases were commonly attributed to disappointed love. Deprivation of hope was inextricably connected to the powerful influence of loss of pride and states of despair.

¹⁴¹ Ibid., p.55.

¹⁴² Ibid.

¹⁴³ Ibid. The poem is quoted from Byron (Manfred, Act 1, 1816). It refers to Byron's failed marriage and his relationship with his half sister, Augusta Leigh.

¹⁴⁴ Ibid., p.56.

The psychiatric view declared that individuals naturally of a proud disposition found themselves less able than others to overcome the distresses of life. They were particularly susceptible to the 'yoke of adversity'¹⁴⁵ and the production of mental derangement as a direct correlation to the advent of this passion. A state of despair and fear emerged that induced the unhappy person to seek relief, from their real or supposed predicament, in the act of suicide.

Despite vehement support from one of the period's most prolific alienists, Dr Forbes Winslow, the psychiatric view remained the theory of the minority. It was constrained by a preoccupation with psychological medicine and moral science. The psychiatric view's downfall lay in its narrow interpretation of suicidal behaviour and adamant declaration that suicide and sanity could not co-exist. As long as Winslow's stance remained diametrically opposed to contemporary changes in psychiatric knowledge and theory then the psychiatric view was likely to remain the minority position.

Suicidal behaviour should be understood in relation to the forms of insanity that it appeared alongside. The general characteristics of melancholia, mania, puerperal insanity and other, less common conditions influenced the manner in which suicidal behaviour was manifested. Destructive and injurious behaviour often mirrored the symptoms of the mental affliction and framed the way in which suicide was planned and attempted. It also determined how, or whether, the patient expressed his suicidal desire through verbal communication or physical action. Melancholic patients were more inclined to bemoan their feelings of misery whilst maniacs were prone to

¹⁴⁵ Ibid., p.66.

impulsive or aggressive actions. Each form of insanity was characterised by its own set of challenging behaviours that created varying degrees of suicide risk. This next section examines the idiosyncrasies of each diagnostic category and the suicidal behaviour associated with them.

Melancholia

Melancholia is a state of mental depression, in which misery is unreasonable either in relation to its apparent cause, or in the peculiar form it assumes.¹⁴⁶

Nineteenth-century diagnostic classification regarded melancholia as a form of insanity characterised by depression and an intensity of ideas. The patient unceasingly pondered his own desperate condition and was gradually consumed by feelings of self-abasement. Often in cases of melancholia intense depression was for a considerable time free from any suicidal desire. When the misery of existing became too tortuous to bear then the patient was forced to choose between perpetual torment or escape by suicide. Burrows argued that when suicide developed from the continued existence of melancholia it was a secondary rather than a primary affection; it was perceived as a distinct and relatively common symptom of melancholia rather than a special form of insanity.¹⁴⁷ The emotional state of the patient and the intense mental suffering experienced gave rise, according to German psychiatrist Wilhelm Greisinger, to certain 'impulses and directions of the will which are manifested in external

¹⁴⁶ Savage, *Insanity and Allied Neuroses*, p.151.

¹⁴⁷ Burrows, *Commentaries on the Causes*, p.413.

actions'.¹⁴⁸ The internalization of negative ideas and feelings manifested itself, outwardly, in the form of hostile and destructive actions.

Simple melancholia constituted the incipient stage of the disease and was characterised by depression. Those afflicted with the condition experienced feelings of misery that were only a slight exaggeration of their natural state of mind, but nonetheless provided no pleasure in life. Delusions and hallucinations were absent during the early stage of melancholia as the patient's intellect was not disordered. The simple melancholic retained a calm, if pensive demeanour. Conolly depicted the lunatic with 'the hands clasped upon the breast; the head hung down...the countenance sad, the voice low; the attention absorbed in one consuming grief'.¹⁴⁹ Lunatics afflicted with simple melancholia were not completely free from the risk of suicide. Daniel Hack Tuke stated that 'simple melancholia of very slight depth is a...common cause of suicide'.¹⁵⁰ The determination to commit suicide was, however, unlikely to have been brooded upon and be deeply rooted. Patients suffering from simple melancholia were a cause for concern, but the threat they posed was moderate. The desire for self-destruction was mild in a mind that was untouched by delusions and deep-seated depression. A strong determination to commit suicide developed as melancholia passed into its active stage.

¹⁴⁸ W. Greisinger, *Mental Pathology and Therapeutics* (London, 1867), p.252.

¹⁴⁹ J. Conolly, *The Croonian Lectures delivered at the Royal College of Physicians: On some of the forms of Insanity* (London, 1849), p.21.

¹⁵⁰ D.H. Tuke, *A Dictionary of Psychological Medicine* (London, 1892), p.1231.

Burrows described active melancholia as the confirmed stage of the condition. The patient was plunged into a deep state of depression that was accompanied by delusions or voices:

One or several delusions are apparent, though sometimes withheld; reveries are longer, and abstraction more intense. The patients are often quite taciturn, or disposed to speak only on the subject of their delusion; greater dejection...very suspicious, especially of conspiracies against them, or of poison.¹⁵¹

The presence of one or more delusions separated simple and active melancholia. Deluded patients frequently dwelled on false beliefs and ideas that had no real existence except in the individual's mind. Although delusions were a figment of a diseased imagination, alienists acknowledged that it was impossible to try and convince a patient of their falseness. Conolly advised his peers that,

No exercise of the senses, nor any opposite and incompatible facts, however plain and undeniable, can convince them that the supposed facts have no real existence, and are the mere result of some disordered actions going on in the brain.¹⁵²

Without the ability to reason and see truth, the patient's mind became fixed on false ideas that could not be removed by argument. It was commonly the patient's deep state of depression that gave rise to a delusion. Fear, jealousy and suspicion typified the delusions of melancholic patients. They felt that their continued existence was

¹⁵¹ Burrows, *Commentaries on the Causes*, p.355.

¹⁵² Conolly, *The Croonian Lectures*, p.59.

somehow detrimental to society or that family and friends were conspiring against them. The latter delusion (which proved particularly common) was exemplified by a female case at Birmingham Borough Asylum. Admitted in 1875, Jane Walter was described as suicidal with a depressed and anxious look. Her case notes recorded continued 'restlessness and melancholy' that was caused by a delusion. She 'fancies she is going to be murdered and is in great dread'.¹⁵³

Similar thoughts were expressed by a male patient admitted to Leicestershire County Asylum in 1848. Thomas Poyner was described 'as a case of melancholia of a very distressing character'. Gloomy and despondent without any apparent reason, Thomas 'hears every body is going to injure him...and fancied every one was conspiring against him to do him wrong. He has expressed his fear that he shall some time destroy himself'.¹⁵⁴ This case supports Savage's assertion that some melancholic patients were driven to kill themselves because voices urged them to do so or they were beset with delusional ideas of persecution and conspiracy. The patient was coerced into thoughts of self-destruction as a means of escaping further mental anxiety and avoiding death at the hands of those who supposedly conspired against him. Delusions were 'chiefly important in relation to the actions which may become the consequences of them'.¹⁵⁵ Conolly suggested that delusions could sometimes be quite harmless, but they could also lead to actions that were dangerous to the patient and others.

¹⁵³ BCA, MS344/12/41, Female Casebook, January 1873 – February 1882.

¹⁵⁴ LRO, DE353/186, Male and Female Casebook, August 1848 – December 1852.

¹⁵⁵ Conolly, *The Croonian Lectures*, p.64.

Patients suffering from active melancholia repeatedly bemoaned their miserable existence rather than internalising their melancholy. Savage described patients consumed by a 'restless misery, as seen in the constant picking of fingers, pulling out of hair, and a tendency to strike or damage anything that appears to be an obstacle to its free exhibition'.¹⁵⁶ Susan Prescott, admitted to Birmingham Borough Asylum in 1853, was described as 'more and more crazy and more restless at night, pulls her clothes to pieces'. This behaviour was brought on by a deeply melancholic disposition that was attributed to poverty and unfounded ideas that she was lost. In addition to general destructive behaviour, the patient also 'refuses to take her food...and tried to destroy herself' before admission.¹⁵⁷

Active attempts to cause damage and inflict self-injury were demonstrated by Eunice Richards, a patient at Birmingham Asylum. Under the delusion that 'there are some men at the bottom of the boards' who follow her wherever she moves, she actively sought to destroy herself. Eunice attempted suicide several times. She 'tried to cut her throat with a piece of glass which she got by breaking a pane' and 'in the night broke a chamber to pieces'. She continued to exhibit 'conduct literally devillish', pulling her hair out, destroying her clothing, breaking windows and 'constantly threatening to destroy herself'. Her increasingly violent and destructive behaviour prompted the use of a strait jacket that was imposed from 6pm to 11pm on 11 May 1880.¹⁵⁸ The decision to employ restraint was justified by the need to curb Eunice's unmanageable and destructive behaviour.

¹⁵⁶ Savage, *Insanity and Allied Neuroses*, p.176.

¹⁵⁷ BCA, MS344/12/2, Male and Female Casebook, 1850-1855.

¹⁵⁸ BCA, MS344/12/41, quote dated October 1880.

The danger posed by melancholic patients was perceived by alienists to be greater than those labouring under most other forms of insanity. The determined suicidal propensity that developed during active melancholia led Strahan to conclude that, 'of the truly insane who commit suicide, the majority are melancholiacs' who have long brooded over their desire.¹⁵⁹ The risk of suicide was considered to be greatest during the early morning. Bucknill and Tuke warned that 'the early morning is generally the occasion for increased mental suffering'¹⁶⁰ following a restless night with little sleep. The patient awoke in a state of gloom with morbid thoughts intensified, thus making him more inclined to harm himself. The case of Mary Ethell, admitted to Birmingham Borough Asylum in January 1862, demonstrates the reality of Bucknill and Tuke's warning. She believed that she 'has had the clock of death upon her for 4 months' and made three attempts to cut her throat, all of which occurred in the early hours of the morning:

This morning [6 January 1863] cut her throat with a table knife...this morning [23 July] soon after 6 cut her throat again...she obtained a table knife from a drawer in the nurses room...this morning [7 October] cut her throat again, not known how.¹⁶¹

Mary's renewed attempts suggest that patients seized their opportunity during the morning because the presence of attendants was unlikely to be constant. As

¹⁵⁹ Strahan, *Suicide and Insanity*, p.105.

¹⁶⁰ Bucknill and Tuke, *A Manual of Psychological Medicine*, p.149.

¹⁶¹ BCA, MS344/12/2a, Male and Female Casebook, 1855 – 1866.

attendants commenced their duties they left 'the patient quietly in bed at the very time of all the twenty-four hours that his presence is needed'.¹⁶²

A determined suicidal propensity commonly appeared alongside melancholia. In 1887, 59.6 per cent of suicidal patients admitted into asylums were said to be afflicted with melancholia.¹⁶³ This suggests that a melancholic state of mind possessed certain characteristics and feelings that were conducive to the emergence of a suicidal tendency. Depression, delusions and a growing disdain for life pushed a large number of melancholic patients towards suicide as the lesser of two evils. When the mind was absorbed in an intense depression, a dangerous propensity often pre-occupied the patient's thoughts and so 'he prefers severing the thread of life, to the endurance of its misery'.¹⁶⁴ Melancholic patients were always a source of anxiety and could never be fully trusted. Daniel Hack Tuke noted that it 'is generally accepted as an axiom that no patient suffering from melancholia should be trusted'.¹⁶⁵ The intensely despondent state that typified active melancholia led most alienists to conclude that the suicidal melancholic was the most difficult patient to manage. The patient developed a strong determination to commit suicide that made 'it virtually impossible to prevent him carrying out his intention'.¹⁶⁶

¹⁶² Blandford, *Insanity and its Treatment*, p.209.

¹⁶³ Tuke, *A Dictionary of Psychological*, p.1229. The number of suicidal patients with mania was 20 per cent and a lowly 16 per cent suffered from dementia.

¹⁶⁴ Bucknill and Tuke, *A Manual of Psychological*, p.201.

¹⁶⁵ Tuke, *A Dictionary of Psychological*, p.1231.

¹⁶⁶ *Ibid.*, p.790.

Mania

mania, in general, is marked by incoherence of language, a rambling from one subject to another, which are the most opposite kinds, and have no apparent connexion with each other; ideas seem to pass through the mind too rapidly for distinct utterance.¹⁶⁷

Alienists diagnosed mania as a chronic 'cerebral affection', largely unattended by fever, and characterized by 'exaltation of the understanding'. According to Prichard, it affected the intellectual faculties, and 'interferes with their exercise even for the shortest period'.¹⁶⁸ This generated an increased rapidity of ideas and actions based upon impulse rather than rational judgement and reflection. 'Paroxysms' of high excitement propelled the patient into a state of confusion and increased mental activity. Samuel Bakewell described how 'they seem to have lost the power of regulating their thoughts, like a vessel tossed on the waves, without a rudder to direct its course'.¹⁶⁹ The faculties of understanding were displaced in a sudden and spontaneous manner that turned the patient from a courteous and civil demeanour to one of fury and wild ravings. Esquirol attributed a lack of self-control to the rapidity and incoherence of ideas present within the mind, together with a defect in the patient's powers of reflection. This caused errors of judgment and corrupted the individual's desires and impelled 'him to determinations more or less strange, unusual or violent'.¹⁷⁰

¹⁶⁷ S.G. Bakewell, *An Essay on Insanity* (Edinburgh, 1833), p.19. Samuel Bakewell was the son of Thomas Bakewell, proprietor of Spring Vale Asylum. He established his own institution called Oulton Retreat. L. D. Smith, 'To Cure those Afflicted with the Disease of Insanity: Thomas Bakewell and Spring Vale Asylum', *History of Psychiatry*, vol.4 (1993), pp.107-127.

¹⁶⁸ Prichard, *A Treatise on Insanity*, p.71.

¹⁶⁹ Bakewell, *An Essay on Insanity*, p.19.

¹⁷⁰ Esquirol, *Mental Maladies*, p.378.

The patient's 'determinations' manifested themselves in the form of general destructive behaviour, which was a primary characteristic of mania. Destructive behaviour was symptomatic of the patients' desire to rid themselves of the affliction or protest against their incarceration. It was common for patients to destroy articles of clothing and furniture. The case of Henry Pitt, admitted to Birmingham Asylum in 1851, demonstrates the unpredictable behaviour displayed by maniacal patients. Suffering from acute mania, his demeanour was characterised by wild, excited and incoherent speech together with a tendency to be noisy at night and 'towards the morning very destructive'. Henry 'tore the bedclothes, broke the chamber vessel, window frame and cut his finger with the broken glass.'¹⁷¹ His behaviour remained disruptive throughout the duration of his confinement, regularly '[r]aving, singing and swearing'. Henry was discharged for the third time on 13 April 1854 having been 'tranquil and rational' for some time. Sadly, three months later he 'destroyed himself at home by hanging with a handkerchief to the bedpost'.¹⁷² This case illustrates how maniacal behaviour fluctuated and could assume a dangerous form. Durkheim believed ideas and feelings surfaced, disappeared or changed with intense rapidity in the patient's mind and brought with them violent desires and actions that would be acted upon instantaneously. He summarised the evolution of maniacal suicide as the appearance of a hallucination or delirium that suggested self-destruction, the attempt immediately followed 'then instantly the scene changes, and if the attempt fails is not resumed'.¹⁷³

¹⁷¹ BCA, MS344/12/2, Male and Female Casebook, 1850-1855.

¹⁷² Ibid.

¹⁷³ Durkheim, *Suicide. A Study in Sociology*, p.63.

The transition from destructive behaviour to an actual suicide attempt was driven largely by the patient's awareness of his condition and a desire to be free from its hold. Death was sought as an escape from the pain of insanity rather than 'moral impressions' and a general weariness of life, as in melancholia. Blandford acknowledged that patients afflicted with mania were most likely to hurt themselves or others during ungovernable episodes of excitement. Patients had a tendency to inflict self-injury by dashing their heads against a wall or biting their arms, but Blandford was unwilling to accept that such behaviour was, in itself, suggestive of suicidal mania; 'We can not say that they are suffering from suicidal melancholia or suicidal mania. Suicide is like breaking the windows, or tearing in pieces their clothes or furniture – a mode in which vehement destructiveness finds vent'.¹⁷⁴

Blandford accepted that inflicting self-injury was a common and recognisable symptom of maniacal fury. He was, however, less willing to accept that it was a direct indication, or precursor, of suicide. He stated that dashing the head against a wall was, in the majority of cases, not an attempt to commit suicide but a common outlet for maniacal behaviour during 'paroxysms of ungovernable fury' when patients 'will try and hurt themselves as well as others'¹⁷⁵. The classification of suicidal mania was only appropriate when the patient's behaviour became more ferocious with intent, for example breaking glass or tearing clothing. Blandford's distinction between injurious and suicidal behaviour is evident in the case of Mary Walker. She was admitted to Worcestershire County Asylum in January 1868, suffering from acute mania. Mary's mind was occupied by various delusions of a religious nature and fears of damnation

¹⁷⁴ Blandford, *Insanity and its Treatment*, p.192.

¹⁷⁵ Ibid.

as well as general restlessness and agitation. Her difficult behaviour made it necessary to place her in a padded room as she was 'in the habit of smashing windows – attempting to injure herself, declaring that she wishes to put an end to her existence'.¹⁷⁶ The destructive and violent behaviour of John Birch, a patient at Worcestershire County Asylum, produced implements that were later used in suicidal acts. He was suffering from 'mania epilepsy' and attempted suicide before his admission. John openly confessed that 'without being watched and guarded', he could not control his own actions and thoughts. Early on the morning of 16 February 1879 a night attendant discovered that John had cut his throat rather severely:

the medical officer was at once summoned and on his arrival found that he (Birch) has inflicted a severe wound on himself, it was about an inch and a half extending horizontally across the throat...the wound was inflicted with a small piece of glass which was afterwards discovered in his bed.¹⁷⁷

John made a second suicide attempt two months later. On this occasion, he inflicted a severe wound to his throat with a piece of tin which he had sharpened and secreted. Described as intensely suicidal during periods of excitement, he continued to express 'both wishes and determination to make away with himself', a desire compounded by frequent fits of severe epilepsy and maniacal excitement. It would appear John laboured under feelings of despondency, but it was the aggressive nature of his epileptic mania that encouraged him to seek solace in death. He

¹⁷⁶ WRO, BA10127/18, Male and Female Casebook, vol. 14, January 1867-January 1870.

¹⁷⁷ Ibid.

attempted suicide to escape the impulsive and violent behaviour that frequently accompanied or followed the 'paroxysms' that were caused by mania.

Closely linked to motive was the manner in which suicide was attempted or committed. Conolly asserted that the wild and ungovernable impulse that typified mania meant patients were endowed with 'an acute perception of the readiest means of death, demanding constant watchfulness'.¹⁷⁸ Unlike the melancholic who planned and carefully chose his method, patients afflicted with mania were inclined to grasp the most readily available means when the impulse struck. Alfred Pardoe, a patient of the Worcestershire County Asylum, acted impulsively to procure his means of committing suicide. His condition was varied, 'he is sometimes more composed and tranquil at others he has a recurrence of his maniacal seizures'.¹⁷⁹ Alfred committed suicide on 3 January 1871 by cutting his throat:

The attendant of his ward states that he missed him from the table where the patients had been dining...on seeking him in the ward he was found lying with his throat cut in the lavatory, a large knife which he had evidently managed to conceal immediately after the clearing of the table, lying beside him on the floor. Death must have been almost instantaneous.¹⁸⁰

The circumstances of Alfred's suicide reinforce Conolly's insistence that only constant watching could counter the impulsive and acute perception of maniacs. When a suicidal impulse struck, the patient tended to seek their end with a

¹⁷⁸ Conolly, *The Croonian Lectures*, p.14.

¹⁷⁹ WRO, BA10127/20, Male and Female Casebook, vol. 15, October 1870-February 1873.

¹⁸⁰ Ibid.

determination and quickness that easily outwitted or caught attendants off guard. Driven by mere impulse, Conolly proclaimed that 'no dread of pain, no shirking from suffering, seems to remain...and...the most terrible forms of self-destruction become attractive'.¹⁸¹ Conolly considered death by strangulation, starvation and drowning to be representative of the violent methods chosen by patients suffering from mania. The correlation Conolly drew between suicidal mania and violent methods of self-destruction can be questioned as patient case notes reveal that suicide by strangulation and starvation was not specific to patients with mania. As discussed later in this chapter, suicidal patients suffering from melancholia, monomania and puerperal insanity were found to utilise the same means of committing suicide.

Conolly made specific reference to suicidal patients with acute mania in his Croonian Lecture of 1849. He discussed the suicidal impulse and declared:

There is scarcely anything connected with recent cases of insanity more important for the practitioner to know than that in no form of it is the suicidal impulse stronger than in acute mania – not in the deepest despondency – not in the profoundest melancholia.¹⁸²

The management of suicidal behaviour was difficult in cases of mania because of the unpredictable nature of the disease. The melancholic appeared ever the same and presented few peculiarities in behaviour. In contrast, the changing disposition of maniacal patients meant that 'it is very common to see maniacs pass suddenly and without any apparent cause from joy to sorrow, from defiance to shrinking cowardice,

¹⁸¹ Conolly, *The Croonian Lectures*, p.14.

¹⁸² *Ibid.*, p.14.

from indifference in violent reaction to furious rage'.¹⁸³ The previously cited case of Alfred Pardoe is representative of the protean nature of mania and its implications for suicidal management. It was during periods of maniacal excitement that Alfred was noisy, violent and destructive. After these disruptive episodes, he regained composure and was employed in his ward. It is probable that attendants relaxed their stringent observation when Alfred's maniacal behaviour receded and the threat of suicide supposedly declined.¹⁸⁴

Strahan acknowledges that there were only a small proportion of patients suffering from mania who had a propensity for self-destruction.¹⁸⁵ Despite their numbers being fewer than suicidal melancholics, the management of mania remained complex. Patients were not continually bent upon self-destruction; instead, they attempted suicide as a sudden and spontaneous action. This made it hard for attendants to familiarise themselves with the behavioural patterns of maniacal patients. Suicide was often sought with a quick determination and an acute awareness of the readiest means of death. There was present a certain, if not significant, degree of aggression that heightened the patient's propensity and made their behaviour hard to control or counteract. The lunatic was 'the very genius of evil, who delights in the confusion, disorder and fear which he spreads around'.¹⁸⁶ Patients with suicidal mania were not difficult to manage because of their suicidal tendency but because of the disease with which it was allied (mania).

¹⁸³ Greisinger, *Mental Pathology*, p.281.

¹⁸⁴ WRO, BA10127/20, admitted 30 April 1870, patient no. 2407.

¹⁸⁵ Strahan, *Suicide and Insanity*, p.110.

¹⁸⁶ Esquirol, *Mental Maladies*, p.377.

Puerperal insanity

Puerperal insanity has received limited attention from historians. The work of Marland remains the most significant contribution to the study of this exclusively female disorder. In her book, *Dangerous Motherhood*, Marland traces the emergence of puerperal insanity as a medical term and the emerging psychiatric profession's attempt to define and take ownership of the condition. The dangerous behaviour associated with insanity related to childbirth is discussed and specific cases of suicidal behaviour are utilised to demonstrate that patients were a danger to themselves and their infants.¹⁸⁷ Marland emphasises the extent to which acceptable behaviour permeated the diagnosis of puerperal insanity and the decision to commit women. This section will build on Marland's work by exploring contemporary interpretations of suicidal behaviour in relation to puerperal insanity. It also develops the theme of dangerousness and anti-social behaviour as a precursor to admission.

Puerperal insanity could occur at any time between conception and 'parturition', but most commonly set in shortly after childbirth. Explanations of the disorder were closely tied to nineteenth-century ideas that the female had a weaker physical and mental constitution. Elaine Showalter demonstrated in her study of the 'female malady' that the psychiatric explanation attributed a direct biological cause to puerperal insanity because it was believed that after childbirth a woman's mind was greatly weakened and control over her behaviour reduced.¹⁸⁸ In a state of mental and physical deterioration, women were deemed more susceptible to the emergence of insanity either as a brief attack or a long-term affliction. The mental disorders

¹⁸⁷ Marland, *Dangerous Motherhood. Insanity and Childbirth in Victorian Britain*.

¹⁸⁸ E. Showalter, *The Female Malady. Women, Madness and English Culture, 1830-1980* (New York, 1987), pp.58 -59.

associated with puerperal insanity could take a number of disturbing forms. Writing on the subject in Bucknill and Tuke's *A Manual of Psychological Medicine*, Savage stated that 'it must not be supposed that mania is the only form of insanity which results from this condition of the system in women. On the contrary, melancholia, delusional forms of insanity, and even dementia, may ensue'.¹⁸⁹ Alienists generally viewed puerperal insanity as a temporary condition, but this was not a guaranteed rule. It was possible for mania to become chronic and violent or for long-term melancholia to render the patient deeply despondent. In protracted cases, the patient's behaviour was more problematic and dangerous and the prospect of recovery greatly diminished.

Women suffering from puerperal insanity posed a risk to their husband, their newborn child and most commonly themselves. In an examination of 155 cases admitted into the Royal Edinburgh Asylum, Dr John Batty Tuke argued that 'in no form of insanity is the suicidal tendency so well marked...in some the attempts were most determined, a loathing of life and intense desire to get rid of it being the actuating motives'.¹⁹⁰ To guard against this danger, Robert Gooch, an eminent London obstetrician and the first physician to write on puerperal insanity, stressed that it was vital 'to protect the patient from injuring herself...to procure sleep at night...to manage the mind of the patient...encouraging it during depression'.¹⁹¹

¹⁸⁹ Bucknill and Tuke, *A Manual of Psychological*, p.237.

¹⁹⁰ J.B. Tuke, 'On the statistics of Puerperal Insanity in the Royal Edinburgh Asylum, Morningside', *Edinburgh Medical Journal*, vol.10 (1865), p.1015.

¹⁹¹ R. Gooch, *Observations on Puerperal Insanity* (London, 1820), pp.21-22.

Alienists recognized the close relationship between childbirth and mental weakness, but Marland argues that 'they were quicker to link the condition to poverty and need...and the hardships of rearing children born in rapid succession'.¹⁹² Severe depression could be precipitated by the delivery of an illegitimate child, desertion of the patient's husband or the death of the child. Feelings of despair or guilt merely exacerbated the patient's already weakened mental state and increased the risk of suicide. The link between domestic life and puerperal insanity was apparent in the case of Elizabeth Bedsley. She was admitted to Leicestershire County Asylum in September 1847, having suffered from 'puerperal mania of four months standing'. Following the onset of the disorder 'her head became violently affected...and...her temper lately has become very irritable, and her conduct occasionally violent'. Although puerperal mania had commenced a 'week after her confinement' and was partially attributed to a biological cause, Elizabeth's case notes give reference to discontent in her domestic circumstances: 'she has lived very unhappily with her husband, and domestic annoyance have tended not a little to aggravate her mental disorder'. In consequence of both biological and 'moral causes', her habits and conduct became dangerous to the extent that 'she has more than once attempted to strangle herself'.¹⁹³

Despondency and low spirits were particularly marked in puerperal insanity of a melancholic form. Conolly outlined the general characteristics of the condition as 'a general apathy and listlessness, mingled with anxiety about domestic affairs...is indifferent to food, very silent, and exhibits no affection towards her infant or

¹⁹² Marland, *Dangerous Motherhood*, p.310.

¹⁹³ LCRO, DE3533/185, admitted 18 September 1847, admission no. 833.

husband'.¹⁹⁴ In addition, delusions and suspicion of others manifested themselves as melancholia became more protracted. According to Tuke, the emergence of delusions could frequently be traced to 'the morbid fears, restlessness, capriciousness, and irritability of the pregnant woman, which becoming exacerbated, amount to actual insanity, and prompt the unhappy victim to self-destruction'.¹⁹⁵ The symptoms described by Conolly and Tuke were present in the case of Celia Rickett, admitted to Worcestershire County Asylum in March 1864 suffering from puerperal mania. She was said to be 'restless, excitable and violent', as well as harbouring the delusion that 'she has been cut to pieces, killed and buried alive'. Although admitted as suffering from the maniacal form of puerperal insanity, her condition passed into despondency; 'the expression of her countenance is thoughtful and melancholic...she is very low'. It was during the transition from mania to melancholy that her delusion came to the fore. In Celia's case, the emergence of a delusion was connected to 'the morbid fears...and...irritability of the pregnant woman', in the way Tuke had outlined.¹⁹⁶

The maniacal form of puerperal insanity was largely consistent with the general characteristics of mania. Conolly stated that the condition 'is most frequently of a lively character. The patient sings, talks incoherently, and laughs much; is sleepless and restless...overturning chairs, breaking windows'.¹⁹⁷ It was a disturbing subdivision of puerperal insanity simply because of the pronounced outward manifestations of mania. Marland suggests that the conduct of female maniacs was

¹⁹⁴ J. Conolly, 'Clinical Lectures on the Principal Forms of Insanity: Description and Treatment of Puerperal Insanity', *The Lancet*, vol.1 (1846), p. 349.

¹⁹⁵ Tuke, 'On the statistics of Puerperal Insanity', p.1015.

¹⁹⁶ WRO, BA10127/19, admitted 19 March 1864, patient no. 1496.

¹⁹⁷ Conolly, 'Clinical Lectures', p.349.

deplored because it was 'associated with the contravention of decent female behaviour and maternal duty'.¹⁹⁸ Rather than tending to their matrimonial role and domestic chores, women afflicted by puerperal mania neglected themselves and their husbands, but far worse they sometimes conducted themselves improperly in public, swearing and uncouth language being a feature. Patients like Celia Rickett contravened the prevalent ideal of femininity and the duty of women to care for their husband and children. On admission, 'she was brought here [to Worcestershire County Asylum] in a straight jacket' presumably because endeavours to hang herself and threats 'to cut her throat' had proved too difficult for family members to provide domestic care. The safety of those around her, particularly the child, was also a concern because she 'has bitten severely several people about her, and has attempted to tear the child'. To endanger the life of an infant was conduct worthy of grave concern and propelled patients like Celia towards institutionalisation as a means of prevention against future attempts on her own life and that of the child.¹⁹⁹

The symptoms and behaviour of women suffering from puerperal insanity remained akin to mania or melancholia that occurred outside of the puerperal state. There was nothing unique or distinctly different about the mental affliction or the suicidal behaviour that emerged. Patients remained cunning in their attempts, chose the same methods and required the same preventative measures as other suicidal patients. Instead, what differed were the 'moral' and biological causes that induced insanity during the time of pregnancy and birth. The dangers of childbirth, domestic troubles or the fear of delivering an illegitimate child placed enormous anxiety and

¹⁹⁸ Marland, 'Disappointment and Desolution: women, doctors and interpretations of puerperal insanity in the nineteenth century', *History of Psychiatry*, vol. 14 (2003), p.308.

¹⁹⁹ WRO, BA10127/19, admitted 19 March 1864, patient no. 1496.

emotional strain on the female body and mind. It was the convergence of mental stress and often physical weakness after birth that made women susceptible to insanity. Women were at greater risk of choosing suicide as an escape either from the hardship of motherhood and domestic life or the shame of delivering an illegitimate child.

Other diagnostic categories

Dementia and monomania accounted for only a small number of suicides among the insane and received little attention from nineteenth-century alienists. The uncommon occurrence of such cases is also borne out in the case books of Birmingham, Leicestershire, Rainhill, Warwickshire and Worcestershire Asylums where very few suicidal cases have been found in which dementia or monomania were present. Although a causal link between dementia or monomania and suicide was rare, it is still necessary to acknowledge that some cases did exist and so a brief exploration of this relationship is worthwhile. In Hack Tuke's *A Dictionary of Psychological Medicine*, dementia was defined as 'a state in which manifestations of mind are to a greater or less degree absent in consequence of disease or decay of the brain itself'.²⁰⁰ This condition was found to exist in two main forms, the senile and the ordinary:

The ordinary includes all those who are robbed of their reason during youth and maturity, and the senile those who have arrived at old age before losing their intelligence...each of these

²⁰⁰ Tuke, *A Dictionary of Psychological Medicine*, p.348.

contributes a very small number to the annual total of suicides; the senile more largely than the other.²⁰¹

Strahan emphasised the difference between suicide which occurred among 'the maniacal and the melancholic, and that which took place among the 'demented'. He perceived that the maniacal or melancholic patient fell victim 'to the promptings of a disordered intelligence', whilst the 'latter being deprived of reason, in destroying their lives only follow an unnatural instinct left in them when reason has fled'.²⁰² The notion that suicide was more common in cases of senile dementia related strongly to the relationship between old age and a diminished love of life. Strahan argued that the love of life decreased considerably as life advanced towards old age, 'hence when we find suicide much more common proportionately among the aged than among the young and the mature, we may infer that the love of life gradually becomes more easily overcome as life advances, that is, that it gradually fades'.²⁰³

The most prominent characteristics of both ordinary and senile dementia, and possible contributory factors in suicide, were diminished mental power and loss of self-control. Esquirol declared that 'individuals in a state of dementia are incapable of concentrating their attention sufficiently; and being incapable of forming a clear and correct notion of objects, they can neither compare nor associate ideas; nor have they the power of abstraction'.²⁰⁴ The impaired thoughts of the 'demented' were either transitory or persistent and produced actions, such as a suicidal impulse, that Thomas Clouston considered 'automatic acts unaccompanied by motive, reason, or

²⁰¹ Strahan, *Suicide and Insanity*, pp.110-111.

²⁰² *Ibid.*, p.111.

²⁰³ *Ibid.*

²⁰⁴ Esquirol, *Mental Maladies*, p.418.

remembrance, and were the mere motor signs of some organic discomfort'.²⁰⁵ A case example recorded in Clouston's treatise, *Clinical Lectures on Mental Diseases*, demonstrates 'the transitory thoughts and actions present in senile dementia. L.A., 83 years old when he died, suffered from a failing of the mental powers. 'At first there was failure of the memory, irritability, exaggerated opinions of himself...restlessness and lack of self-control'. It became increasingly difficult to 'engage his attention for more than a few seconds on any one subject'. At times, he 'would tell old stories...and look as wise as possible...or suddenly, causelessly, become intensely suicidal, trying to strangle himself, running his head against the wall, or clutching his throat with his hands...but in half an hour after all this he would be calm'. Clouston believed 'the mental depression was merely outward in muscular expression, not being felt in any proper subjective sense, and it was certainly not remembered'.²⁰⁶

The introduction of monomania into the language and diagnostics of nineteenth-century psychiatry was synonymous with Esquirol. Monomania was defined by Esquirol as a type of paranoia whereby the 'patients seize upon a false principle, which they pursue without deviating from logical reasonings, and from which they deduce legitimate consequences, which modify their affections, and the acts of their will'.²⁰⁷ The condition could manifest itself as emotional, intellectual or suspicious monomania. Emotional monomania was when the patient was obsessed with only one emotion or several related to it and was free from delusions or hallucinations. It was mental dejection or melancholy that extinguished hope in the patient's mind and

²⁰⁵ T.S. Clouston, *Clinical Lectures on Mental Diseases* (London, 1883), p.569. Clouston was Physician Superintendent of the Royal Edinburgh Asylum.

²⁰⁶ Ibid.

²⁰⁷ Esquirol, *Mental Maladies*, p. 320.

laid the foundation for emotional monomania. 'Illusions, hallucinations, vicious associations of ideas, false and strange convictions'²⁰⁸ were the basis for intellectual monomania. The delirium that followed was often characterised by hallucinations and were considered 'the cause of the perversion of their [the patient's] affections, and the disorder of their actions'.²⁰⁹ Finally, monomania of fear or suspicion led the patient to believe that an enemy, who was plotting against them and wished them harm. The low and desponding feelings aroused by monomania of fear appeared in the case of Benjamin Rowley, who was admitted to the Worcestershire County Asylum in March 1861. False beliefs and delusions were the basis of his condition and dictated the course of his actions. 'His certificates state that he fancies that a fire is being made to burn his body and bones together'. His behaviour was described as 'very restless and excitable; wanders about the gallery and asks everyone why he is not killed, and begs them to kill him; refuses the whole of his food, consequently he is obliged to be fed with force'. Labouring under the intense fear of being burnt to death, Benjamin developed a suicidal tendency. 'Before admission he had made several attempts to destroy himself, and has once attempted to do so since he has been in the house'.²¹⁰

This relatively brief discussion of dementia and monomania has demonstrated that the risk of self-destruction in either condition was considered to be very low. The mental decay that led to dementia was unlikely directly to encourage suicidal desires since it diminished the patient's desire, their ability to reason, 'to energise mentally

²⁰⁸ Ibid.

²⁰⁹ Ibid., p.328.

²¹⁰ WRO BA10127/15, Male and Female Casebook, vol.6, May 1860-December 1861.

and bodily²¹¹, and therefore rouse any motivation for suicide. Cases of suicidal monomania remained few because, throughout the century, it was a rarely diagnosed condition and contributed only a small number of patients to the asylum population. The lack of contemporary discourse about dementia and monomania, and patients' cases indicates that there existed only a tentative link between these conditions and the evolution of a suicidal tendency.

The favoured means of suicide

It is a somewhat curious fact, considering the immense number of feasible means of terminating one's existence, that there should be such a small number of methods in constant use.²¹²

In his study of suicide, Westcott listed the most frequently used methods of suicide as: 'hanging, drowning, shooting, cut throat, and other wounds, falls from a height, placing the body in the path of railway trains and other vehicles, poison and suffocation by want of air, or poisonous gases'.²¹³ These methods were common amongst suicides in wider society, but not all of them were viable in the asylum. The potential for taking one's life by drowning or poison was largely withdrawn when the patient was committed to an institution. According to Clouston, 'the suggestions offered in the shape of opportunity, that is, the sight of knives, ropes, water, open windows, poison,...in certain cases can rouse into activity a till then dormant suicidal desire'.²¹⁴ This suggests that there existed a notable correlation between environment and favoured means. Some methods, such as hanging, remained

²¹¹ Clouston, *Clinical Lectures*, p.565.

²¹² Westcott, *Suicide. Its History*, p.144.

²¹³ Ibid., p.144.

²¹⁴ Clouston, *Clinical Lectures*, pp.114-115.

popular both in and outside of the asylum, but the change in environment from the home to the institution usually changed the 'shape of opportunity' and restricted the feasibility of certain means.

Although this discussion will focus on the favoured means used within the asylum, it is important to briefly mention the trends that occurred before admission. As calculated by William Ogle in his study of suicide in England and Wales, 'by far the most common method of suicide in this country is hanging or strangulation, which accounts for 365 suicides out of 1,000...next in order come drowning and cut-throat'.²¹⁵ Ogle determined that men favoured hanging whilst women preferred suicide by drowning. Evidence from the case books of Birmingham, Leicestershire, Rainhill, Warwickshire and Worcestershire asylums supports Ogle's claim. Of the 95 cases where suicide was attempted prior to admission, the most commonly employed means were hanging, cutting the throat and drowning (see appendix 1 and 2). 22 out of 37 male patients chose to attempt suicide either by hanging or cutting the throat. This suggests that men had greater, or at least easier, access to the articles that facilitated such acts, namely a rope or razor. The 13 female patients who tried to drown themselves before admission fit in with the stereotypical image of 'a distraught girl flinging herself from a high bridge'.²¹⁶ Commonly held as the desperate act of a deserted or 'fallen' girl who sought death in the aftermath of betrayal or shame, women found the prospect of drowning favourable because it was less violent and its facilitation was made relatively easy with only a nearby canal, river or pond needed.

²¹⁵ W. Ogle, *On suicides in England and Wales in relation to age, sex, season and occupation* (London, 1886), p.18.

²¹⁶ Anderson, *Suicide in Victorian and Edwardian England*, p.197.

Once committed to the asylum, patients generally refrained from drowning and poisoning themselves, seemingly because the asylum did not contain the means necessary to facilitate these acts. The method most commonly used in the asylum, among both male and female patients was strangulation. Of the 42 patients identified who attempted suicide during their stay in Birmingham, Leicestershire, Rainhill and Worcestershire asylums between 1840 and 1860, 21 did so by strangulation; many often made repeated attempts. In his discussion of accessibility, Ogle asserts that 'chief of all, and most universally available and independent of locality, is a rope, which thus comes to be the most commonly used instrument of self-destruction'.²¹⁷ In the context of the asylum, it is inaccurate to state that any article was 'universally available', but despite stringent attempts to prevent suicide, patients did procure and make cunning use of the aids at their disposal. Rope was substituted by apron strings, sheets, cord, handkerchiefs and gas brackets, all of which were available in the asylum and made suicide by strangulation an attractive and attainable method.

The preference for strangulation and the ingenuity shown by patients is exemplified in two cases of completed suicide. James Palpreyman was readmitted to Leicestershire County Asylum in November 1852 having been previously 'taken out of the asylum by his friends on the 3 November'. Suffering from 'the most intense melancholia with strongly marked suicidal propensities...within a fortnight of his removal to his home he made two most determined attempts at suicide by means of throwing himself downstairs'. Induced by this behaviour, his friends were once again

²¹⁷ Ogle, *On suicides*, p.18.

forced to place him in the asylum 'as a precautionary means against his frequent attempts at suicide'. Their concern was justified when 'after many elaborate attempts at suicide Mr Palpreyman succeeded on the 21 July in strangling himself by means of a strip of sheet fastened to the handle of his dormitory window'.²¹⁸ Elizabeth Berwich, admitted to Worcestershire County Asylum in December 1868, demonstrated similar ingenuity. She occupied herself 'by assisting in the domestic work of the ward' and being 'moderately cheerful in her demeanour'. Unfortunately, Elizabeth was also prone to periods of discontent and depression 'without any cause'. It was four months after her admission that:

On the 17th of this month, Sunday, the deceased was found by the attendant of her ward on entering the lavatory belonging to the gallery, suspended to the gas-bracket by a means of twine and calico and a chair placed in such a position as to enable the deceased to attach the string around her neck – on the ligature being severed life was found to be quite extinct.

An inquest was later held and 'a verdict returned of – died from hanging herself whilst in a state of unsound mind'.²¹⁹ The actions of Elizabeth Berwich, and John Palpreyman, were partly incited by the presence of a feasible means of strangulation. Gas brackets and handles were a necessary part of the asylum's design, but they were also an obvious means by which suicide could be attempted.

²¹⁸ LRO, DE353/186, admitted November 1852, admission no.1305.

²¹⁹ WRO, BA10127/19, admitted 18 December 1868, admission no.2206.

The trend for suicide was heavily skewed towards strangulation, but a significant number of male and female patients chose to cut their own throats. Cutting the throat was likely to be achieved using either a knife or broken glass. The conduct of a male patient admitted to Leicestershire County Asylum in July 1846 demonstrates the preference some patients had for cutting their throat. William Layers was diagnosed as 'a case of melancholia with a most determined disposition to suicide'; prior to admission, he had cut his throat. William's condition started to improve soon after his admission. This prompted his 'employment out of doors...where after working for some time he one morning possessed himself of a knife and when it was supposed he was engaged in his usual occupation he retired into one of the shrubberies and destroyed himself by cutting his throat'.²²⁰ Patients who attempted or committed suicide by cutting the throat followed William's approach, utilising the resources found in their surrounding environment. They procured a knife or similarly sharp implement from the dining table, kitchen or garden; an opportunity that was often facilitated by employment.²²¹

The asylum's institutional environment changed the process by which individuals assessed and chose their favoured means of committing suicide. Gender, social stereotypes, and to a lesser extent environment, acted as the key determinants among suicides in wider society. In the asylum, patient decisions were dictated by the question of accessibility. The opportunities and the possible means by which suicide could be affected were significantly scaled down from the relatively small number acknowledged by Westcott and other contemporaries. The moderate, rather

²²⁰ LRO, DE 3533/185, admitted 1 July 1846, admission no.705.

²²¹ The risks associated with engaging suicidal patients in employment and recreational activities are given significant attention in chapter five.

than universal, availability of knives, razors, cord, string, and sheets from the surrounds of the institution reduced patients to a choice of strangulation or cutting their throats; very few alternatives were readily available.

* * * * *

Nineteenth-century explanations of suicidal behaviour were representative of the growing secularisation that had commenced in the previous century. The advancement of a medical model extended eighteenth-century developments in attitude and understanding. Insanity and suicide needed medical credibility if they were to be fully disassociated from religion and the supernatural. Alienists took ownership of suicide so that it could be defined as a medical and social problem that fell within the remit of the emerging psychiatric profession. The profession offered a psychiatric explanation that identified the irrational and depressive aspects of suicide. Explanations of suicide were influenced by the profession's evolving knowledge of insanity and the behaviours associated with its varied forms. The introduction of moral insanity proved particularly important because it widened the boundaries of mental illness. It acknowledged that the emotions and passions were as debilitating as intellectual derangement. This supported the idea that social causes contributed to the onset of insanity and the emergence of suicide as a secondary condition.

The debate about whether suicide was or was not an indicator of insanity generated new interpretations of suicidal behaviour, but it also acted divisively within the ranks of the emerging psychiatric profession. Discussion around this pivotal issue was

potentially debilitating to the profession's bid for uniformity and the validity of its medical model of insanity and suicide. Establishing a definitive relationship between suicide and insanity was a virtual impossibility. Medical and psychiatric explanations of suicide were dependant upon, and influenced, by alienists' knowledge of insanity. Definitions of insanity and diagnostic categories evolved throughout the nineteenth century, shifting the boundaries of mental illness and the behaviours associated with it. Changes in psychological theory expanded the parameters of insanity and suicide and allowed both to be perceived as a medical and social problem. Healthy debate encouraged differing interpretations of the relationship between suicide and insanity that prevented professional consensus, but stimulated on-going discussion and progressed psychiatric explanations of self-destruction.

Psychiatry's growing body of empirical knowledge allowed alienists to relate manifestations of suicidal behaviour to the symptoms and behavioural traits of mania, melancholia and puerperal insanity. They were able to differentiate the characteristic features associated with suicide in each condition and assess the level of risk based on the patient's mental affliction. The primary material referred to in this discussion highlights the value of case examples in illustrating different aspects of suicidal behaviour. There were, for example notable differences in the behaviour displayed by melancholics and maniacs. Alienists had to recognise the variances that existed within the different forms of insanity and how this affected the manifestations of individual suicidal episodes. A suicidal propensity or actual attempt was precipitated by emotional, moral and social causes that were specific to the patient and subsequently influenced the nature of their behaviour, determination to

commit suicide and the method adopted. The various categories of mental illness, and suicidal behaviour, had some general characteristics that were apparent in all cases, but it was the idiosyncrasies of each patient that complicated matters and made it difficult to treat patients and prevent suicide under a blanket policy of management. It was important, as demonstrated by case examples, for the handling of suicidal lunatics to be reactive and for alienists to develop their understanding through practical experience. Psychiatry's bid to take medical ownership of suicide was facilitated by the profession's development as a branch of medicine. By asserting their right to a monopoly over the definition, identification and treatment of the suicidal insane, alienists began the piece-meal process of eroding the social and religious stigma previously associated with acts of suicide. This aspect will be further considered in chapter two.

2

THE INCIPIENT PSYCHIATRIC PROFESSION AND SUICIDE

In a 'professional society' occupational groups are superseded by collective organisations, who, laying claim to specific skills, are able to declare themselves a profession. This situation, according to Harold Perkin, allowed industrial society's dependence upon 'actively managed capital' to be replaced by a social structure and service market that was based on human capital. Human capital was created by education, possession of a skill and the exclusion of the unqualified. The 'professional ideal' differed because it exchanged 'the simple labour theory of value' with selection by merit, which was determined by trained and certified expertise in a niche market.²²² Despite Perkin's emphasis on education and training, a profession is not solely defined by this criterion. The key components of a profession extend beyond knowledge to include the establishment of a self-governing organisation that unites its members and has the right to control its own work. The latter component is dependent on the profession gaining autonomy and state recognition of the monopoly status it has achieved.²²³

Nineteenth-century medical practitioners, including those involved in the care of the insane, were pre-occupied with establishing themselves as a recognised and respectable profession based on criteria that were similar to Perkin's later model. There was in the eighteenth and nineteenth centuries a concerted effort to transform

²²² H. Perkin, *The Rise of Professional Society. England since 1880* (London, 1993), pp.2-6.

²²³ A. Digby, *Making a Medical Living. Doctors and Patients in the English Market for Medicine* (Cambridge, 1994), p.24.

the relatively non-existent medical profession that was characterised by pluralism, into a uniform and united group of practitioners. At the same time there was growing recognition amongst 'mad-doctors' that they needed to improve their professional standing in the eyes of their medical brethren and society. Insanity was considered a fringe subject by many in the medical world which in turn affected the status of those involved in the treatment of the insane. 'Mad-doctors' held a distinctly low status, a position which they increasingly wished to reverse. As Scull has identified, the emerging psychiatric profession was not a refuge for the more disreputable members of the medical profession.²²⁴ In fact, by the early to mid-Victorian period the vast majority of alienists, as they had come to be called, were educated men who possessed a growing body of knowledge about mental illness. Despite the possession of specialist skills, 'alienists' remained a fragmented group who operated in the isolation of their institutions. They lacked a cohesive identity, there was no clearly marked route of education and training, and they did not possess autonomy over the practices of their 'trade'.

At this early stage of development, the basic criterion that determined a profession was missing, but alienists were at least beginning to develop a sense of professional consciousness and self-awareness. This chapter will explore the evolution of psychiatry²²⁵ during the nineteenth-century and its eventual emergence as an

²²⁴ A. Scull, 'From Madness to Mental Illness: Medical Men as Moral Entrepreneurs', *Archives Europeenes De Sociologie*, vol.16 (1972), pp.223-224.

²²⁵ It is acknowledged that psychiatry was not a recognised term in the nineteenth-century and that 'psychological medicine' was more frequently utilised to describe the study and practice of insanity. However, to avoid confusion over the use of terminology, from this point on the word psychiatry will be adopted when referring to the medical specialty that dealt with mental illness and the insane.

organised profession, albeit still in its infancy.²²⁶ It will look at how alienists sought to elevate their status and validate claims of expertise by means of education, practical observation, publications and the creation of a professional organisation. Within this discussion particular attention will be paid to the development of knowledge and any notable changes in attitude and practice that resulted. The second part of the chapter is concerned with the profession's attitude towards risk and suicide. It will focus on the assimilation of suicide in to psychiatry's domain and consider how, and indeed if, the development of the profession reaped any significant benefits for the prevention and management of suicide.

The medical profession and insanity

Nineteenth-century British society was characterised by a transformation in social structure and what Perkin termed 'the rise of professional society'.²²⁷ There was an expansion in sectors, such as commerce and manufacturing, but it was amongst the knowledge-based professional classes that the most notable growth occurred. Knowledge became a valuable resource by which organised professions could assert their specialised expertise and secure recognition for their skills. The rise of psychiatry as a recognised profession is one example of a much broader phenomenon. Medical practitioners were also engaged in their own struggle to raise the respectability and status of the medical profession as a collective organisation. Many practitioners were keen to distance themselves from the study and practice of

²²⁶ By the close of the nineteenth century the psychiatric profession had transformed in several ways but it still remained a marginal medical specialty. Internal division, public distrust and stigmatization continued to impede the profession's development into the early decades of the next century. For further discussion of psychiatry's professional status at the end of the nineteenth century see Scull, MacKenzie and Hervey, *Masters of Bedlam*, pp.268-274.

²²⁷ Perkin, *The Rise of Professional Society*.

mental health, which they continued to perceive as a peripheral subject within medicine. It was important that medicine did not align itself too closely to the stigmatised subject of insanity since there were, as Irvine Loudon stated, two related aspects to the status of the general practitioner.²²⁸ First, he had to consider his 'status in the eyes of his fellow practitioners and, secondly, in the eyes of society as a whole'.²²⁹ In both instances the general practitioner's status was likely to be weakened if he was associated with the treatment of the insane. Despite the desire to maintain a safe distance, it was impossible for a practitioner to avoid all contact with the mentally afflicted. Before embarking on a discussion of the professionalisation of psychiatry, it is worth considering the role general medical men played in preventing and treating suicidal lunatics outside of the asylum. It is important to determine under what circumstances they dealt with suicidal behaviour, and their perception of psychiatry.

As the professional classes rose to prominence throughout the nineteenth century, it was medicine that evolved most rapidly to become a recognised profession. Intrinsic to this change was the increased attention paid to education, particularly the development of teaching hospitals and universities with departments of medicine. These two arenas of education provided medical students with a range of lectures, demonstrations, dissections and an opportunity to walk around the wards of the hospital. Unfortunately, the majority of general practitioners ended their studies unfamiliar with the basic rudiments of mental illness. A lack of knowledge and

²²⁸ The term general practitioner emerged in the early decades of the nineteenth century and referred to community doctors who could be either a physician, surgeon or apothecary. For a comprehensive discussion of the rise of the general practitioner see I.Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford, 1986).

²²⁹ *Ibid.*, p.189.

experience hampered their efforts, but general practitioners were also held back 'by their conception of their professional province'.²³⁰ The medical profession failed to take sufficient interest in the treatment of insanity and as a consequence practitioners were ill-prepared to detect and treat mental illness.

Some practitioners received a limited amount of formal instruction on insanity, but this did not provide familiarity with the early stages of mental illness when the condition was hard to detect. Conolly attested to this omission in the medical curriculum declaring that,

Not only in pauper practice, but in practice generally, the treatment of the insane is conducted, often for the first two or three months, always for the first two or three weeks, by medical men engaged and skilful in general practice, but unpractised in these severe forms of cerebral disorder, and disconcerted and alarmed by their occurrence among their patients.²³¹

Apprehension also characterised the general practitioner's response to suicidal patients. Regardless of medical training, general practitioners, on the whole, did not possess a strong, professional inclination towards the identification of suicidal tendencies.²³² Since medical opinion closely associated insanity with suicide, it is possible that practitioners did not consider it their duty or responsibility to detect and

²³⁰ Anderson, *Suicide in Victorian*, p.384.

²³¹ Conolly, *The Treatment of the Insane*, pp.279-280.

²³² Anderson, *Suicide in Victorian*, pp.381-382.

prevent self-destruction in all cases; this was for the expertise of the emerging psychiatric profession.

General practitioners usually came into contact with suicidal patients when they were called to attend someone following a suicide attempt. In this situation the practitioner was concerned with administering routine medical treatment. He was not there to determine symptoms of insanity or attribute the suicide attempt to mental illness. He was expected to treat bleeding from cuts and deal with incidents of poisoning, asphyxiation and drowning. His general medical skills were urgently needed after a suicide attempt and it was this practical role, and not suicide prevention, that characterised the general practitioner's interaction with suicidal patients.

The psychiatric profession

In connecting ourselves with lunacy we are almost compelled to share the seclusion of our patients. Certainly we have to renounce our chances of many posts of professional distinction.²³³

The biggest obstacle to the professionalisation of psychiatry was the stigma associated with insanity and the insane. Those associated with the treatment of the insane were often subject to the same taboo as the patients for whom they cared. Bucknill acknowledged that alienists sacrificed 'the good-will of the community...because the public extends its unreasonable antipathy to the insane, to

²³³ W.H.O Sankey, 'Presidential Address', *JMS*, vol.14 (1868), p.297.

all those connected with insanity'.²³⁴ The position of alienists was made even more tenuous by the lack of respect they obtained from other branches of medical science. By mid century, psychiatry was still perceived as inferior and alienists were considered 'Levites among our medical brethren'.²³⁵ Sankey claimed that 'we cannot look to them for support, for they do not understand us'.²³⁶ Medical men entrusted with the treatment of insanity were professionally isolated for two reasons. Firstly, their area of expertise was a fringe subject within medicine and, secondly, the participation of lay persons in the care of the insane undermined claims of medical expertise and jurisdiction.²³⁷

As previously argued, professions are defined by their dominance of a specialized service market and the unique, scientifically-based knowledge that allows them to assert ownership over the marketplace. This was the position that alienists desired and endeavoured to achieve for themselves. They understood that professionalisation could only be realised if alienists made a collective effort to establish professional institutions and raise the status of their occupation by improving education and gaining greater autonomy.²³⁸ They needed to establish a view of madness based on medical and scientific reasoning and to succeed in gaining widespread acceptance of it. The latter of these was vital to the establishment of professional autonomy because it allowed alienists to assert their superiority over competing lay groups. Scientific explanation and evidence from

²³⁴ J.C. Bucknill, 'Presidential Address', *JMS*, vol. 7 (1860), p.6.

²³⁵ Sankey, 'Presidential Address', p.299.

²³⁶ Ibid.

²³⁷ Lay persons such as the Tukes at the York Retreat and Thomas Bakewell, proprietor of the Spring Vale private asylum, were prominent in the early nineteenth century.

²³⁸ I. Waddington, *The Medical Profession in the Industrial Revolution* (Dublin, 1984), pp.178-179.

patient observation was a valuable resource to promote public belief in the efficacy of alienists to diagnose and treat the mentally afflicted.

Autonomy is emphasised within the process of professionalisation, but psychiatry in its early stages was to a large extent still dependent upon the state.²³⁹ Without government acceptance of its responsibility to provide medical care for the insane psychiatry's professional position remained weak. Medical claims required statutory endorsement and alienists needed to be acknowledged, by the state, as the accepted and rightful body to preside over the treatment of the insane. The first significant piece of lunacy legislation passed in the nineteenth century was the 1808 County Asylum Act. The act stipulated that asylums should 'afford a Probability of the Vicinity of constant Medical Assistance'.²⁴⁰ The role of medical men was subtly acknowledged, but at this early stage in asylum reform and regulation their participation was still peripheral.

With the passing of the Madhouse Act of 1828, the asylum doctor was able to cultivate a solid position for himself in the treatment of mental illness. The Act introduced specific requirements pertaining to medical attendance. It was necessary for each asylum to arrange for a doctor to make weekly visits to all patients and for him to sign a Weekly Register. When more than a hundred patients were housed in

²³⁹ State endorsement was extremely important in cementing the position of alienists but it should be noted that a number of mad-doctors had successfully established themselves before the legislation of 1808. An association with voluntary lunatic hospitals and private practice enabled individuals such as William Battie, Thomas Arnold and John Monro to secure a position of authority. For further discussion on eighteenth-century lunacy provision see Andrews and Scull, *Undertaker of the mind: John Monro and mad-doctoring in eighteenth century England* (Berkeley, 2001), and Smith, *Lunatic hospitals in Georgian England, 1750-1830* (London, 2007).

²⁴⁰ Geo. III, Cap.96, Section XVI An Act for the Better Care and Maintenance of Lunatics, Being Paupers or Criminals in England, 1808.

an individual asylum, a medical superintendent had to be employed. The position of medical men at the centre of institutional care was later cemented by the 1845 Lunatics Act. The medical superintendent was now required to keep a Medical Visitation Book, a record of the treatment given to each patient in a Medical Case Book, an Admission Book, and a book in which to enter the cause of a patient's discharge or removal.²⁴¹ By 1845 alienists had been designated as the official experts in lunacy care; a position formally established by law. With the help of state endorsement, the asylum doctor had succeeded 'in restricting access to his clientele, and transforming his dominance of the treatment of mental illness into a virtual monopoly'.²⁴²

The asylum provided an institutional base in which alienists oversaw the day-to-day care of insane persons. This was a significant development in the drive for professional status, but it had to be consolidated and a greater measure of autonomy achieved. The emerging psychiatric profession was in an empowered position, but it still lacked a distinct identity, formal organisation of its members, and an outlet for expressing concerns and sharing knowledge. The establishment of the Association of Medical Officers of Asylums and Hospitals for the Insane in 1841, marked the birth of an organisation that aimed to represent the professional interests of alienists. The association was founded by Samuel Hitch, medical superintendent at Gloucestershire County Asylum. Hitch was aware that many medical superintendents felt isolated and detached from each other. In a bid to overcome

²⁴¹ For further discussion on the legal requirements laid down by nineteenth-century legislation see Jones, *A History of the Mental Health Services* (Part one) and Scull, *The Most Solitary of Afflictions*, p.231.

²⁴² Scull, *The Most Solitary of Afflictions*, p.230.

this, he issued a circular to the visiting physicians and medical superintendents of 26 asylums and hospitals in England that outlined the objectives of the new Association:

It having been long felt desirable that the Medical Gentlemen connected with Lunatic Asylums should be better known to each other – should communicate more freely the results of their individual experience...and, above all, should assist each other in improving the treatment of the Insane...several Gentlemen who have the conduct of Lunatic Asylums have determined on making an attempt to form 'An Association of the Medical Officers of Lunatic Asylums.'²⁴³

The Association's members were drawn from the medical staff of both private and public asylums. Although this prevented bias towards the interests of public institutions, division still existed between members of the respective sides. Scull attributes this to variations in the social status of the patients treated by the two sets of practitioners and the divergences of interest and opinion that arose between public employees and fee-dependent entrepreneurs.²⁴⁴ This created internal division that hampered the Association's efforts to unify its members. Several dormant periods of activity also impeded the organisation's effectiveness. After the 1844 annual meeting, the Association did not convene again until June 1847. Another gap then followed from 1847 until July 1851.²⁴⁵ There are no clearly stated reasons why the Association met infrequently during this period. It can be interpreted as an expression of the

²⁴³ S. Hitch cited in E. Renvoize, 'The Association of Medical Officers of Asylums and Hospitals for the Insane, the Medico-Psychological Association and their Presidents', *150 Years of British Psychiatry* (vol.1), p.36.

²⁴⁴ Scull, *The Most Solitary of Afflictions*, pp.232-233.

²⁴⁵ Renvoize, 'The Association of Medical Officers', pp.38-39.

fragmented and isolated nature of the Association's membership. Low attendance and periods of absence infer that alienists were pre-occupied with the running of their institutions and were still not fully committed to the Association and its activities.

To strengthen its position as a professional organisation and encourage communication among members, the Association needed an outlet for discussion in the form of a periodical. In Conolly's opinion, the formation of the Association was an indication of alienists' wish to share knowledge and unite the emerging profession,

for which the establishment of "The Asylum Journal"...affords every facility, by the diffusion of information, interesting and instructive to all readers whose duties whether medical, or magisterial, or general, have any relation to insane persons.²⁴⁶

Publication of the *Asylum Journal* commenced in November 1853 following a proposal at the Association's seventh annual meeting by William Ley (medical superintendent at Littlemore Asylum in Oxford). This was not the first periodical to be published on the subject of insanity. The *Journal of Psychological Medicine and Mental Pathology* appeared in 1848 under the editorship of Dr Forbes Winslow, the owner of two licensed houses in the Metropolitan area. The journal was published independently of the Association and reserved many of its pages for the discussion of matters relating to private asylums.²⁴⁷

²⁴⁶ Conolly, *Treatment of the Insane*, pp.340-341.

²⁴⁷ Scull, *The Most Solitary of Afflictions*, p.233.

The *Asylum Journal* provided the Association with much needed cohesion, extending and uniting its widely dispersed members. The journal raised the profile of psychiatry by conveying to a wide audience the expertise and knowledge being amassed by alienists. Keen to reinforce the profession's scientific credentials, the *Asylum Journal* became known as *The Journal of Mental Science*. The journal's original title was perceived as too modest. By introducing a new title, members of the Association professed 'that we cultivate in our pages mental science of a particular kind...as appertains to medical men who are engaged in the treatment of the insane.'²⁴⁸ The journal's existence made it abundantly clear to the medical profession that advances were being made in the understanding of insanity as a disease and treatment methods. These benefits prompted Bucknill, the journal's editor, to declare that the periodical formed the 'centre of our vitality'.²⁴⁹

The Association's standing was bolstered by the introduction of its own periodical, but in 1865 the decision was made to change its name. The Association of Medical Officers of Asylums and Hospitals for the Insane became the Medico-Psychological Association. Edward Renvoize attributes this change to members recognising that the Association's role had to be strengthened, and its expertise should extend outside the confines of the institutional environment.²⁵⁰ Membership was subsequently made available to all legally qualified medical men who were interested in the study and treatment of insanity. The Medico-Psychological Association continued to operate with the same objectives as its predecessor, but they were pursued with greater confidence

²⁴⁸ Anon, 'What's in a name?', *JMS*, no.37 (1861), p.137.

²⁴⁹ Bucknill, 'Presidential Address', pp.4-5.

²⁵⁰ Renvoize, 'The Association of Medical Officers', p.41.

and vigour. The importance of changing the Association's title and the expectations this raised were outlined by W.A.F. Browne in his Presidential address of 1866:

We can no longer be mistaken for a mere friendly club or a mutual defence society. We may now claim as among our objects the investigation of all subjects bearing upon the science of mind in connection with health and disease...We claim an even wider, almost universal range for the science of Medico-Psychology, and we claim for it a distinct position in science.²⁵¹

The establishment of the Association of Medical Officers of Asylums and Hospitals for the Insane had proven a missed opportunity since it was never fully exploited as a self-governing body. The frustration that arose from this failing prompted leading alienists to establish an Association that was competent and firmly committed to the advancement and professionalisation of psychiatry. Sankey claimed that 'Unless we place our own case before the public it is more than probable that it will remain unknown'²⁵²; the Medico-Psychological Association was one way of achieving this.

Professionalisation was as much dependent on the efforts of medical men themselves as it was on changes in the 'wider structure of society which provided the structural conditions favourable to the emergence...of medicine'.²⁵³ Alienists had to play a leading role in the evolution of psychiatry because it was from their performance and persona that the profession's image was largely derived by outsiders. Publications on

²⁵¹ W.A.F., Browne, 'Presidential Address', *JMS*, vol.12 (1866), pp.309-327.

²⁵² Sankey, 'Presidential Address', p.299.

²⁵³ Waddington, *The Medical Profession in the Industrial Revolution*, p.179.

the subject of insanity provided an ideal opportunity for alienists to engage with a wide audience and to disseminate the knowledge and theories they had developed based on clinical experience. These works also give an insight into the profession's perception of itself. Alienists frequently used the preface or introduction of their work to acknowledge that the subject of insanity deserved greater investigation. It was hoped and intended that the publication would make a significant contribution to the understanding of insanity. In the introduction to *Cases of Mental Disease*, Alexander Morison made clear his intention:

The information we possess respecting the clinical treatment of mental diseases being very limited, I have been induced to add a little to it by this elementary publication, the object of which is to contribute towards supplying that deficiency, by presenting to students a collection of cases of ordinary occurrence.²⁵⁴

Alienists realised that the acquisition of expert knowledge was a vital resource in the professionalisation of their occupation. They knew it was important to substantiate claims of expertise with theoretical understanding and practical based observation. When a publication was informed by empirical evidence, the alienist could support his hypotheses and conclusions with specific case examples. Slade Knight, house surgeon and superintendent at Lancaster County asylum, stated in the preface to his work, *Observations on the Causes, Symptoms, and Treatment of Derangement of the Mind*, that:

²⁵⁴ A. Morison, *Cases of Mental Disease with Practical Observations on the Medical Treatment* (London, 1828), p.1.

the following pages are founded on the notes and observations, the result of a personal examination of the Symptoms of Insanity, in the cases of about seven hundred lunatics, and which examinations were carefully made, and very frequently repeated during the progress of treatment.²⁵⁵

Alienists made effective use of their practical experience to legitimise the knowledge and skills they claimed to have acquired. Their constant 'intimacy with the modifications of both physical and mental phenomena'²⁵⁶ imparted to them an extensive understanding of insanity and its treatment. This separated alienists from the general medical profession who received an education that barely touched upon the subject of insanity.

Few doctors in the nineteenth century, including medical superintendents in county asylums, had received either undergraduate or postgraduate training in psychiatry. Alienists were acutely aware that this down-graded the profession's credibility and individual claims of expertise. If the public's perception of psychiatry was to improve then it was essential that alienists received comprehensive training. Medical men who wished to study insanity had very few opportunities of doing so and 'of preparing themselves for its treatment, in the same manner in which they prepare themselves for the treatment of other disorders'.²⁵⁷ Conolly claimed that the medical student never saw a case of insanity during the term allotted to medical study. Although students had

²⁵⁵ Slade Knight, *Observations on the Causes, Symptoms, and Treatment*, preface (i).

²⁵⁶ Conolly, *Treatment of the Insane*, p.376.

²⁵⁷ J. Conolly, *An Inquiry Concerning the Indications of Insanity* (London, 1830), p.2.

access to hospital wards, 'every lunatic is closed to him; he can study all diseases but those affecting the understanding'.²⁵⁸

Alexander Morison recognised that medical men involved in the treatment of the insane needed to be fully acquainted with 'mental manifestations in a state of health, as well as disease'; this he deemed indispensable.²⁵⁹ In 1823, Morison ventured to present a course of lectures, covering the principal topics connected with insanity. He was encouraged by the belief, 'that well meant endeavours, which might eventually contribute to the advancement of a difficult branch of science, would be received with indulgence'.²⁶⁰ An annual series of between eleven and eighteen lectures was established, first in Edinburgh, followed in 1826 by a similar course in London. Morison acknowledged that he had:

not hesitated to borrow from books, or to make use of the observations of others; my object being to convey useful information to those to whom it is to be supposed the subjects are new. At the same time I would add, that most if not all of the facts and observations detailed, have been verified by my own experience.²⁶¹

Morison subsequently published an associated textbook that ran to four editions between 1825 and 1848. Together with the lecture series, it marked the first significant attempt to provide students with a practical guide to the numerous forms of mental

²⁵⁸ Ibid.

²⁵⁹ A. Morison, *Outlines of Lectures on the Nature, Causes, and Treatment of Insanity* (London, 1848), p.1.

²⁶⁰ Ibid., p.3.

²⁶¹ Ibid.

disorder. Morison's lecture series and textbook provided an opportunity for self-promotion, but his actions also prove that alienists were active in the evolution of their profession. He recognised the value of teaching and the prestige that psychiatry could gain from advances in education, especially clinical demonstration.

In the 1850s, thirty years after Morison's lectures, the study of insanity remained a non-essential part of a medical education. This state of affairs was a matter of concern to Thomas Green, the medical superintendent at Birmingham Borough Asylum. He was dissatisfied with the attention awarded to insanity and proposed to:

give a series of clinical lectures at the asylum, on one or two days in the week, for about three months in the year – each lecture, with the preliminary visit to these patients on whose cases it is intended to comment, to occupy about an hour.²⁶²

Green declared that there was no provision made for the study of insanity in any of the major medical schools. To compensate, he suggested that students who were keen to acquire an insight into the treatment of insanity should embark on a residence in a large asylum. By accompanying the medical superintendent on his daily rounds, and assisting in his medical duties, the student would be afforded 'a most valuable opportunity for improvement'.²⁶³

Nineteenth-century alienists were pre-occupied with securing a recognised professional position for their occupation. They worked consistently to obtain a

²⁶² BCA, MS344/2/1, Monthly Report, September 1852.

²⁶³ Ibid.

competent knowledge of insanity, promote discussion on the subject via publication and establish a collective identity by forming a professional organisation. These developments represent the educational and structural modifications that psychiatry needed to undergo as part of its drive to become a profession, but its evolution can also be charted by looking at the changes that occurred on a practical level within the asylum. As the century progressed, further investigation into mental illness and empirical observation facilitated a change in attitude towards institutional care, treatment methods and the role of asylum staff. Institutional experience allowed alienists to become better acquainted with the symptoms and treatment of insanity. This enabled them to refine their theories, advance new ideas and promote the efficacy of a somatic as opposed to psychological approach to mental illness.

Changing attitudes to asylum care and treatment

From the early to late nineteenth century public and professional perceptions of the asylum changed as the reality of institutional provision necessitated a re-evaluation of the asylum's function. The rise of the public asylum was an important development in both lunacy reform and the emergence of a psychiatric profession. Reformers and alienists had to persuade the public that institutional care provided the best chance of cure and recovery for the insane. At the heart of this pro-institutional ideology was the promise of medical expertise and an environment in which humane care would restore large numbers of lunatics to sanity. Reformers' efforts to reshape attitudes towards insanity and promote asylum treatment coincided perfectly with psychiatry's own professional objectives. Families needed to be convinced that the asylum was preferable to domestic care or the workhouse. Leading reformers endeavoured to do this by contrasting an idealised image of the asylum with the abuse and maltreatment

that often characterised private or domestic provision. By itself, this claim was not sufficient to persuade the public because it emanated from a predominately lay body. The public wanted to be reassured that asylums were places of treatment and not punishment. In Scull's opinion this required an 'elaborate ideological justification' of institutional care that provided alienists with the 'necessary material from which the self-image of expertise can be constructed'.²⁶⁴

The image of the asylum as a curative institution was not just a propaganda creation. Alienists genuinely perceived the asylum as a place of cure and actively pursued this objective in their work. The leading principle of Rainhill asylum, like other institutions, was:

to aid the recovery of the curable; and, as a point of scarcely less importance, to make the incurable as happy and comfortable as their condition permits. No other system of management would accord with the present humane and enlightened views of the care and treatment of the insane.²⁶⁵

The cure of insanity was dependent on effective patient management and treatment. This could only be provided by those who had extensive practical experience. It was this thesis that alienists developed and stressed to the public and other medical professionals. They emphasised that care in the home was unlikely to bring recovery because the domestic environment usually nurtured the patient's affliction.

²⁶⁴ Scull, *The Most Solitary of Afflictions*, pp.136-138.

²⁶⁵ LRO, M614 RAI/40/2/26, Annual Report of the County Lunatic Asylum at Rainhill (1856), p.46.

The importance of obtaining medical assistance was stated by eminent alienists such as Burrows, Haslam and Maudsley.²⁶⁶ They insisted that removal to the asylum was vital in the treatment of the insane and that it should be enforced as soon as signs of insanity became apparent. Haslam recommended early confinement on the basis that:

During his continuance at his own house he can never be kept in a tranquil state. The interruptions of his family, the loss of the accustomed obedience of his servants, and the idea of being under restraint, in a place where he considers himself the master, will be constant sources of irritation to his mind²⁶⁷

He acknowledged that the chance of a patient recovering was 'increased by his being subjected to medical treatment at the commencement of his disorder'; this was a fact confirmed by his own experience.²⁶⁸ Yet, it remained that many cases of insanity often failed to come 'under the care of those specially qualified by their experience to treat it' until the disease had become firmly established.²⁶⁹

The professional standing of psychiatry and the efficacy of the asylum were intimately bound with the promise of expert treatment and high cure rates. However, during the second half of the nineteenth century it became apparent that these claims were unrealistic and increasingly unsustainable. Early ideals of cure and

²⁶⁶ Burrows, *Commentaries on the Causes*, p.454; J. Haslam, *Observations on Madness and Melancholy*, (London, 1809), p.308; H. Maudsley, *The Physiology and the Pathology of Mind* (London, 1867), p.432.

²⁶⁷ Haslam, *Observations on Madness*, p.308.

²⁶⁸ J. Haslam, *Considerations on the Moral Management of Insane Persons* (London, 1817), p.2.

²⁶⁹ *Ibid.*, p.432.

recovery had to be abandoned as asylums evolved into mammoth institutions housing unimaginable numbers of insane persons. The asylum was no longer considered a place of curative treatment, instead it was a refuge for the incurable, who required little medical skill. The continued retention of chronic cases lowered cure rates and forced medical superintendents to redefine their success in relation to patient comfort, cleanliness and institutional efficiency. This reversal in priorities was blamed partly on the failure to secure sufficient cases of incipient insanity. Medical superintendents argued that their techniques were less effective once the condition had taken hold. The build up of chronic cases and increasing size of asylums encouraged a drift towards custodialism and the virtual abandonment of curative pretensions. Public and professional attitudes transformed as the 'spectre of chronicity' came to 'haunt the popular imagination...and to dominate Victorian psychiatric theorizing and practice'.²⁷⁰

The majority of alienists were prepared to reconcile themselves to their new task as managers of predominately custodial institutions, but some were unwilling to accept this position. A minority of prominent alienists, including Bucknill, Lockhart Robertson, and Maudsley, chose to speak openly about the flaws that existed in the asylum system. The belief that insane persons should be immediately removed from the home was once an accepted truth, but the deteriorating cure rate prompted Bucknill to question its legitimacy:

The author's fullest and latest experience has convinced him
that the curative influences of asylums have been vastly

²⁷⁰ Scull, *The Most Solitary of Afflictions*, p.272. For an extensive discussion of the accumulation of chronic cases and the growth of asylums see chapters six and seven.

overrated, and those of isolated treatment in domestic care have been greatly undervalued.

Bucknill developed his argument, claiming a broader knowledge of insanity would have proven that, in a significant number of cases, insanity ran for only a short period and recovery 'in domestic life with no great amount of treatment' was possible.²⁷¹ Bucknill's admission openly criticised institutional care and was potentially damaging to the professional status of psychiatry. Unabated criticism from one of the profession's most esteemed members seriously undermined the efficacy of asylum care and raised doubts about the knowledge and skills that alienists claimed to possess. By suggesting that domestic care could be beneficial, Bucknill challenged the established opinion that medical men were best equipped to treat the insane in a specialised institution; his negative view placed the professional status of psychiatry in a precarious position.

During the 1870s Maudsley emerged as one of the most vocal critics of asylumdom and its failings. He was disillusioned with institutional care and the therapeutics that it was supposed to offer. The transition from cure to custody meant the patient's individuality was neglected and 'he becomes one of the crowd, the majority of whom are not expected ever to get well'.²⁷² The disciplined and monotonous environment that characterised asylums was in Maudsley's opinion counter productive to the patient's condition:

The confinement, the monotony, the lack of interest and occupation, the absence of family relations, which are

²⁷¹ Ibid.

²⁷² H. Maudsley, 'Insanity and its Treatment', *JMS*, vol.17 (1871) p.327.

inevitable in the asylum,...more than counterbalance the benefit of seclusion. The patient has no proper outlet for his energies, and an outlet is made for them in maniacal excitement...he goes through recurrent attacks of that kind, and finally sinks into a state of chronic insanity.²⁷³

Maudsley was ardently critical of the over-crowded asylums that stemmed from indiscriminate committal and advocated the 'lessening of sequestration and increasing the liberty of them [the insane]'.²⁷⁴ The doctrine of wholesale institutionalisation was based on the principle that an insane person, 'by the simple warrant of his insanity, should be shut up in an asylum'.²⁷⁵ Maudsley opposed this lack of discrimination believing that:

The true principle to guide our practice should be this, _ that no one, sane or insane, should ever be entirely deprived of his liberty, unless for his own protection or for the protection of society.²⁷⁶

Maudsley's remarks were a devastating assault on his own profession. His scrutiny and criticism condemned the institutions on which alienists depended, to a large extent, for their professional status and legitimacy. Maudsley claimed his comments did not 'overlook the value of the skilled attendance and of the supervision which asylums furnish'²⁷⁷, but they still added considerable weight to the growing public and professional scepticism that surrounded the question of institutionalisation. It

²⁷³ Ibid., p.330.

²⁷⁴ H. Maudsley, 'On the Alleged Increase of Insanity', *JMS* (1877), p.54.

²⁷⁵ Maudsley, *The Physiology and Pathology*, p.424.

²⁷⁶ Ibid.

²⁷⁷ Maudsley, 'Insanity and its Treatment', p.327.

was no longer possible for asylum treatment to be justified on the basis of cure, so alienists rallied to promote the notion of protection and social order. Alienists' claims of medical expertise and specialist knowledge were significantly undermined by this admission, making it necessary to cultivate a new attitude towards the asylum in which the expertise of the alienist lay in his ability to contain and manage rather than cure the afflictions of the insane.

Efforts to establish psychiatry as a branch of medical science also rested on the development of specific medical treatments and the cultivation of a medical model that classified insanity as a disease. Unfortunately, alienists were immediately disadvantaged by the subject they chose to study and practice. Psychological medicine was concerned with the workings of the mind, an abstract immaterial instrument that did not allow a physiological interpretation of its function. To justify claims that insanity required medical treatment alienists needed to prove that mental illness was a disease which operated through the material organ of the brain.²⁷⁸ Sir Andrew Halliday was most specific when he argued that:

The mind itself, being immaterial, can only manifest its existence to the external world, by means of material instruments; and taking it as a fact...that the brain is the instrument...it must follow that in proportion as these instruments...have become deranged, disordered, or diseased, so, in proportion, will the manifestations of the mind.²⁷⁹

²⁷⁸ Morison, *Outline of Lectures*, pp.35-37.

²⁷⁹ Sir A. Halliday, *A General View of the Present State of Lunatics and Lunatic Asylums in Great Britain and Ireland* (London, 1827), p.5.

Halliday believed that had the profession's 'attention been directed to this view...our list of cures would have been more numerous than they have yet been'.²⁸⁰ A somatic-pathological approach to insanity would reinforce medical claims and enable psychiatry to place itself within the province of the medical profession. Alienists' authority and expertise would also be validated if it was established that insanity had a physical aetiology and was diagnosed and treated as a disease.

The transition from a psychological to physiological paradigm of insanity took place, according to Michael Clark, during the last four decades of the nineteenth century.²⁸¹ He argues that this period was 'characterised by a growing preponderance of somatic-pathological approaches' and a tendency 'to disparage any kind of "psychological" approach to the problems of mental illness'.²⁸² When surveying the work of alienists writing in the later nineteenth century, such as Bucknill and Maudsley, it is clear that they rejected psychological approaches on the basis that they were unscientific. Yet similar opinions were expressed by alienists in the first half of the century. Burrows, Conolly, Ellis and Knight all discussed the need for insanity to be recognised and investigated as a bodily disease.²⁸³ This suggests that the shift from a psychological to physiological approach commenced sooner than Clark infers. The efficacy of psychological approaches was questioned from the early decades of the nineteenth century and continued to be scrutinised throughout the

²⁸⁰ Ibid., pp.5-6.

²⁸¹ M.J. Clark, 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry', in A. Scull (ed.) *Madhouses, Mad-Doctors and Madmen*. pp.271-312.

²⁸² Ibid., p.271.

²⁸³ Burrows, *Commentaries on the Causes*, p.9; Conolly, *An Inquiry Concerning*, p.15; Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity* (1838), p.13; Slade Knight, *Observations on the Causes, Symptoms, and Treatment* p.2.

period until a physiological explanation, based on medical investigation, was justified and accepted.

Amongst the moderns it [insanity] has more frequently been considered purely a mental disease, and requiring only moral remedies, though within the last few years, the doctrine of its being a bodily disease seems again to prevail.²⁸⁴

Ellis' assertion was certainly supported by the works of his contemporaries. A few years earlier, in 1827, Slade Knight declared his 'firm conviction, that in every case of deranged intellect the disease proceeds immediately from corporeal disorder'.²⁸⁵ Conolly shared in this enthusiasm stating that mental disorders were ascribed to bodily disease. He argued that insanity was not attributed to 'any specific corporeal disease, but to any disease capable of disturbing the functions, or impairing the structure of the brain'.²⁸⁶ Alienists used their publications as a forum for discussing and promoting their theories to a wider medical audience. They articulated their claims and theories in the form of coherent arguments, supported by empirical evidence and medical investigation. The literature alienists produced both emphasised and reinforced the transition from 'madness' as a psychological condition to a physiologically-based mental illness.

Adoption of a somatic or physiological viewpoint influenced interpretations of mental illness as an affliction and alienists' understanding of how the brain acted upon the functions of the intellect and emotions. W.A.F Browne recognised that:

²⁸⁴ Ellis, *A Treatise on the Nature*, p.13.

²⁸⁵ Knight, *Observations on the Causes*, p.2.

²⁸⁶ Conolly, *An Inquiry Concerning*, p.15.

From the admission of this principle, derangement is no longer considered a disease of the understanding, but of the centre of the nervous system, upon the unimpaired condition of which the exercise of the understanding depends. The brain is at fault and not the mind.²⁸⁷

Browne believed that the brain was susceptible to irritation and inflammation from which insanity was produced. If the irritation could be removed then the mind was capable of regaining its 'native strength, clear and calm'.²⁸⁸ It may have been the mind that was disordered, but Browne was quick to reinforce that 'it must and can only be traced directly or indirectly to the brain'.²⁸⁹ Ellis and Bucknill also identified the relationship between the nervous system and the activities and function of the brain. Ellis argued that the first sign of insanity was manifested by 'some injurious alteration either in the intellectual manifestations, or in the conduct, or both'.²⁹⁰ He considered the alteration in 'extreme cases, and most probably in all instances' to be accompanied by 'diseased organisation, or by diseased action in the brain'.²⁹¹ The primary cause of diseased action of the brain was over-exertion:

When the brain has been for too long a time intensely employed upon any subject, it is thrown into such a state of excitement that its operations are no longer under the control of the will: the incipient stage of insanity then commences.²⁹²

²⁸⁷ 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* (Edinburgh, 1837), p.4.

²⁸⁸ Ibid.

²⁸⁹ Ibid.

²⁹⁰ Ellis, *A Treatise on the Nature*, p.17.

²⁹¹ Ibid., p.24.

²⁹² Ibid., p.57.

If the diseased action remained unchecked then diseased organisation or a state of chronic insanity would follow. Impairment of the intellectual faculties featured in Bucknill's explanation of insanity as a disease. He concluded that insanity 'is a condition in which the intellectual faculties, or the moral sentiments...have their free action destroyed by disease, whether congenital or acquired'.²⁹³ Insanity resulted from a 'false action of conception or judgment...or an uncontrollable violence of the emotions'²⁹⁴ which were separately or conjointly produced by a disease in the brain.

Arguments for a somatic interpretation of insanity permeated contemporary discussions and literature, but it was not until the publication of Maudsley's work in the 1860s and 1870s that a formidable attack was launched on psychological approaches. *The Physiology and Pathology of Mind* was first published in 1867 and, as Scull notes, the title itself 'announced with characteristic aggressiveness Maudsley's uncompromising materialism'.²⁹⁵ The preface of the book outlined his conviction that mental phenomena should be treated as a physiological rather than a psychological condition. Maudsley was scathing in his attack on metaphysical explanations of insanity which he considered absurd and unscientific. Studies of the mind from a psychological approach were of no relevance in comparison to physiological and pathological investigations which proved more fruitful.

²⁹³ Bucknill and Tuke, *A Manual of Psychological*, p.78.

²⁹⁴ Ibid., p.79.

²⁹⁵ Scull, MacKenzie and Hervey, *Masters of Bedlam*, p.234.

Maudsley firmly believed that the brain was a bodily organ that interacted with and was affected by internal and external stimuli. The brain had a 'relation with external nature through the inlets of the senses' and also 'a relation with the other organs of the body through the nervous system'.²⁹⁶ Maudsley concluded that 'Life in all its forms, physical or mental, morbid or healthy, is a relation; its phenomena result from the reciprocal action of an individual organism and external forces'.²⁹⁷ Mental illness was produced when 'unfavourable action from without conspires with an infirmity of nature within'.²⁹⁸ The infirmity within usually emanated from a defect in the body's nervous system which created mental anxiety and initiated the onset of insanity. Once mental illness had taken hold the patient displayed apparent psychological symptoms which constituted the visible manifestations of the condition. Maudsley criticised this assumption, declaring that 'the features that provoked social intervention were, from the "scientific" point of view, purely epiphenomenal'. He classified them as 'mere surface reflections of the underlying morbid state of the brain and nervous system'.²⁹⁹ Maudsley remained resolute that, when a definitive explanation of insanity was formulated, it would come from a study of the brain and nervous system rather than the mental or psychological symptoms of the affliction. This he believed to be true on the basis that 'every phenomenon of the mind is the result, as manifest energy, of some change, molecular, chemical, or vital, in the nervous elements of the brain'.³⁰⁰

²⁹⁶ Ibid., p.21.

²⁹⁷ Ibid., p.199.

²⁹⁸ Ibid.

²⁹⁹ Cited in Scull, MacKenzie and Hervey, *Masters of Bedlam*, p.235.

³⁰⁰ Maudsley, *The Physiology and Pathology*, p.39.

Growing acceptance of a somatic viewpoint had implications for treatment practices, as well as the understanding of mental illness as a disease. Treatment had to be prescribed with the intention of removing those bodily conditions which stimulated and sustained the patient's insanity. It was firmly held that medical treatment should restore the body's equilibrium as an improvement in physical health alleviated mental disorder. Bucknill outlined three objectives that were to be kept in view when medical treatment was administered:

To obviate any general derangement or diseased condition of the system...To remove the pathological condition of the brain, whether consequent upon, or independent of, general physical disturbance...To treat urgent and dangerous symptoms.³⁰¹

With these objectives in mind, alienists utilised physical treatments that were intended to soothe the body and calm the mind. Cold and warm baths often featured in the treatment of mania and melancholia. Robert Gardiner Hill, formerly house surgeon at Lincoln Asylum, asserted with confidence that there 'can be no doubt that baths, judiciously applied, are very useful, allaying irritation, and procuring sleep; especially the warm and shower bath together'.³⁰² The technique adopted by Hill was immersion of the body:

in warm water in one of the ordinary baths, and then, having a vessel of cold water at hand, to apply it to the head by means of the hand shower-bath...In this way you may apply any

³⁰¹ Bucknill and Tuke, *A Manual of Psychological*, p.470.

³⁰² R. Gardiner Hill, *A Concise History of the Entire Abolition of Mechanical Restraint in the Treatment of the Insane: A Lecture on the Management of Lunatic Asylums and the Treatment of the Insane, Delivered at the Mechanics Institution, Lincoln, on the 21st June, 1838* (London, 1839), p.70.

quantity of water without danger to the patient, or without occasioning pain.³⁰³

The beneficial effects of the warm bath were also supported by Harrington Tuke. He considered the treatment to be a valuable 'means of promoting general health'.³⁰⁴ The warm bath was capable of calming maniacal fury or soothing the anguish of melancholia. Depending on the patient's condition, a warm bath 'will act either as tonic or as a depressant, as a sedative or as a stimulant'.³⁰⁵

The body's constitution was also targeted by medical and physical treatment. Until the mid-nineteenth century bleeding, emetics and purgatives were widely employed to cleanse and re-balance the body. The abstraction of blood often divided opinion because practitioners were unable to accurately determine whether it was more harmful than beneficial. Slade Knight approached the issue with caution, suggesting that its application was most appropriate when 'the patient is strong, and of a plethoric habit, and where the disorder has not been of any long continuance'.³⁰⁶ Under these circumstances, he found bleeding 'to be of considerable advantage, and as far as I have yet observed is the MOST BENEFICIAL REMEDY that has been employed'.³⁰⁷ In cases of mania when the patient was in danger of exhaustion, Thomas Mayo believed that depletion 'has a direct effect in weakening him, AN INDIRECT EFFECT IN PREVENTING HIS WEAKNESS, by lessening excitation'.³⁰⁸

³⁰³ Ibid., p.71.

³⁰⁴ H. Tuke, 'On Baths in the Treatment of Insanity', *JMS*, vol.5 (1858) p.106.

³⁰⁵ Ibid., 108.

³⁰⁶ Slade Knight, *Observations on the Causes, Symptoms and Treatment*, p.43.

³⁰⁷ Ibid.

³⁰⁸ T. Mayo cited in Slade Knight, *Observations on the Causes, Symptoms, and Treatment*, p.43.

Whether general or local bleeding was administered, the amount of blood to be removed needed to be regulated by circumstances specific to the patient. According to Burrows 'the strong and the weak, difference of sex, constitutional varieties, the highly and the moderately excited, all demand consideration, and required different measures'.³⁰⁹

The therapeutic effect of emetics and purgatives courted divided opinion. In Joseph Mason Cox's opinion, the use of emetics and purgatives to induce vomiting 'takes the precedence of every other curative means' by removing the stomach of impurities.³¹⁰ Castor and croton oil were commonly prescribed purgatives that relieved congestion in the stomach and bowels and often aided the patient's recovery. As well as their cleansing properties, emetics and purgatives were considered to be cathartic and capable of calming the agitated or excited behaviour often exhibited by patients afflicted with mania. The tranquilising effect caused a reduction in the patient's energy levels, bringing respite to the patient's bodily and physical health. The emphasis that early nineteenth-century practitioners placed on the value of emetics and purgatives gradually subsided so that their use became minimal rather than central in medical treatment and therapeutics.³¹¹

The status of medical men involved in the treatment of the insane and the medical model they had established was for a time, during the early to mid-nineteenth century, challenged by the ideas of moral treatment. Under a moral regimen, the

³⁰⁹ Cited in V. Skultans, *Madness and Morals. Ideas on Insanity in the Nineteenth Century* (London, 1975), p.110.

³¹⁰ Cited in Smith, *Cure, Comfort and Safe Custody*, p.198.

³¹¹ *Ibid.*, pp.198-199.

patient was to be treated with kindness and humanity in an environment that encouraged him to reassert the power of self-control.³¹² Moral treatment attempted to effect cure by focusing on the patient's psychology and mind. The moral paradigm rejected standard medical and scientific responses to mental illness. It undermined alienists' claims to possess expert medical skills and threatened the foundation on which psychiatry was building its professional status. However, Scull believes that the challenge moral treatment posed to medical dominance was in reality not as threatening as first perceived. The term 'moral treatment' whilst 'profusely and empirically employed', was little understood. Bucknill struggled to conceptualise moral treatment declaring:

It may be easy to say what is not moral treatment, but it is by no means so, for the physician of an English asylum to say in what this treatment really does exist...If the English physician looks to the writings of his countryman for some description of that moral treatment with which they boast to have replaced the barbarisms of mechanical restraint, he finds little more than vague generalities.³¹³

Although Bucknill was uncertain of moral treatment's efficacy he did not disregard its relevance in the treatment of insanity. Instead, he proposed a cautious and considered approach to its use. He stated that when applying moral treatment it was important 'to discriminate correctly between that part of wrong conduct which

³¹² Moral Treatment and its therapeutic value in the care of suicidal patients will be discussed extensively in Chapter four.

³¹³ Bucknill and Tuke, *A Manual of Psychological*, p.507.

patients are able, and that which they are unable to control'.³¹⁴ The conduct patients were unable to control included the most violent and dangerous manifestations of insanity. Bucknill classified such behaviour as 'the expression of pathological states of the brain' that must 'be resisted solely by physiological and pharmaceutical means'.³¹⁵

The vague generalities that defined moral treatment made it easier for medical men to absorb the technique into their jurisdiction. The lay therapists who cultivated moral treatment did not formulate a coherent, alternative, non-medical model that was rooted in abstract knowledge. The therapeutic techniques proposed in moral treatment were not intended to act directly as a cure but rather 'assist Nature, in the performance of her own cure'.³¹⁶ This modest approach lacked the promise of active intervention and was less appealing than the claims being made by medical men. Moral treatment was left 'vulnerable to assimilation by a medical profession less scrupulously modest in its claims'.³¹⁷ Moral treatment was a non-medical technique, but those who promoted it chose to employ terms such as 'patient' and 'illness' that were obviously borrowed from medicine. Medical connotations allowed alienists to suggest that moral treatment rightly belonged to their field of expertise. It enabled them to advocate a combination of medical and moral treatment, but within this eclectic approach moral treatment assumed a position that was secondary to the superiority of medical treatment. Bucknill was clear that 'in cases of confirmed

³¹⁴ Ibid., p.511.

³¹⁵ Ibid.

³¹⁶ S. Tuke, *Description of the Retreat* (York, 1813), pp.216-217.

³¹⁷ Scull, *The Most Solitary of Afflictions*, p.200.

insanity “moral agencies” properly so called, possess but limited efficacy in its treatment’.³¹⁸

Changing attitudes to risk and suicide

However various may be the opinions regarding the mental state of suicides, there is no practical dissent from the acknowledgement of the desirability of preventing the commission of suicide.³¹⁹

Suicide prevention was one of the most important duties assigned to medical superintendents and their staff. Preventing acts of self-destruction was a priority for asylum authorities and medical staff alike, as any failures were subject to criticism and investigation. Asylum staff were also motivated by a desire to prevent suicide for its own sake, to prevent harm and suffering to patients. Rates of suicide, like those of cure, were a means of assessing asylum care and the effectiveness of individual institutions’ prevention techniques. Conolly recognised that the management of suicidal cases involved many important considerations and as a consequence should engage the ‘best attention of the practitioner’.³²⁰ He advocated a psychiatric profession that possessed both scientific credentials and ‘a practical art, of which the great object is to prevent the effects of disordered actions’.³²¹ Conolly was not alone in his belief; suicide prevention appeared as a recurrent theme in contemporary

³¹⁸ Bucknill and Tuke, *A Manual of Psychological*, p.454.

³¹⁹ Westcott, *Suicide Its History*, p.167.

³²⁰ Conolly, *An Inquiry Concerning*, p.256.

³²¹ *Ibid.*

discourse. By developing a culture of prevention within asylums, the number of completed suicides would, at least theoretically, be kept to a minimum. This success could then be attributed to alienists' growing experience and expertise in the management of suicidal behaviour.

Suicide prevention demonstrated that alienists' skills were diverse and extended beyond a medical understanding of insanity and the treatment of its various forms. Their apparent ability to manage the behaviour of a demanding patient group further raised the status of psychiatry. This was reflected by the growing prominence of suicide prevention in contemporary discourse and the day-to-day running of institutions. Alienists were aware that acts of suicide were subject to scrutiny by the Lunacy Commission and often gained public attention in the local press. They recognised that their professional standing could gain gravitas if suicide prevention proved successful and a consistent pattern of low suicide rates was maintained. This would substantiate claims that the asylum was a safe haven for suicidal lunatics because alienists were skilled in the 'practical art' of suicide prevention.

The early removal of insane persons from their domestic setting was, as already discussed, a prominent theme in the work of nineteenth-century alienists. It was believed that suicidal lunatics should be isolated from the environment and people who exacerbated their suicidal propensity.³²² Burrows stated that the 'only removal in the first instance to be recommended, is from the place where the patient has been

³²² John Haslam believed that separation from family and friends was particularly important when the individual was suffering from melancholia, a condition frequently associated with suicidal behaviour. Haslam, *Observations on madness and melancholy*, pp.308-309.

living'.³²³ He substantiated his argument by claiming that a propensity to suicide, 'like the access of mania and melancholia...is then comparatively responsive to medical aid'.³²⁴ For Westcott, the presence of a suicidal propensity made early removal essential:

I have only to insist on the urgent necessity that exists for the immediate removal from society of any person exhibiting mind failure, who shows any tendency to self destruction...no time should be lost in commencing the care and treatment of a lunatic.³²⁵

Westcott's emphasis on the patient's 'removal from society' is indicative of alienists' presentation of the asylum as a safe haven. Despite the secularisation of suicide and its increasing association with insanity, self destruction still brought a significant degree of stigmatization to the individual and their family. Members of the psychiatric profession were aware of the advantage they could derive from marketing institutional care as a solution to the fears and concerns experienced by families when a relative displayed suicidal behaviour. The idea that the asylum was a caring environment in which patients were protected from their own destructive behaviour encouraged public acceptance of institutional care and the efficacy of the psychiatric profession. Patient protection was an important objective for any institution. Suicide prevention was dependent on strict surveillance, foresight, and restrictions on patient activity; it did not entail direct medical intervention. It was a practical skill that added to, and enhanced, the expertise already developed by alienists.

³²³ Burrows, *Commentaries on the Causes*, p.454.

³²⁴ Ibid.

³²⁵ Westcott, *Suicide, Its History*, p.168.

Institutional experience enabled alienists to observe the idiosyncrasies of suicidal behaviour among the insane. These observations enabled alienists to begin formulating a systematic approach to the identification and management of suicidal patients. The knowledge they had procured was reproduced in written form in the growing body of literature that was published during the nineteenth century. Medical treatises on the subject of insanity usually included a brief section on suicide, but works specifically dedicated to a discussion of self destruction remained rare. The publication, in 1840, of Forbes Winslow's *The Anatomy of Suicide* marked the first major work to consider suicide as a medical problem. Winslow's discussion of the subject exemplifies the growing tendency to consider suicide as a social and medical problem. This was a distinct departure from Charles Moore's *A Full Inquiry into the Subject of Suicide*. Published at the close of the eighteenth century, this treatise focused heavily on the traditional moral and theological interpretations of suicide. Moore embarked on a comprehensive survey of suicide that was designed:

to collect into one view all that concerns the Subject; to consider it on natural, Social, moral and religious grounds; to point out its "general" guilt arising from the distant preparations of the mind for its commission and from its immediate incitements.³²⁶

Moore was concerned with determining guilt in cases of suicide. He argued that suicide went against the impulses of nature, the authority of God, the order of society

³²⁶ C. Moore, *A Full Inquiry into the Subject of Suicide* (London, 1790), introduction.

and one's own self-interest and thus incurred 'special guilt'.³²⁷ Insanity, as a cause of suicide, was discussed in Moore's work, but it received only minor attention. He concluded that no guilt was incurred when the suicide was attributed to madness. In the case of insanity, 'a man being deemed under no moral guidance, can be subject to no imputation of guilt on account of his behaviour'.³²⁸

Winslow was critical of the approach adopted by his predecessors.³²⁹ Their concentration on the moral and religious implications of suicide 'induced the profession to conceive the subject as one foreign to their pursuits...belonging rather to the province of the moral philosopher'.³³⁰ He argued that medical men had 'not considered with that degree of attention commensurate with its importance the relationship between physical derangement' and the mental afflictions that frequently led to 'the commission of suicide'.³³¹ Winslow's work intended to fill the void as yet not dealt with sufficiently by the emerging psychiatric profession. He was concerned with the 'science of the mind' so that greater knowledge of the human 'mental frame' could be obtained. When the influence of mental emotions over bodily functions was considered, it would become apparent to medical men that 'serious functional disorder' and 'actual organic disease', leading to suicide, would be the outcome. Winslow's interpretation makes it clear that medical men, 'to whose care is entrusted the lives of his fellow creatures, should have made this department of philosophy a matter of serious consideration'.³³²

³²⁷ Ibid.

³²⁸ Ibid., p.4.

³²⁹ In addition to Moore's publication, see J. Sym, *Life's Preservative Against Self-Killing* (London, 1637).

³³⁰ Winslow, *The Anatomy of Suicide*, preface.

³³¹ Ibid., p.195.

³³² Ibid., p.48.

The adoption of a physiological approach to insanity in the mid to late nineteenth century was embraced by Winslow in his explanation of suicidal behaviour. He was keen to connect suicide with cerebral disease and stressed the importance of the brain. He advised that when a suicidal propensity was present, 'the physician should carefully ascertain whether the patient is not labouring under cerebral congestion or a determination of blood to the head'.³³³ From his own investigation, Winslow found that sixty per cent of suicide cases were linked to cerebral disease of either a primary or secondary nature. He argued that in the majority of cases it was found that the patient had been afflicted with depression and other symptoms of 'cerebral derangement', either at the time of the act or previous to it. Consequently, the attention of medical men should be directed to the organ of the brain, as this was the seat of the disease.³³⁴

Winslow's efforts to classify suicide as a derivative of cerebral disease were intended to strengthen psychiatry's right to care for, and treat, the suicidal. Alienists were keenly pursuing a physiological, somatic viewpoint of insanity to legitimise their alliance with medical science. To justify their expertise in the prevention and treatment of suicide, it was necessary for them to demonstrate similar developments in their understanding of the condition as it related to insanity. Winslow's work was an example of the knowledge that alienists were gaining from closer examination of suicidal lunatics. Medical superintendents were developing expertise in the identification of those at risk but, more importantly, their observations made them

³³³ Ibid., p.198.

³³⁴ Ibid., p.199.

better acquainted with the 'physical disturbance going on in the system'.³³⁵ Suicide's association with the somatic viewpoint, and its superior efficacy, supported the psychiatric profession's attempt to persuade the public and medical world that its skills were indispensable. Suicide prevention was best handled by medical men who understood the nature of insanity and self destruction. It was the expertise offered by alienists that made the asylum a haven in which patients would be protected from their self-destructive tendencies.

Patient safety was the prime, but not sole motivation, for enforcing stringent prevention techniques within the asylum. As Pamela Michael rightly asserts, successful prevention provided a benchmark on which the efficiency of the asylum was judged.³³⁶ An institution's suicide rate was reflective of its staff's ability to put in place effective methods of prevention. A low suicide rate inferred tight regulation of suicidal behaviour by conscientious and skilled attendants. This success added weight to the reputation of the institution and its medical superintendent. Suicide rates and accounts of successful prevention were recorded in asylum annual reports. This allowed the institution to declare their success in a relatively public fashion. Annual reports were often circulated amongst the Committee of Visitors, magistrates, the Commissioners in Lunacy and occasionally even appeared in local newspapers. The collation and distribution of asylum statistics, particularly suicide figures, influenced public, medical and professional opinion about the efficacy of asylum provision. It was common for medical superintendents to attribute a low suicide rate to the skill of attendants and the efficiency of the institution. This reinforced the notion advanced by the psychiatric

³³⁵ Ibid., p.220.

³³⁶ P. Michael, 'From Private Grief to Public Testimony: Suicides in Wales, 1832-1914', p.53 in A. Borsay (ed.), *Medicine in Wales c.1800-2000 Public Service or Private Community?* (Cardiff, 2003).

profession that the asylum, with its resources, was the most suitable environment in which to care for suicidal lunatics.

Samuel Gaskell, the medical superintendent at Lancaster Asylum, proudly announced in his annual report of 1841 that no suicides had occurred since his previous report:

A large proportion of patients admitted have evinced this propensity [suicide]: and, although attempts to effect this purpose have been both numerous and ingenious, yet we are happy to report that in no instance have they been successful, notwithstanding such patients are not subject to any species of mechanical restraint.³³⁷

Gaskell's reference to mechanical coercion reinforced the asylum's compliance with non-restraint and demonstrated that, in its absence, prevention remained successful because of the vigilance of attendants. This pattern of success continued and, in 1845, Gaskell declared that 'no case of suicide has occurred in the institution during a period of three years'.³³⁸ At Warwickshire County Asylum even greater success was achieved. In 1863 the medical superintendent, W.H. Parsey, reported that 'It is with much satisfaction...I am able to mention that in the ten and a half years that the Asylum has been open I have not had to record the occurrence of suicide'.³³⁹ He and his staff were not free from the anxiety of suicide since patients with suicidal propensities were 'continually among us in a proportion apparently as large as that of

³³⁷ LRO, QAM5/38, Report of the Lunatic Asylum for the County of Lancaster (1841), p.12.

³³⁸ LRO, QAM5/41, Report of the Lunatic Asylum for the County of Lancaster (1845), p.20.

³³⁹ WCRO, CR 1664/30, Warwick County Asylum Annual Report (1863), p.10.

other Asylums'. Parsey's success was not attributed to 'the adoption of special protective measures'.³⁴⁰ He stated that patients:

have been treated on the principle of not leading them to suppose that they are objects of more than ordinary attention; of keeping them as much as practicable within sight and mixed with other patients in the day time; and at night placing them in associated dormitories.³⁴¹

Experience and empirical observation informed Parsey's approach to patient management and suicide prevention. Over the course of ten and a half years, his understanding of suicidal behaviour and the most effective methods of preventing it would have developed significantly. Parsey's success at Warwickshire was symptomatic of the knowledge medical superintendents acquired through practical experience in a specialised institution. This supplemented the limited knowledge often gained from a medical education, and separated the skills of the alienist from other medical professionals.

In his annual report of 1879, the medical superintendent of Nottingham asylum, W. Phillimore Stiff, emphasised that preventive action meant his institution had been 'free from such calamity [suicide] for seven years'.³⁴² By comparison, the number of persons 'who committed suicide in the Nottinghamshire district during the last year recorded by the Registrar-General was 36'.³⁴³ The following year, Stiff was again able to record that no suicides had occurred. He concluded that 'this is numerical

³⁴⁰ Ibid.

³⁴¹ Ibid, pp10-11.

³⁴² NA, SO/HO/1/6/, Nottingham Lunatic Asylum Annual Report (1879), p.7.

³⁴³ Ibid.

proof of the value of the curative and preventive measures where one half of the inmates are suicidally disposed'.³⁴⁴ In the county of Nottingham, 29 suicides were committed during the same year, some of which 'had doubtless premonitory symptoms of melancholy'. Stiff proceeded to suggest that these individuals 'might have been benefited by special treatment and care'.³⁴⁵ The term 'special' was strategically applied to reinforce the fact that asylum care was overseen by a specific group of medical men who had developed specialist knowledge of insanity. When their expertise was applied in practical terms, the outcome was a consistent pattern of successful suicide prevention throughout the public asylum system. Of the annual deaths recorded in asylums, only a minute number of these were attributable to suicide. Anderson presents evidence that, in 1867, suicides accounted for only 0.63 per cent of asylum deaths.³⁴⁶ The psychiatric profession was able to draw on this achievement as a positive example of the benefits of asylum care. Publicising low suicide rates instilled further public confidence in the profession's work, proving that suicide 'could be deflected by correct management in a public asylum'.³⁴⁷

* * * * *

Nineteenth-century alienists were acutely aware of the subservient position they, and their profession, held within the field of medical science. Psychiatry was perceived as a disreputable profession that lay on the fringe of the medical world. Alienists responded to their weak position by taking a pro-active role in the construction of a professional identity and the establishment of professional authority. They focused

³⁴⁴ NA, SO/HO/1/6/1, Nottingham Lunatic Asylum Annual Report (1880), p.8.

³⁴⁵ Ibid.

³⁴⁶ Anderson, *Suicide in Victorian*, p.403.

³⁴⁷ Michael, 'From Private Grief', p.59.

their attention on improving the perception of the subject they studied and the patients they treated, but this was not sufficient to raise the status of insanity and its practitioners. The asylum was inherently associated with, and intrinsic to, the care and treatment of the insane. Alienists had to concern themselves with fostering greater public and medical confidence in their skills and the services that the asylum could provide. This evolved through a campaign of persuasion and marketing that emphasised the expertise alienists possessed and the indispensable skills they deployed within their work. The emerging profession worked hard to carve out a solid reputation that would assist in legitimising the study and practice of psychiatry. Alienists demonstrated their professional credentials by cultivating and extending a body of knowledge that belonged specifically to them. When this knowledge was combined with practical experience, the profession gained significant leverage with which to encourage society to make extensive use of their services. In the absence of formal education and training on mental illness, asylum experience and observation gained strategic importance. The care and treatment of the insane was an intangible skill, the efficacy of which was best proven by practical experience and successful treatment.

Success was primarily defined by an institution's cure rate, but the reputation of an asylum was also influenced by additional measures, such as the number of completed suicides. Suicide prevention was part of the management of insanity and was a marketable service emphasised by alienists. Prevention was a concrete example of the specialist care alienists were capable of delivering within a secure institutional environment. This prospect was often appealing to families who were concerned for their relatives' safety and wished to offload the stigmatisation of

insanity and suicide to other carers. Suicide prevention extended the territory of psychiatry and strengthened alienists' claims of expertise, but it placed grave responsibility on asylum staff. The importance of safeguarding one's professional reputation once again came to the fore, as completed suicides tainted an institution's record and cast doubt on the medical superintendent's capabilities. A culture of suicide prevention permeated nineteenth-century asylum practice for both practical and professional reasons. Although safety was a leading concern, alienists used the 'practical art' of suicide prevention to enhance their skill set and offer a more extensive range of services to the patient and their family.

Throughout the nineteenth century, the emerging psychiatric profession was engaged in a continuous struggle to elevate its status and overcome public distrust. Alienists tried repeatedly to boost confidence in their work and achieve acceptance by the public and their medical brethren. Efforts to establish a monopoly over the practice of psychiatry fell short of their goal. Autonomy was not fully achieved, but by the late nineteenth century alienists had at least succeeded in raising the profile of their profession. They had created an extensive body of knowledge that conveyed, to a wider medical audience, the development that had occurred in their understanding and treatment of insanity. The profession's status was still precarious within the broader medical world, but a sense of collective identity had been established and, for some of psychiatry's leading practitioners, individual eminence was achieved.

3

THE ADMISSION AND DISCHARGE OF SUICIDAL LUNATICS

The committal and discharge of suicidal patients centred on the dangerousness of their suicidal tendency and the severity of their mental condition. Once a lunatic was committed, dangerousness and risk framed the institutional context of suicide management and patient treatment. The processes of admission and discharge were fundamentally about suicide prevention and patient protection. Protection against dangerous or violent behaviour also extended to the family and asylum staff, as both were targeted by patients.³⁴⁸ Suicidal behaviour and the difficulties of managing it became intolerable for many families. As a result, David Wright argues that families assumed the role of an active agent in the certification and admission of the insane.³⁴⁹ This chapter focuses on the communication and exchange of information that occurred between lay individuals and asylum staff. Their 'conversation' and evidence from admission documents will reveal the forms of dangerous behaviour that precipitated admission and informed patient assessment.

The discharge of patients, whether suicidal or not, has yet to be treated in satisfactory depth. Wright's work on the Buckinghamshire Asylum offers a starting point; it identifies that discharge was not just a medical evaluation.³⁵⁰ The decision to release a patient depended on an improvement in behaviour and the presence of an

³⁴⁸ M. Finnane, 'Asylums, Families and the State', *History Workshop Journal*, vol.20 (1985), pp.134-148.

³⁴⁹ Wright, 'The Certification of Insanity', pp.267-290; Wright, 'Getting Out of the Asylum', pp.137-155.

³⁵⁰ D. Wright, 'The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England. The case of Buckinghamshire, 1853-1872', in Melling and Forsythe (eds.), *Insanity, Institutions and Society*, p.93-112.

adequate external support network that would ensure continued recovery and protection. In this chapter Wright's argument is explored and developed in relation to the discharge of suicidal patients. Much attention is placed on the tests of fitness used to determine a patient's suitability for discharge and the negotiation and preparation that occurred between the asylum and relatives. A definition of recovery and the criterion for discharge is established and then tested by examining the incidence of readmission and completed suicide after discharge.

The admission process

The 1811 County Asylums Amendment Act made certification of insanity for the confinement of any insane person to a county asylum, private establishments or voluntary hospital a legal requirement. Committal had to receive medical and legal validation in the form of a certificate of insanity which, under the 1811 Act, required the statement and signature of one medical person. Subsequent modifications were made in 1828 and 1845 that introduced tighter controls over the process of certification. To prevent collusion or misrepresentation of an individual's condition the certificate of insanity had to comprise a statement that presented both a medical and social history of the patient, signed by the petitioner. In addition, there had to be two medical statements that concluded, based on fact, that the person was insane or of unsound mind.³⁵¹

Focusing on certification in terms of government legislation and legal requirements leads to the conclusion that the committal of the insane remained within the sole

³⁵¹ Wright, 'The Certification of Insanity', p.267-290.

remit of Poor Law officials, medical officers, and asylum doctors. It suggests the existence of medical control over the civil liberties of the mentally afflicted and places the authority of medical men at the centre of confinement. What remains absent from this historiography is the role of the family and other external agencies which must be considered if the context of confinement is to be fully understood. Wright's work on the certification of insanity in nineteenth-century England redresses this balance. It argues that 'control over confinement was predicated upon the desires of families to care for, and control, dependent and violent relatives'.³⁵² The involvement of medical men, notably medical superintendents, is seen by Wright as secondary to the pivotal role played by the family. Declaring that there is little indication that medical men controlled the process of committal, Wright argues that admission to the asylum was actually a 'strategic response of households to the stresses of industrialisation'.³⁵³

The majority of patients admitted to the asylum came directly from the domestic sphere where families had endeavoured to provide whatever care they could. As the primary carers, prior to confinement, it was usually the family who made the decision whether or not to confine an individual. It was the family who approached the poor law authorities and set the wheels in motion. This, according to Wright, made them 'active agents in the process of certification', whilst medical superintendents were 'peripheral agents in the great confinement of the insane'.³⁵⁴ Wright's paradigm

³⁵² Wright, 'Getting Out of the Asylum', p.137.

³⁵³ Ibid, p.137. The correlation Wright draws between the stresses of an industrialising, urban, society and an increased number of asylum admissions can be contested. By identifying industrialisation as the primary catalyst Wright overlooks the high proportion of admissions from rural areas. The case examples used in this study are drawn from a rural/ urban cross section of the Midlands region and do not reveal any distinct variation. Rural and urban households, generally, responded in the same way to suicidal behaviour. Admission was a necessity to protect the family from the threat of suicide and violence rather than a reaction to social and demographic change.

³⁵⁴ Ibid., p.154.

suggests that the wishes of the family and lay opinion overshadowed medical men's monopoly over admission and certification. The expansion of the asylum was not a consequence of legislation and professionalisation but the demands of families struggling to cope with difficult and violent behaviour.

Cases that reached the asylum tended to be of the most severe nature and were characterised by violence to others or attempted suicide. In milder cases of insanity institutionalisation was likely to be a last resort, but where violence or suicide attempts were evident admission came much quicker. The hastened approach to suicidal admissions could mean several things: that families were unwilling to endanger themselves and the individual; that the family had genuinely exhausted all of their available resources; or, that easier access to institutional provision made them less inclined to struggle with domestic care. These suppositions may be indicative of many families who committed suicidal patients to the asylum. By examining the admission process and interplay between lay and medical opinion the context of confinement for the suicidal can be understood within Wright's paradigm.

In his study of the Leicestershire County Asylum, Peter Bartlett sampled the institution's admission records for the 1860s and found that 60 per cent of patients came from households straight to the asylum. Bartlett's qualitative sampling included all patient categories admitted during a period of ten years, but even more striking results are found when analysing suicidal admissions. At Leicestershire County Asylum between 1846 and 1860, 91 per cent of patients who attempted suicide before admission were admitted from the home. This pattern was repeated, though to

a lesser extent, at Rainhill asylum where 63 per cent of suicidal patients, during the period 1853 to 1860, came from domestic settings, and at Birmingham Borough Asylum figures reached 86 per cent between 1851 and 1860. (See Table 1)

Table 1: Previous residence of suicidal admissions.

Figures only include those patients who had actually attempted suicide prior to admission.

Asylum	Admission dates	Total suicidal admissions	Admission from domestic household	Admission from workhouse	Admission from prison/other institution/lodgings
Birmingham	1851-1860	21	18	2	1
Leicestershire	1846-1860	57	52	2	3
Rainhill	1853-1860	8	5	2	1

Sources: BCA MS344/12/2a, LCRO DE3533/185-189, LRO M614 RAI/8/3 & M614 RAI/11/1-2.

Certification offered the family, first and foremost, protection from the patient's extreme behaviour. It was common for suicidal patients to act violently towards friends and relatives. This was manifested in either actual bodily harm or threats to murder their spouse or children. Fear of violence was the overriding motivation expressed by the husband of Caroline Finch who was admitted to Birmingham Asylum in May 1871. On her reception order she was classified as both suicidal and dangerous to others, facts supported by her husband's testimony. Charles Finch stated that she 'has threatened to destroy herself and the children and has attempted to strangle one of the children'.³⁵⁵ The reception order for Susanna Goode, admitted in January 1870,

³⁵⁵ BCA, MS344/15/1, Reception Orders, 4 June 1850 – 27 December 1871.

detailed violent and unmanageable behaviour in the facts communicated by her mother. She was described as 'very violent in her manner, that she has struck her [mother] several times...and that she has thrown her son, 3 years old, from the bed on to the floors'.³⁵⁶ In each of these cases, the women posed a serious risk to themselves and others, in particular their children. In this crisis situation, Mark Finnane argues that the asylum alleviated responsibility by acting as an arbiter for social and familial conflict.³⁵⁷ The asylum had an obvious custodial function, but it could also be a safe haven. In its role as arbiter, Finnane perceives the asylum's function to be 'the institutionalisation, often for short periods though often repeated, of those whose demeanour, behaviour, antagonism, resistance or withdrawal failed to fit their immediate context'.³⁵⁸

Respite and safety was not the primary motivation for all families wishing to commit a suicidal relative. Some were concerned with obtaining effective treatment once it became apparent that their best endeavours were no longer practical or sustainable. Despite the use of personal restraint or the introduction of a medical attendant within the home, domestic provision often proved inadequate when dealing with suicidal lunatics. Before her admission to Worcestershire County Asylum in May 1863, Elizabeth Adams 'was attended by a medical man at her home'. Owing to her suicidal propensity, and 'several attempts to hang herself', 'she was watched day and night by two attendants, and a straight jacket, as well as manual restraint, was frequently employed'.³⁵⁹ The behaviour of Elizabeth Jackson also warranted the assistance of a

³⁵⁶ Ibid.

³⁵⁷ Finnane, 'Asylums, Families and the State', pp.134-148.

³⁵⁸ Ibid., p.135.

³⁵⁹ WRO, BA10127/20, Male and Female Casebook, April 1863-October 1863.

medical attendant. Later admitted to Leicestershire County Asylum in March 1848, Elizabeth's husband employed the services of an attendant in 'consequence of her determination to destroy herself'. She was deemed to be:

in a state unfit to be left alone, and her husband was strictly enjoined by her medical attendant to remove everything out of her reach by which she could possibly injure herself. He, however, unfortunately left his razors in their usual place, and his wife in a maniacal paroxysm attempted her life by cutting her throat with one of them.³⁶⁰

The failure of interventions, like restraint, often precipitated committal to the asylum. Families were forced to concede that domestic provision was incapable of providing effective care and treatment. The relinquishment of responsibility was eased, however, by a growing belief that removal to the asylum was necessary to ensure recovery.

It cannot be disputed that the majority of asylum admissions came from the home, but another important source was the workhouse. The threat of suicide was intolerable to workhouse staff for two main reasons: firstly, the demands that careful supervision placed on their resources; secondly, the danger suicidal patients posed to attendants and other patients. In their work on admissions to the Devon County Asylum, Adair, Forsythe and Melling, conclude that 'dangerousness' was the basic criteria for the transference of patients from Plympton workhouse.³⁶¹ The forms of

³⁶⁰ LCRO, DE3533/185, admitted 19 March 1848, admission no.860.

³⁶¹ Adair, Forsythe and Melling, 'A Danger to the Public?', pp.1-25.

behaviour deemed unacceptable, and frequently cited as reasons for prompt admission, were 'incendiarism, attempted suicide, and outrageous immorality'.³⁶² It was not just a question of the workhouse authorities being unwilling to tolerate suicidal behaviour. The provisions of the 1834 Poor Law Amendment Act prohibited the detention of dangerous lunatics for more than 14 days. The intention of section 45 was to relieve pressure on the workhouse by diverting difficult patients to the asylum.³⁶³ Bartlett and Scull both emphasise the issue of manageability and the maintenance of order as a criterion for the removal of dangerous lunatics. Efficient management meant that staff were concerned with 'the good administration of the workhouse and, in so far as the insane compromised that order, the workhouse staff would have viewed them as problematic'.³⁶⁴ The asylum afforded relief to workhouse staff and placed patients in the care of attendants that were better experienced to manage dangerous and suicidal behaviour.

Workhouse officials justified their decision to commit suicidal patients on the basis that the asylum was a more appropriate institutional environment. It was generally not until the mid-nineteenth century that special wards were built to house lunatics in the workhouse. Prior to this the majority of the insane were housed with the general inmate population.³⁶⁵ Deficiencies in classification meant that lunatics in workhouses unavoidably remained an extreme annoyance to the other inhabitants. Disruptive behaviour led Nottingham Union Workhouse to transfer James Millward to

³⁶² Ibid., p.14. These three forms of behaviour were identified as common factors at Plympton St Mary and although they may be considered as representative of a broader trend it should not be presumed that other workhouses used them as their sole criteria for removal to the asylum.

³⁶³ Bartlett, *The Poor Law of Lunacy*, p.44.

³⁶⁴ Ibid., p.181.

³⁶⁵ Ibid., p.44.

Leicestershire County Asylum in January 1852. Millward suffered from mania of a 'chronic character, and violent form'. He was described as 'the annoyance, and terror of all the inmates...extremely violent...on two occasions he has manifested the most dangerous, and suicidal propensity, having twice attempted to hang himself'.³⁶⁶

Rhoda Freer was also removed to Leicestershire County Asylum in May 1860. The workhouse authorities stated that 'she attempts to tear her clothes...she has been a disorderly inmate...at times she threatens suicide'. The threat of suicide was later followed by an attempt to strangle herself.³⁶⁷ These examples, together with evidence from the Devon County Asylum, validate the argument that dangerous behaviour triggered admission. Dangerousness or a determination to suicide was central in the decision to commit an individual, whether from a domestic or workhouse setting. Neither party had at their disposal the necessary resources nor operated in an environment that was conducive to suicide prevention and the management of difficult behaviour.

In most cases attempted suicide or threats of self-destruction acted as direct triggers for admission to the asylum. Suicidal behaviour was considered by many, in both the lay and medical world, to be irrefutable evidence of insanity and justification in itself for confinement. It is unsurprising that threats of suicide and violence dominated the admission tables of nineteenth-century asylums as the major precipitants of committal.³⁶⁸ Part of this trend was the frequent occurrence of attempted suicide on

³⁶⁶ LCRO, DE3533/186, admitted 2 January 1852, admission no.1235.

³⁶⁷ LCRO, DE3533/189, Male and Female Casebook, September 1858-May 1861

³⁶⁸ Evidence from Walton's study of Lancaster Asylum draws this conclusion. Based on admissions to the institution between 1842 and 1843 Walton lists drink, suicide and violence as the predominant

the day of admission or during the days immediately before. Geoffrey Reaume, in his study of the Toronto Hospital for the Insane, suggests that some patients approached their impending committal with a grave sense of fear and loathing. Citing the case of Elizabeth W, it was noted that she was 'very nervous and much distressed at the thought of returning to the hospital', so much so that she had threatened to commit suicide if returned to the institution.³⁶⁹

Attempted suicide as a reaction to institutionalisation provides a plausible explanation when the reasons for this action are only looked at from the patient's perspective. An alternative conclusion can be reached if the evidence given by family and friends becomes the focus of attention. If, as Reaume infers, the patient responded out of apprehension and fear, it is conceivable that those seeking admission were driven by similar emotions. In this context, it is likely that desperation and fear encouraged some families to embellish the true facts and include a dramatic suicide attempt on the day of admission to emphasise the level of danger posed by the patient. The suggestion here is not that families indiscriminately concocted tales of suicide attempts, but that a genuine act of self-destruction prior to admission could be used to stress the immediacy with which the patient needed to be committed. Caution is however needed, as this inferred explanation cannot be fully confirmed by the brief statements given on admission documents. Patients' motivation to commit suicide so near to their admission and the reliability of family evidence cannot be gleaned from these sources. Yet despite these inherent limitations what remains

features of patient's behaviour before and at the time of admission. J.K. Walton, 'Casting out and bringing back in Victorian England: pauper lunatics, 1840-70', in *The Anatomy of Madness*, vol.2 (1985), pp.132-146.

³⁶⁹ G. Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Ontario, 2000), p.24.

apparent is the notable trend of attempted suicides on the day before or that of admission.

Elizabeth Cound, admitted to Worcestershire County Asylum in April 1868, was certified as suffering from acute mania. She was considered 'dangerous to those around her' and it was stated by her aunt 'that the day previous to admission she had attempted suicide by drowning'. This was 'her first mental illness' and was attributed to the birth of 'an illegitimate child and hereditary predisposition'. Details of the patient's history disclosed that:

she attempted to drown both herself and the child in a pool, near her home, but was rescued by a passer-by and taken to the Stourport Police Station on a charge of attempting to destroy herself but the magistrate doubting her sanity, at once sent for a medical man who certified that she was of unsound mind and an order was made for her admission to the asylum.³⁷⁰

Elizabeth's experience demonstrates the speeded approach to admission when evidence of insanity and suicide presented itself in a very public fashion. Thomas Moffat also chose drowning when attempting suicide on the day of his admission to Birmingham Borough Asylum. On 2 March 1871 'he ran to the canal...and would have drowned himself had not two men been present.'³⁷¹ Unlike the previous examples, the actions of Frederick Sheward took place within the private sphere.

³⁷⁰ WRO, BA10127/18, admitted 17 April 1868, admission no.2087.

³⁷¹ BCA, MS344/15/1, Reception Orders, June 1850- December 1871.

Frederick suffered from melancholia and was admitted to Worcestershire County Asylum in September 1863. He had 'twice attempted to hang himself' and on the morning of admission 'he was cut down by his wife when black in the face'.³⁷²

It was not always necessary for a patient to physically attempt suicide to gain admission to the asylum. Repeated threats of self-harm and a desire for self-destruction were commonly cited in suicidal cases and taken as sufficient evidence that the person required institutional care. Walter Davies, described as a quiet man and suffering from melancholia, was admitted to Rainhill Asylum in October 1880. He was under the delusion that 'he had killed his children and eaten them', and presumably in consequence of this false belief, 'he said he wanted some one to shoot him'. This was substantiated by a neighbour who stated 'that he wanted her or some one to kill him with a knife'. Once admitted Walter 'on several occasions tied his shirts and pillow cases round his throat', behaviour that required him to 'be very closely watched'.³⁷³ Lucy Smith was admitted to Birmingham Borough Asylum in April 1870 having suffered an attack of insanity for three months. Her mother declared that 'she has threatened to drown herself and has used violence towards her [mother]'. Facts indicating insanity, as observed by the certifying officer, also referred to the patient's suicidal propensity; 'she is tired of her life and would throw herself in the water if she could'.³⁷⁴ Similar intent characterised the behaviour of Esther Lawson, admitted to Birmingham in July 1871. Her sister gave evidence 'that she often threatened suicide and has threatened to kill her child'. This was confirmed during certification when it was concluded that she was suffering from melancholia

³⁷² WRO, BA10127/20, Male and Female Casebook, March 1863- October 1863.

³⁷³ LRO, M614 RAI/11/7, Male Casebook, July 1877-June 1881.

³⁷⁴ BCA, MS344/15/1, Reception Orders, June 1850- December 1871.

and 'is tired of life and has an idea of destroying herself'.³⁷⁵ These cases show how seriously threats of suicide were taken as a precursor to admission. If a person contemplated suicide and verbalised their desire then intent was clearly present in the mind and eventually this could, as seen in Walter Davies' case, be manifest in an actual suicide attempt.

'Facts indicating insanity'

Legislation determined the criteria and protocol for certification of the insane. It provided a framework within which medical men were to operate and safeguarded the patient from wrongful confinement. As outlined at the beginning of this discussion, certificates of insanity had to contain two medical statements that declared the individual was of unsound mind. Legal requirements appeared to place medical men in a position of authority, but according to Wright 'legislation enshrined the centrality in, rather than the monopoly over, the certification of insanity by the medical profession'.³⁷⁶ An outright monopoly was prevented by the necessary intervention of lay observations in the certification of insanity. Although facts indicating insanity as observed by the certifying doctor were considered by alienists to carry greater weight than those communicated by family or friends, the strong influence of lay evidence can not be denied. Lay and medical observations were based on a distinctly different interpretation and understanding of insanity, but in the process of certification both were required so that a cohesive picture of the patient's condition could be formed and a diagnosis established.

³⁷⁵ Ibid.

³⁷⁶ Wright, 'The Certification of Insanity', p.288.

An initial diagnosis of insanity was made by a Poor Law medical officer that was based on the 'facts indicating insanity' observed by himself. According to John Millar, medical superintendent of the private Bethnall House Asylum, the diagnosis should be 'a statement of facts observed by the medical man himself, which would carry conviction to the mind of any one reading it, that the person to whom it referred must be of unsound mind'.³⁷⁷ Bucknill's work on certificates of insanity also stressed the importance of the medical statement since it was 'the gist and marrow of the medical certificate'.³⁷⁸ Bucknill drew attention to the legislative requirement that the medical man signing the certificate should:

distinguish in such certificate facts observed by himself, from facts communicated to him by others; and no person shall be received into any registered hospital or licensed house, or as a single patient under any certificate which purports to be founded only upon facts communicated by others.³⁷⁹

Facts communicated by others were considered insufficient evidence on which to certify and diagnose an insane person. Bucknill did not discount the information provided by lay persons, nevertheless he remained resolute that at best this should be used only to confirm the medical man's own observations and that 'it is on the facts observed by himself that the validity of the document really depends'.³⁸⁰

³⁷⁷ J. Millar, *Hints on Insanity* (London, 1866), p.79.

³⁷⁸ J.C. Bucknill, 'Medical Certificates of Insanity', *Journal of Mental Science*, vol. II (1860-61), p.81.

³⁷⁹ *Ibid.*, pp.81-82.

³⁸⁰ *Ibid.*, p.82.

The sections in which medical men recorded the indications of insanity they had observed were somewhat small and restricted the level of detail that could be provided. Medical statements were characterised by short phrases rather than detailed expositions on the patient's symptoms and behaviour. Bucknill took issue with the written style adopted in medical statements. He begged to suggest that:

in these certificates, the statement of facts observed by the medical man should always be written in complete phrases, and that they should be thrown into the sort of rough classification I have suggested, namely of appearance, conduct, and speech.³⁸¹

Since the law demanded that the medical statement provide details of the patient's symptoms, Bucknill questioned 'in what form can the grounds of this conclusion be stated in a brief and formal, though sufficient, manner'.³⁸² His answer was a system that classified symptoms under three headings: (1) The appearance of the patient; (2) His conduct; (3) His conversation. Or to put it in other words, how he looks, what he does, and what he says.³⁸³

Despite Bucknill's suggestion, 'facts indicating insanity' remained brief. In general the statement gave a limited summary of the patient's condition, including any indications of a suicidal propensity. Hannah Carter was admitted to Birmingham Borough Asylum in February 1863. She was considered epileptic, dangerous to others and suicidal. The facts indicating her insanity were 'begging of me to finish her

³⁸¹ Ibid., p.86.

³⁸² Ibid., p.82.

³⁸³ Ibid., p.83.

by means of poison. States that it is owing to irritability of her feelings and not pain. Threatens to destroy herself and attempted suicide this morning'.³⁸⁴ The medical statement for Caroline Lilley's admission to Birmingham in April 1870 contained short phrases like those Bucknill protested against; 'Dejected look, fixed absent stare, has delusions, melancholy'.³⁸⁵ This amounted to little more than a vague description of the patient's demeanour; it lacked a discursive exposition on which certification could be validated. The presence of a delusion was sufficient evidence in the certification of Eliza Lee in March 1870. Under the heading 'Facts Indicating Insanity', only one sentence was written stating 'delusions – believing that policemen are constantly looking at her through telescopes'.³⁸⁶

Indications of suicidal intent were drawn from the patient's own words and evidence of self-inflicted wounds. Patient comments were useful, not only to evaluate their state of mind, but to supplement and clarify lay reports of suicidal behaviour. Mary Ann Taylor, a housewife admitted to Birmingham in June 1865, indicated that she was 'tired of life, she wishes to kill herself and says to me [certifying doctor] she leaves home to starve herself'.³⁸⁷ *Tedium vitae* was the underlying cause in the case of Lucy Smith, a patient at Birmingham in April 1870. She too expressed that she was 'tired of her life and would throw herself in the water if she could'. This statement confirmed the facts communicated by her mother that 'she has threatened to drown herself'.³⁸⁸ Suffering from melancholia, Sarah Price was admitted to Birmingham in August 1871. The certifying doctor described her as 'anxious and

³⁸⁴ BCA, MS344/15/1, Reception Orders, June 1850- December 1871.

³⁸⁵ Ibid.

³⁸⁶ Ibid.

³⁸⁷ Ibid.

³⁸⁸ Ibid.

depressed'. She herself 'says she feels unhappy, that she is lost...is always feeling she must destroy herself'.³⁸⁹

Comments like these indicated the patient's preoccupation with suicide, but evidence of a healing wound or scar confirmed that the patient had progressed from a state of contemplation to actively seeking their objective. 'Facts indicating the insanity' of Charles Starkin, admitted to Birmingham in February 1871, recorded 'a wound in his throat which he says he inflicted upon himself, feeling under an uncontrollable impulse to destroy himself, he says he was for some months past determined to destroy himself'.³⁹⁰ Andrew Murphy was committed to Rainhill Asylum in February 1870 and [under facts certified at the time of admission he] was described as 'very wild and excited'. Alongside comments about his mental state and general demeanour was a brief reference to 'marks on his throat' which had resulted from 'attempted suicide'.³⁹¹ The external appearance of George Harrison, admitted to Leicestershire County Asylum in March 1847, was described as unfavourable due to a loss of blood, 'the consequence of a wound in the throat extending from ear to ear'. During a relapse, that was attributed to diverse circumstances and unemployment, he became dejected and 'under the influence of his wretched feelings, committed suicide by cutting his throat'.³⁹² Verbal and physical confirmation direct from the patient provided the certifying doctor with an additional source of information that was likely to be less ambiguous. Personal testimony enabled a comprehensive

³⁸⁹ Ibid.

³⁹⁰ Ibid.

³⁹¹ LRO, M614 RAI/11/4, Male Casebook, June 1865- May 1870.

³⁹² LCRO, DE 3553/185, admitted 29 March 1847, admission no.785.

assessment of the patient's condition and the severity of their suicidal behaviour. It could also be used to confirm or contest lay evidence provided by the family.

*'Other facts indicating insanity'*³⁹³

although these facts cannot be made to supersede those observed by the medical man himself, they may be of vast importance to the medical officer of the asylum, by informing him of any propensity the patient may have shown as to suicide, and the mode in which it has been attempted.³⁹⁴

Millar was not alone in his belief that 'facts indicating insanity', as communicated by others, could be of great value in cases of suicidal insanity. Bucknill recognised that whilst 'facts communicated by others are surplusage' in the majority of instances, they could 'be allowed to form the prominent feature of the statement' where a suicidal tendency existed. Under these circumstances it was common for the facts observed by the certifying doctor to be 'accepted as quite subordinate' since 'the signs and symptoms of mental disease, which the medical man is capable of noting, are often meagre in the extreme'.³⁹⁵ Suicide attempts were not likely to be known personally by the certifier so the testimony of others provided vital details about the patient's history. In his study of *'Madness at Home'*, Suzuki draws attention to the importance of lay narrative in medical decision making. Before the emergence of reliable physical examinations, he states that the 'diagnosis of disease...[was] heavily dependent on laypersons' narratives of sickness'. As a direct consequence

³⁹³ This heading is taken from contemporary admission certificates. 'Other facts indicating insanity' denoted the information provided by lay parties.

³⁹⁴ Millar, *Hints on Insanity*, p.80.

³⁹⁵ Bucknill, 'Medical Certificates of Insanity', p.87.

the diagnosis of insanity was heavily influenced by the information received from the patient's family.³⁹⁶ When called to examine a patient Bucknill advised that the certifying doctor 'should not...proceed directly to personal examination, but listen to the narrative of the family or the near relations of the patient' in order to gain vital information that would assist diagnosis and subsequent treatment.³⁹⁷

The inclusion of lay evidence, although valuable, needed to be treated with caution. To take the family's testimony at face value was naïve because it could contain potentially unreliable information. Ambiguity arose from the emotive language used to describe the patient and stress the most dangerous aspects of their condition. Alternatively it could be found in the lay interpretation and diagnosis that was often applied by families prior to medical certification. In the admission of Alice Davis to Birmingham Borough Asylum in April 1871, her sister stated that 'she [Alice] is very dangerous if left alone'. The same comment was made of Sarah Martin's behaviour prior to admission in May 1871. Her sister in law claimed that 'she is dangerous to be left alone'.³⁹⁸ The certificate of William Wyatt, admitted to Worcestershire County Asylum in January 1869, stated that 'he made a determined attempt to commit suicide by cutting his throat on December 7th'.³⁹⁹ The certificate of Sarah Atkins, admitted to Birmingham in October 1855, stated she was 'apparently determined upon suicide, which she has once or twice recently attempted'.⁴⁰⁰ These examples reveal how frequently phrases like 'very dangerous' and 'determined attempt' were deployed in lay narratives. The implication being that these words were used to

³⁹⁶ Suzuki, *Madness at Home*, pp.41-43.

³⁹⁷ Bucknill and Tuke, *A Manual of Psychological Medicine*, p.275.

³⁹⁸ BCA, MS344/15/1, Reception Orders, June 1850- December 1871.

³⁹⁹ WRO, BA10127/187, Male and Female Casebook, January 1867- January 1870.

⁴⁰⁰ BCA, MS344/12/2a, admitted 27 October 1855.

emphasise and suggest the patient's condition was severe enough to warrant committal. If an individual was considered to be 'determined', as proven by repeated suicide attempts, then the family's claims of unmanageable and intolerable behaviour were strengthened and legitimised.

The juxtaposition of lay and medical opinions challenged the credibility of the family's testimony. Although comments made by relatives offered a unique insight into lay attitudes, it is important to remember that their words were recorded by medical men and were subject to dilution and filtering. The material selected by officials was, as Walton argues, 'coloured by their own preconceptions and by their initial impressions of the patient'.⁴⁰¹ Just as medical evidence of insanity was imperfect, so too were lay narratives. Suzuki concludes that 'neither the family's representation nor personal examination provided a solid or infallible test of insanity'.⁴⁰² A compromise was required, as advocated by Bucknill, in which medical practitioners no longer saw physical examination as the sole solution and over-reliance on the family was avoided so that certification was not influenced by false statements.

Certificates of insanity reveal much about nineteenth-century tolerance of difficult behaviour, the reasons why individuals were committed, and the kinds of behaviour most likely to lead to admission. Evidence of this is drawn from the three main parties involved in the process of certification: the family, the certifying doctor, and the patient. Despite the family's leading role and the important contribution they made, the process of certification for suicidal lunatics remained one of co-

⁴⁰¹ Walton, 'Casting out and bringing back in', p.140.

⁴⁰² Suzuki, *Madness at Home*, p.63.

dependency between medical and lay opinion. Only with the inclusion of both observed and communicated facts could a certificate of insanity provide a comprehensive picture of the disease's aetiology and the manifest form of the patient's suicidal behaviour.

The process of certification had its own problematic issues, but what remains abundantly clear is that suicidal behaviour was one of the chief factors which led to, and often speeded up, admission to the asylum. A suicidal tendency was considered symptomatic of insanity and indicative of the need for institutional care. Within this context, committal was both prompt and justifiable thus bringing much needed relief to desperate families. The asylum offered both the family and the patient safety from the excesses of suicidal behaviour. It was on this basis that dangerousness, particularly in a suicidal form, became a common criterion for removal to an institution.

Recovery and discharge

The broadest and most comprehensive test of fitness for discharge is formed by the question – How far has the residence of the patient in the asylum answered the purpose for which he was sent here?⁴⁰³

Hayes Newington's question implied that recovery and discharge were determined by assessment and observation of the patient's bodily and mental improvement. As already discussed the judgement of others, medical and lay, was influential at the

⁴⁰³ H. Newington, 'What are the Tests of Fitness for Discharge from Asylums?', *JMS*, vol. 32 (1886-87), pp.491-500.

time of admission and remained equally relevant when the decision was made to discharge the patient. An accurate assessment of how well the patient had progressed and 'answered the purpose' for which they had been committed could only be established by the attendants and medical superintendent under whose care the individual had resided. This did not mean that family, friends or Poor Law officials were excluded from the discharge process. Discharge, as with admission, required the active participation of several parties to ensure that adequate provision was guaranteed outside of the asylum.

Recognised improvement was the primary determinant for discharge. Most critically this was observed in the form of rationality, a willingness to be regularly employed, greater social interaction, and the loss of a suicidal propensity. Recovery related directly to the progress made by the patient during their stay in the asylum and the extent to which they overcame or learnt to control the behaviour that had prompted admission. When preparing for discharge, the information recorded at the point of admission became integral to the creation of a benchmark by which progress could be calculated. Signs of improvement could then be mapped against the patient's original state to determine the full extent of recovery and readiness for discharge. The criteria for recovery in suicidal cases differed from the general asylum population as the patient's assessment was based on the suicidal tendency itself and the restoration of self-control. To reduce the risk of relapse and readmission there needed to be careful consideration of factors specific to suicidal behaviour.

For any asylum patient the route to recovery usually commenced with a period of notable convalescence, signs of which were marked by increased rationality and a readiness for 'normal' life as conveyed by participation in social and recreational activities. Digby states that prior to discharge from the York Retreat careful assessment of patient behaviour was undertaken 'during a prolonged convalescent period'.⁴⁰⁴ Marland refers to the use of 'long convalescences to ensure they [female patients] did not relapse' when discharged from Edinburgh's Morningside asylum'.⁴⁰⁵ Guarding against relapse was a key consideration in the decision to discharge a patient but this did not mean that convalescence needed to be prolonged in all cases. The criterion for discharge was not determined by the duration of a patient's convalescence. Of greater importance were outward manifestations that gave a clear indication of mental improvement.

Coherence and rationality were judged against the amelioration of other generic aspects of a patient's mental and bodily capacity, as well as their social conduct. Melling and Forsythe noted that 'Improvement in mood and freedom from delusions were significant, as was the ability to work regularly and to interact positively with other patients and staff'.⁴⁰⁶ Changes of this kind were considered indicative of convalescence and a firm foundation on which to assess a patient's suitability for discharge. However, the loss of delusions, employment and social interaction represented improvements of a different kind when assessing recovery in the context of suicidal behaviour. Rationality remained a prevalent concern, but more significant was an indication that self-control was restored and 'apathy and disgust for life' were

⁴⁰⁴ Digby, *Madness, Morality and Medicine*, p.222.

⁴⁰⁵ Marland, *Dangerous Motherhood*, p.133.

⁴⁰⁶ Melling and Forsythe, *The Politics of Madness*, pp.191-92.

abandoned.⁴⁰⁷ Mary Anne Hewitt, a patient of Rainhill Asylum, was 'considered convalescent' six months after her admission in 1880. When admitted she was described as having a 'dull melancholic expression of countenance', and had previously 'attempted to poison herself with some eye lotion' and 'tried to put herself and a pillow on fire'. No further attempts were made during her time in the asylum; instead she 'improved considerably', becoming 'much more rational' and was employed in the kitchen.⁴⁰⁸ Admitted to Rainhill in 1865 William Pugh was engaged in work once he showed clear signs of improvement. Despite being labelled 'suicidal and dangerous' when committed, a fact confirmed by 'a wound in his throat afflicted by himself', he appeared 'to be convalescent' only a few months later. Prior to his discharge in November 1865 William had 'continued to improve mentally and physically...he works in the garden and seems cheerful and contented'.⁴⁰⁹

According to Newington, evidence of restoration was found in 'more frequent inquiries as to what is going on around'⁴¹⁰, particularly when the patient showed a rejuvenated interest in their family and the outside world. Elizabeth Dawson was admitted to Rainhill in April 1870 having 'attempted suicide on several occasions for no apparent reason'. She also harboured the delusion that 'her husband and children must be dead'. 'This patient [was] much better' by August, 'she does not fret but works well with her needle and writes very good letters to her husband'.⁴¹¹ Ellen Cary, also a patient at Rainhill in 1870, expressed a wish to communicate with her family when mental improvement commenced. Following an initial period of

⁴⁰⁷ Newington, 'What are the Tests of Fitness', p.499.

⁴⁰⁸ LRO, M614 RAI/8/8, Female Casebook, July 1878- July 1882.

⁴⁰⁹ LRO, M614 RAI/11/4, admitted 26 July 1865.

⁴¹⁰ Newington, 'What are the Tests of Fitness', p.499.

⁴¹¹ LRO, M614 RAI/8/6, Female Casebook, January 1870-October 1873.

restlessness and a threat 'to jump out of the window at night', which was treated with chloral hydrate, she gradually became 'much better'. Her convalescence was characterised by employment 'either with her needle or in ward work...and has frequently expressed a wish to see her children'. It was also noted that 'she writes letters to her husband'.⁴¹² Whether patients chose to undertake employment, partake in recreation or reconnect with their family, they demonstrated an ability and desire to re-establish themselves within the realms of 'normality'. Convalescence allowed early yet consistent signs of improvement to be observed and formed the prerequisite to either full or trial discharge, depending on the level of rationality and safety shown.

When patients were discharged from an asylum they were commonly classified as cured, relieved, recovered, or unimproved. Precisely how medical superintendents differentiated the application of each label is neither consistent nor resoundingly clear in case histories; some patients were simply 'discharged'.

There can be no doubt that the disparity in the proportion of recoveries reported from different institutions, is to a certain extent due to the varying degrees of latitude with which the terms cured and recovered are applied to cases upon discharge.⁴¹³

Without clearly defined guidelines each category was open to interpretation, allowing the 'varying degrees of latitude' identified by John Thurnam to emerge. Although

⁴¹² Ibid.

⁴¹³ J. Thurnam, *Observations and essays on the statistics of Insanity* (London, 1845), p.3.

latitude existed, 'discharged recovered' was the most frequently applied label. Patterns of discharge at Leicestershire and Worcestershire County Asylums show relative consistency in the use of 'recovered'; it was used in 35 and 44 per cent of cases respectively. Nonetheless, data for the remaining institutions reveals (see Table 2) that variation was dominant and the omission of a specific label a more common occurrence.

Table 2: Discharge of patients

Asylum	Discharge dates	Total suicidal discharges	Discharged cured	Discharged Relieved	Discharged recovered
Birmingham	1851-1860	47	0	0	1
Leicestershire	1845-1860	101	19	7	35
Rainhill	1851-1860	38	2	0	2
Worcestershire	1859-1870	86	3	6	38
Warwickshire	1852-1860	56	0	0	19

Sources: BCA MS344/12/2-2a, LCRO DE3533/185-189, WCRO BA10127/14-18, LRO M614 RAI/8/1-3 & M614 RAI/11/1-2, WRO CR1664/617-619.

Samuel Tuke believed that recovery was achieved 'where the patient is fully competent to fulfil his common duties, or is restored to the state he was in previously to that attack'.⁴¹⁴ Central to the definition of 'recovered' was the patient's ability to resume his former role in society based on active economic and social participation. Thurnam does, however, draw attention to the fact that in 'some of these cases,

⁴¹⁴ Quoted in Digby, *Madness, Morality and Medicine*, p.221.

upon a minute examination, traces of mental disorder may still be detected'.⁴¹⁵ If the patient was not considered 'recovered' then they may have been discharged as 'relieved' or 'unimproved'. As the words themselves imply patients were not fully restored to sanity and were more likely to struggle with domestic care and social reintegration. The term relieved 'connoted the relief of symptoms of insanity without the belief that the insanity had been cured'⁴¹⁶, thus leaving the patient vulnerable to a future relapse. 'Discharged relieved' allowed those who had started their recovery, and presented no immediate danger, to leave the asylum and continue their progress under domestic care. By comparison, patients considered to be 'unimproved' were extremely unlikely to make a recovery once returned to family or friends. The 'unimproved' were usually patients removed from the asylum at the request of relatives and against the advice of the medical superintendent.

The most obvious criterion for the recovery and discharge of suicidal patients was 'an absence of dangerousness, suicidal intentionality or violence towards others'.⁴¹⁷ To establish this, a system of checks was required by which the patient's recovery could be assessed. In his article, 'What are the Tests of Fitness for Discharge from Asylums?', which appeared in the *Journal of Mental Science* in 1886, Hayes Newington provided detailed guidelines for the discharge of suicidal patients. He emphasised that any judgment concerning discharge needed to consider both why an individual attempted suicide and the emotional and mental conditions that accompanied the act. In answer to the first question he explained that:

⁴¹⁵ Thurnam, *Observations and essays*, p.3.

⁴¹⁶ Melling and Forsythe, *The Politics of Madness*, p.105.

⁴¹⁷ Wright, 'The Discharge of Pauper Lunatics', p.105.

on the one hand a desire or temptation is set in motion by adverse circumstances, while on the other hand those natural instincts and emotions which normally protect life, are, by the reason of their effacement or enfeeblement, not ready to push him back from such temptation.⁴¹⁸

Resistance against a suicidal impulse depended on a combination of two factors. This was 'the presence of what I [Newington] call for convenience, motors; the other, the absence of these restraining agents or repellers'.⁴¹⁹ In Newington's opinion attempted suicide could never be the product of less than two factors so it was necessary to separate the motor and repeller and 'distinguish them as independent of each other'.⁴²⁰ The purpose of separation was firstly to identify a distinct enfeeblement of the power to resist and secondly a definite motor that created the suicidal impulse. With this knowledge 'we are forewarned as to the probable amount of resistance that will be offered by the mental constitution of the patient'.⁴²¹

It was the loss of self-control that dominated the question of suicide, 'and therefore to the loss or recovery of it we must pay the chief attention'.⁴²² Where an impulse or temptation occurred it was normally checked by the individual's power of reflection and an instinctive desire for self-preservation, but where insanity existed and resistance was weakened 'the silly thought grows in power, till at last it must be

⁴¹⁸ Newington, 'What are the Tests of Fitness', pp.492-3.

⁴¹⁹ Ibid., p.493.

⁴²⁰ Ibid.

⁴²¹ Ibid.

⁴²² Ibid., p.495.

ranked as a dangerous impulse'.⁴²³ Commencing with lower instincts Newington provided a list of checks that were absent to repel the motors:

1. Abstract love of life and fear of death
2. Physical fear of death
3. Fear of the future state
4. A wish to remain in the world for its own sake
5. Hope for better days
6. True affection for family and friends
7. Moral sense

He concluded that 'every one of these emotions and instinct may be either abolished or rendered practically inert by various phases of mental disease'.⁴²⁴ Evidence that the repelling agents were restored to a satisfactory level of robustness was in, Newington's opinion, not difficult to recognise:

In place of apathy and disgust for life, more frequent inquiries as to what is going on around, the reading of newspapers...useful work done for a purpose, less talk of sin and hell...and more rational anxiety to help them practically – all these demonstrate *pro tanto* increased safety.⁴²⁵

Admission to the asylum often removed any former irritant, temptation or adverse environment that had acted as a motor. At the same time the repeller was strengthened by treatment and the eventual recovery of the patient's mental capacity. Discharge could not be considered unless the repelling agents had been

⁴²³ Ibid.

⁴²⁴ Ibid., p.497.

⁴²⁵ Ibid., p.499.

adequately restored so that the patient was capable of safeguarding themselves from future temptation or adverse circumstances. Safety was clearly the dominant concern and criteria by which suicidal patients were discharged as recovered.⁴²⁶

Leaving the asylum

The asylum's medical superintendent exercised significant influence over the decision to discharge a patient, but he was not the only person involved in the process. A patient could leave the asylum following 'medical' evaluation or by the request of friends or relatives. Regardless of who made the request, local Poor Law officials and magistrates participated in the patient's return to society, but it remained the superintendent who initially identified a patient as ready for discharge. Under the 1853 Regulation of Lunatics Act medical superintendents were required 'to give notice to the Visiting Committee that inmates had recovered their wits'.⁴²⁷ Failure to discharge a recovered patient within fourteen days meant that the superintendent was obliged to contact the Commissioners in Lunacy and explain why they had not followed procedure. The Act also stipulated that either the Visitors or superintendent were responsible for writing to the Union Guardians to make them aware of the patient's impending discharge. The removal of a patient by the request of family or friends was less common, but still subject to administrative and legal procedures.⁴²⁸

⁴²⁶ Newington's analysis appears significant but it is difficult to assess how influential it actually was. His work is not referenced in contemporary publications on insanity and discharge and it does not feature in Charlotte MacKenzie's study of Ticehurst private asylum.

⁴²⁷ Wright, 'The Discharge of Pauper Lunatics', p.97.

⁴²⁸ In his study of Buckinghamshire Asylum Wright concluded that a patient was less likely to leave the asylum based on the request of family or friends. By contrast Melling and Forsythe assert that relatives frequently requested the discharge of a patient. This conflict may be reflective of variations in the data drawn from two different asylums. However, the statistical evidence presented in this study supports Wright's argument. At Birmingham, Leicester and Warwick the number of patients whose discharge arose from a family request represented between three and nine per cent of the total number of discharged patients in each institution.

Discharge under these circumstances was not dependent on the patient having improved or fully recovered. In many instances relatives applied for discharge before the patient had adequately improved. Medical superintendents were able to veto requests where they felt the patient still posed a significant danger. Discharge could also be refused when family or friends failed to guarantee or convince the authorities that they were capable of caring for the patient.

Assessing the level of external support available to a patient formed an important part of the discharge process. With the 'onus of discharging such patients from an Asylum resting virtually with the Medical Superintendent, he is bound to ascertain beforehand, as far as practicable, what the future provision for them is likely to be'.⁴²⁹ A period of negotiation between all parties allowed mutual confidence and trust to be fostered so that the medical superintendent felt reassured of his decision to release the patient and the family felt capable of assuming the role of carer. In some cases relatives resisted discharge because of the pressure placed upon them by 'the signing of a guarantee, that they [the patient] shall be properly taken care of',⁴³⁰ a task made all the more complicated when suicidal or violent behaviour was a threat.

Reluctance to sign the necessary guarantee was evident in the discharge of John Houghey from Warwickshire County Asylum in 1860. Although John had previously attempted 'suicide by hanging by throwing himself out of the window and jumping into water' and displayed a 'gloomy despondency' he was:

⁴²⁹ LRO, M614/RAI/40/2/2, Rainhill Asylum Annual Report (1872), p.116.

⁴³⁰ NA, SO/HO/1/6/1, Nottingham Lunatic Asylum Annual Report (1871), p.10.

extremely anxious to obtain his discharge and endeavours to prove his sanity by very plausible arguments, but when requested to show his fitness for discharge by his conduct will go on steadily and comfortably and keep to regular work for a few days only; soon passing into a state of dejection or else restless excitement.⁴³¹

His father was also 'anxious for his son's discharge' but 'refused up to the present time to give the usual guarantee and take him out on his own responsibility'. This decision was no doubt influenced by John's escape from the asylum and his continued suicidal propensity, 'for he was noticed to be concealing about his person in a very wilful manner a pair of scissors; has also been found to conceal under his pillow choked handkerchiefs'.⁴³² The prospect of caring for a patient whose behaviour remained dangerous and unpredictable raised concerns about accountability and the likelihood of support should a relapse occur. These concerns were apparent in the mind of John's father who took 'great pains to ascertain the exact conditions of his aberration and the possibility of his re-admission here in case he should break down, a circumstance which he does not appear to think improbable'. Once reassured of the asylum's support John was 'Discharged to day [September 25th 1860] – his father giving the necessary guarantee'.⁴³³ Just as the asylum authorities needed strong external support networks to assist the patient's return to society, so did the family. It was important that negotiation took place to allay the fears of all parties and to make families feel they were a considered and active participant in the decision making process.

⁴³¹ WCRO, CR1664/619, Male and Female Casebook, 1856-1861.

⁴³² Ibid.

⁴³³ Ibid.

Discharge on trial was an additional tool used to address the concerns of reluctant families. Pioneered at Gloucestershire County Asylum by Samuel Hitch, trial leave bridged the gap between institutional life and the patient's reintegration into the outside world.⁴³⁴ Judging a patient's readiness for discharge was difficult because what constituted recovery in the safety of the asylum might be challenged by the 'problems of an unprotected existence in the world outside the asylum gates'.⁴³⁵ Discharge on trial provided a probationary period of:

commensurate advantage to the patient...to accustom the convalescent gradually to the renewed duty of self-control, and to keep under observation so as to detect the slightest indication, not merely of relapse, but of inability to press forward in the path of mental soundness and moral strength.⁴³⁶

It was common practice for patients to be discharged on trial for a month, but this was extended if concerns remained and a longer period of readjustment was needed. During a month's trial the medical superintendent retained a statutory power to recall any patient whose behaviour or mental condition worsened⁴³⁷. A patient could also return to the asylum if their family and friends failed to provide the care which they had guaranteed under the conditions of discharge.

⁴³⁴ L.D. Smith, 'A Worthy Feeling Gentleman': Samuel Hitch At Gloucester Asylum, 1828-1847', in H. Freeman and G.E. Berrios (eds.) *150 Years of Psychiatry vol.II The Aftermath* (London, 1996), p.492.

⁴³⁵ Digby, *Madness, Morality and Medicine*, p.222.

⁴³⁶ J.M. Granville, *The Cure and Care of the Insane*, vol.II (London, 1877), p.184.

⁴³⁷ Ibid.

Discharge on trial was not a legal requirement and was not adhered to in all English asylums. The asylum case studies used in this work reveal a pattern of inconsistency and limited use of trial leave. Warwickshire County Asylum does counter this trend with 45 per cent of suicidal patients being granted trial leave before full discharge was sanctioned.

Table 3: Discharge on trial

Asylum	Discharge dates	Total suicidal discharges	Discharge on trial	Readmission after trial
Birmingham	1851-1860	47	6	2
Leicestershire	1845-1860	101	3	0
Rainhill	1851-1860	38	6	2
Worcestershire	1859-1870	86	6	0
Warwickshire	1852-1860	56	25	1

Sources: BCA MS344/12/2-2a, LCRO DE3533/185-189, WCRO BA10127/14-18, LRO M614 RAI/8/1-3 & M614 RAI/11/1-2, WRO CR1664/617-619.

The need for caution was particularly great when a determination to suicide continued in the asylum. Newington declared that discharge should not be advised ‘unless fully assured of a large margin of self-control under trial’.⁴³⁸ Having displayed both mental and bodily improvement, Anna Leigh was ‘sent out on trial’ from Rainhill Asylum in September 1856. Her initial ‘probationary period was extended for another month’ during which time her friends stated that ‘they feared she was not quite so well’. In consequence, Anna was interviewed on 29 October and ‘their suspicions were found to be correct’. ‘She was found to be labouring under considerable

⁴³⁸ Newington, ‘What are the Tests of Fitness’, p.496.

excitement'. It was subsequently decided that 'she should for a time return to the asylum'. Following readmission her behaviour was 'characterised by want of self-control'.⁴³⁹ Charlotte Biddfield, a patient at Leicestershire County Asylum, was readmitted 'after ten days absence from the institution on trial for a week'. She had been discharged into 'lodgings in Leicester which had been procured for her together with a proper attendant to take charge of her'. Despite this provision she relapsed into her former state, 'threatened violence to herself...and eventually became so unmanageable that it was found absolutely necessary to again place her in an asylum'. On her return to the asylum she 'admitted that she ought not to have left the asylum and that she simulated many symptoms of improvement in order to gain her ends'.⁴⁴⁰

Patients discharged on trial were not always readmitted. Many who underwent a period of probation received their full discharge at the end of the four weeks. The trial period succeeded in its purpose by allowing patients time to consolidate the recovery and recapture of self-control that had commenced in the asylum. George Raynor was 'sent out on a month's trial' from Rainhill Asylum in February 1877. Shortly beforehand he had 'slightly improved' and 'works constantly in the ward and with the barrow party'. His discharge on trial 'seemed to have a beneficial effect' and he 'was finally discharged March 20th 1877'.⁴⁴¹ Continued improvement was evident in the case of Mary Morris when she left Warwickshire County Asylum 'for the month on

⁴³⁹ LRO, M614 RAI/8/2, Female Casebook, June 1853-December 1856.

⁴⁴⁰ LCRO, DE3533/185, admitted 25 September 1846, admission no.742.

⁴⁴¹ LRO, M614 RAI/11/6, Male Casebook, December 1873-July 1877.

trial' in October 1852. Having gone 'on quite satisfactorily' she 'received her full discharge' on 16 November.⁴⁴²

Risk was inevitable when discharging suicidal patients and sadly in some cases relapse led to renewed suicide attempts and ultimately readmission. As Granville wrote:

It is not always possible, and it is rarely easy, to determine when a case has recovered, or reached the point where recovery may be reasonably expected to proceed without the aid – or even better, in the absence – of asylum protection.⁴⁴³

When removed from the familiar and secure environment of the asylum and the reassuring presence of attendants, a minority of suicidal patients found it difficult to retain self-control. The number of completed suicides following discharge was, however, extremely low. Of the five asylums studied such an event was only recorded in the case of two patients at Birmingham Borough Asylum.⁴⁴⁴ The first incident involving a former Birmingham patient took place in April 1854 and followed readmission on two previous occasions. Henry Pitt was originally admitted to the asylum in June 1851 suffering from acute mania of 'a weeks duration'. He was prone to restless and destructive behaviour, particularly during the night when he 'tore the bedclothes, broke the chamber vessel, window frame and cut his finger with the broken glass'. Hyoscyamine and digitalis were administered to control his manic

⁴⁴² WCRO, CR1664/617, Male and Female Casebook, July 1852-December 1854.

⁴⁴³ Granville, *The Care and Cure*, p.183.

⁴⁴⁴ It is perfectly possible that this pattern was repeated elsewhere but details were not recorded in the case books of other institutions.

outbursts after which he became 'quite tranquil and rational'. On this basis Henry was discharged without trial leave on 24 September 1851, but his discharge was short lived and he was readmitted on 11 October. His previous pattern of behaviour resurfaced. Initially Henry was very restless in nature but this was later followed by more rational and tranquil conduct. Having resided in the asylum for five months, he was discharged for the final time on 13 April 1854. The last comment in his case notes recorded that on 16 July 1854 he 'destroyed himself at home by hanging with a handkerchief to the bedpost'.⁴⁴⁵ The second suicide was that of Sarah Johnson, a private patient admitted in February 1853. To begin with she was 'very much depressed' but gradually overcame this and instead adopted a 'more cheerful' demeanour. 'Having continued quite well' she was 'taken out by her husband' on 26 March and proceeded to commit suicide on 13 June; she 'hanged herself in her bedroom...at home'.⁴⁴⁶

Not all suicide attempts in the home proved successful. After a failed suicide attempt, patients were usually readmitted. Sarah Atkins was admitted to Birmingham Borough Asylum in 1855 and was 'apparently determined upon suicide, which she has once or twice very recently attempted'. Despite claims that 'she would not make another attempt' Sarah retained her propensity and wished 'to get to the canal'. Eventually she became 'tranquil, rational and cheerful' and was 'Discharged having continued well'. Three days later, on 21 August 1856, she was readmitted having the previous day 'jumped into the canal and tried to drown herself'.⁴⁴⁷ Sarah Fielding found herself

⁴⁴⁵ BCA, MS344/12/2, admitted 7 June 1851.

⁴⁴⁶ Ibid.

⁴⁴⁷ BCA, MS344/2/2a, admitted 27 October 1855.

readmitted to Birmingham after making several suicide attempts. During her stay in the asylum she 'cut her throat with a knife making a wound 3 inches long, but not deep'. At night she 'was still trying to injure her throat' which resulted in the use of 'some additional means of security' in the form of 'wrist and waist belts'. When her wound healed she began to show bodily and mental improvement. This culminated in her discharge on 8 March 1862. A month later she was 'readmitted having been insane 3 weeks' and attempted 'to cut her throat and to throw herself through the window'.⁴⁴⁸ What appears significant in the examples from Birmingham is the absence of trial leave as a precursor to full discharge. The patient's determination to commit suicide remained present in the asylum despite manifestations of rational and tranquil behaviour. Their continued preoccupation with self-destruction should have prompted a cautionary approach to discharge, whether trial or full.

When discharging a patient the priority for institutions and relatives was the avoidance of relapse and readmission. For the suicidal this objective could only be met if equal consideration was given to the patient's recovery and the domestic provision that awaited them. After-care was a secondary consideration, but the increased attention it received, and the negotiation that arose from it, distinguished discharge of suicidal patients from that of others. Discharge became a judgment not only about mental improvement and patient safety but care outside of the asylum. It was a process that affected the institution, patient, and relatives, all of whom experienced apprehension and anxiety because of the omnipresent risk that suicidal behaviour may return. To counter these fears it was essential that the determining

⁴⁴⁸ Ibid.

criteria for recovery recognised the complexities of a suicidal propensity. A cheerful, rational and tranquil demeanour had to represent more than a general improvement in mood. Behind the emotional checks it was essential that instinct and self-control were restored to act as repelling agents. Yet despite 'medical' assessment and discharge on trial it was impossible to guard against suicide attempts in every case. The tests of fitness for suicidal patients were, as Newington recognised, 'liable to be upset by individual cases'...and...'in active cases there will be difficulty of application'.⁴⁴⁹

* * * * *

Dangerousness was extremely influential when a suicidal patient was received into and allowed out of the asylum. The processes of admission and discharge were largely dictated by concerns for patient safety. As a consequence co-dependent relationships formed between medical and lay parties as each pursued both a common interest and individual objectives, whose success depended on mutual co-operation. The co-dependency that existed in this relationship actively empowered families, whilst preventing medical men from establishing a monopoly over the certification and discharge of suicidal lunatics. Determining dangerousness and the manageability of a patient's behaviour was only possible when medical opinion was supplemented and strengthened by the inclusion of lay information and showed due consideration to the wishes of the family.

The decision to admit and discharge suicidal lunatics followed a period of assessment that judged the patient's condition and the suitability of asylum or

⁴⁴⁹ Newington, 'What are the Tests of Fitness', p.500.

domestic provision. At the beginning and end of the patient's asylum stay, his behaviour was subject to critical evaluation that focused on risk and the restoration of self-control. The label 'dangerous' or 'suicidal' was applied as the outcome of this judgment and remained with the patient until he was released from the asylum. The dangerousness associated with suicidal behaviour dictated the pattern of treatment and management received by the patient. The label 'suicidal' did not stigmatise patients, instead it ensured that the care they received was guided by a concern for protection and prevention.

Managing and preventing suicide was a burden of responsibility that passed between lay and medical carers. Admission transferred patient welfare in to the hands of asylum attendants, but at the point of discharge the onus fell back to family and friends. Alienists' and families' preoccupation with determining dangerousness was a reflection of each party's desire to avoid suicide and guarantee patient safety. It was imperative that judgements made about the patient's behaviour, either during admission or discharge, were based on a comprehensive evaluation of the dangerousness of the suicidal tendency. The criterion for admitting and releasing suicidal patients was checked against signs of self-control, destructive and violent conduct, risk to themselves and others and external support. These factors formed the basis for determining dangerousness and the most appropriate location for patient treatment. A patient's dangerousness governed whether asylum or domestic provision was judged to be capable of effectively managing their behaviour and preventing suicide.

4

THE MANAGEMENT OF SUICIDE IN THE ASYLUM

Asylum patients required management of their behaviour alongside curative treatment. The extent of this depended on their mental affliction and the behaviour that resulted from it. The patient's insanity brought with it specific forms of behaviour that were characteristic of the disease itself but this was complicated, in some cases, by a destructive or suicidal tendency. Management in this context was not just about calming or controlling the 'natural' excesses of the affliction; it had to focus closely on patient welfare. By definition, management implies the regulation of a person's behaviour by means of control or containment. It was important that the asylum provided a suitable environment in which to manage suicidal patients. Suicidal lunatics were an exceptional patient group that challenged the standard practices of asylum management and patient treatment. Alienists had to question the unique nature of suicide in the asylum and translate their understanding in to an informed approach that placed suicide prevention and patient safety at the fore. The creation of a safe and secure therapeutic environment relied on close collaboration between alienists and architects. The opening section of this chapter questions the extent to which both parties actively considered the needs of suicidal patients and sought to use architecture as a functional and remedial tool. The concept of treatment through environment permeates much of the discussion as internal design increasingly operated with the dual function of prevention and cure.

Patients disposed to suicide lacked self-control and the innate ability to 'check' their own actions, so they required external, 'therapeutic', intervention to protect them. This was implicit within the treatment of insanity, but in suicidal cases the emphasis was on containment as opposed to outright control or punishment. Mechanical restraint and seclusion acted as a substitute for self-control, whilst constant watching ensured the patient's actions were closely monitored. Mechanical restraint and seclusion were accepted and integral methods of patient management that remained largely unchanged until the mid nineteenth century and the advent of non-restraint. There exists a clear dichotomy in the use of restraint and seclusion that is defined by changing attitudes and practices in the pre and post 1840s. The efficacy of constant watching was challenged, and hindered, as public asylums expanded, but its position as a leading method of suicide prevention was never really questioned. By comparison, the legitimacy of mechanical restraint and seclusion was extensively debated as asylums adopted a non-restraint policy. Restraint was no longer favoured and only when the patient was deemed highly dangerous and posed an 'extreme' threat was it justifiably imposed.

This second part of this chapter assesses the manner in which broadly accepted management techniques were adapted and applied to suicidal patients. It explores the benefits and limitations provided by each. Within this discussion consideration is given to the changing context in which all three techniques were practised and the ramifications for each, particularly mechanical restraint, in the post abolition period. The chapter also identifies and evaluates the criteria used to determine the imposition of each management technique. Attention falls on the classification of

‘extreme’ or ‘exceptional’ cases as necessary justification for the employment of restraint and seclusion. Linking together all of these ideas, this chapter aims to determine the meaning of ‘management’ when applied to suicidal lunatics and the extent to which protection, not control, was the main motivation.

Asylum architecture

The construction, arrangement, and government of Asylums for the Insane are subjects at this time so important, in consequence of the many new asylums about to be built in England and Wales...as well to deserve very careful consideration. Like everything connected with such institutions, they are of consequence in relation to the treatment of the patients; to their bodily as well as to their mental health; to their comfort or to their recovery.⁴⁵⁰

Prior to the nineteenth century there had been only a small number of public institutions for the insane, so the construction of asylums had occupied little attention. Although the County Asylum Act of 1808 empowered local authorities to construct asylums it offered very little practical guidance on precisely what kind of structure to erect. The Act suggested that asylums should house a maximum of 300 patients and be built in a healthy location. The internal design fared no better with only marginal consideration being given. Christine Stevenson describes the interior of these early institutions as consisting of a ‘range of cells banked onto a gallery

⁴⁵⁰ Conolly, *The Construction and Government of Lunatic Asylums*, p.1.

serving as both corridor and day room'.⁴⁵¹ The design appeared in various forms, such as the radial plan at Cornwall, but Stevenson states that this early blueprint remained 'the fundamental unit at larger nineteenth century asylums' until the 1860s when discussion of detached blocks and wings emerged.⁴⁵²

Contemporary alienists were also critical of early asylum design. In his work 'Practical Hints on the Construction and Economy of Pauper Lunatic Asylums',⁴⁵³ Samuel Tuke criticised the lack of ingenuity shown in asylum construction. He attributed this to 'the rarity of such erections, which excited but little stimulus, and led few, if any, to study the wants of their inhabitants'.⁴⁵⁴ Drawing on personal and practical experience within their own institutions, alienists published guidelines on the most appropriate construction and management of asylums. In her study of British hospital and asylum architecture, Harriet Richardson draws attention to John Conolly's *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (1847), 'which served as a pattern-book for asylum designers'.⁴⁵⁵ Conolly's publication provided guidance on aspects of planning, internal design and asylum management. It was 'the growing corpus of literature on hospitals' which, according to Richardson, provided further impetus for architectural change.⁴⁵⁶

⁴⁵¹ C. Stevenson, *Medicine and Magnificence. British Hospital and Asylum Architecture 1660-1815* (London, 2000), p.97.

⁴⁵² *Ibid.*, p.97.

⁴⁵³ Watson and Pritchett, *Plans, Elevations, Sections and Description of the Pauper Lunatic Asylum, lately erected at Wakefield, for the West Riding of Yorkshire; to which is added, a new and enlarged edition of S. Tuke's Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* (York, 1819).

⁴⁵⁴ *Ibid.*, p.11.

⁴⁵⁵ H. Richardson, *English Hospitals 1660-1948. A Survey of their Architecture and Design* (Swindon, 1998), p.5.

⁴⁵⁶ *Ibid.*

The basic principles of internal and external design were a reflection of judgements made by others upon the best environment for asylum patients. Judgements were based on the perceived needs of the patient, and any danger their behaviour presented, as well as concerns about security and rudimentary issues such as ventilation and sanitation. Although functionality underpinned institutional design, alienists began to perceive the asylum building as a remedial agent in the care and treatment of the insane. This fostered closer collaboration between the architect and the alienist. If the asylum's internal structure was to be fully utilised as a therapeutic tool then the premise of curative treatment had to feature in and, to a certain extent, determine the arrangement and construction of the asylum. The architect's vision was vital to the creation of an environment that facilitated cure. Barry Edginton emphasises how important the skills of the architect became. He states that 'it was their task to prepare the physical space of confinement, where in, turn physicians could create the proper therapeutic atmosphere'.⁴⁵⁷

Treatment through environment was motivated by a desire to 'facilitate a transfer of the salubrious nature of a well-ordered place of treatment to the body and mind of the lunatic'.⁴⁵⁸ For the majority of patients a well-ordered environment was established to promote recovery. Unfortunately, the demanding behaviour of suicidal and violent patients introduced another dimension. It was crucial that architects and alienists took into account patients' ingenuity in using their surrounding environment to commit acts of self-destruction. Internal design had to operate with the dual function of prevention and cure (in that order). The underlying concern to prevent

⁴⁵⁷ B. Edginton, 'The Well-Ordered Body: the Quest for Sanity through Nineteenth-Century Asylum Architecture', *Canadian Bulletin of Medical History*, vol.11 (1994), p.376.

⁴⁵⁸ *Ibid.*, p.375.

suicide led Dr Maximilian Jacobi, medical superintendent at the Seigburg Asylum in Prussia, to declare that the first characteristic feature of an institution's design should be 'the security of the patient, in so far as his mental derangements may induce him to make attempts on his own life'.⁴⁵⁹ Although a leading somatic psychiatrist in Prussia, Jacobi's work was translated into English at the suggestion of Samuel Tuke.

To ensure even a modicum of success, suicide prevention had to feature explicitly within the architect's internal design. Only by acknowledging and including suicide provision at the earliest stages of planning could certain design features be avoided or modified and special arrangements made in areas where suicidal patients would be housed. If the asylum was constructed with an explicit appreciation of the danger posed by suicidal patients, it was capable of acting as a remedial agent. More importantly, the asylum environment could form an important tool in the prevention and management of suicidal behaviour. It is that possibility, and the extent to which suicidal patients were actively considered by both the architect and alienist, that this section is concerned with.

The asylum's basic function was to provide secure custody and curative interventions for those who came to inhabit its space. Establishing and maintaining equilibrium between these two strands posed a dilemma. Alienists recognised that the pursuit of recovery was an essential aspect of asylum care, but often it was sidelined in favour of security and surveillance. The creation of an internal lay out and structure that facilitated secure superintendence of patients was a prominent

⁴⁵⁹ M. Jacobi, *On the Construction and Management of Hospitals for the Insane* (London, 1841), p.15.

objective in the design of institutions. A secure environment was applicable to all who resided in the asylum and should not be perceived as a unique requirement of suicidal patients. Naturally, the need for prevention and security was far greater and required close attention when the architect designed areas to be occupied by suicidal patients.

Supervisory concerns were reflected in the adoption of either the H, radial, or panopticon designs.⁴⁶⁰ The central principle of each design was inspection, which in turn provided security. Bentham's panopticon design, versions of which appeared mainly in Ireland and Scotland, aimed to ensure a 'mild and yet vigilant system of management based upon the 'unseen eye'.⁴⁶¹ William Stark's radial design provided 'a superintendence unusually active and efficient, which follows and watches every motion of the patient'.⁴⁶² Stark was overtly critical of what he viewed to be inadequate classification and surveillance in English asylums. In his discussion of Glasgow's radial design, Thomas Markus concludes that 'Stark's sole goal was to overcome these deficiencies'.⁴⁶³ To facilitate a system of vigilance long corridors became an essential and common feature of all three designs. Their inclusion in the asylum's structure allowed easier access to, and views of, the dormitories, galleries, and day rooms where patients spent much of their time. Stark's design and the panopticon recognised that surveillance should not equate to a prison-like

⁴⁶⁰ The H design was a linear structure with symmetrical buildings. The two long wings were used to separately house male and female patients. The radial design had a central administrative building from which the various corridors and wings spanned out in a semi circle. The panopticon was designed to allow round-the-clock surveillance. A central tower was incorporated into a circular building that was divided into dormitories and wards.

⁴⁶¹ M. Donnelly, *Managing the Mind: a Study of Medical Psychology in Early Nineteenth Century Britain* (London, 1983), p.66.

⁴⁶² Ibid.

⁴⁶³ T. Markus, *Buildings and Power. Freedom and Control in the Origin of Modern Building Types* (London, 1993), p.135.

environment. Stark emphasised that superintendence should be conducted so that 'it assures to him [the patient] a more than ordinary degree of individual liberty...of ease, comfort, and enjoyment'.⁴⁶⁴ Albeit contradictory to conceive that security and 'cheerfulness' could co-exist, this was in fact a scenario which alienists, including Conolly and Tuke, advocated. Conolly stated that 'security does not require gloom, or a frightful apparatus'.⁴⁶⁵ This assertion was borne out of alienists' collective desire to disassociate their institutions from prisons and the workhouse, both of which carried distinctly punitive overtones.

It was necessary to create a civilised environment that detached itself from any penal connotations because patients were sensitive to their surroundings. As Scull points out 'it was thus not an extravagance to design and build institutions which emphasized cheerfulness by being aesthetically pleasing'.⁴⁶⁶ It was assumed that patients retained a certain degree of humanity and rationality which allowed them to remain aware of, and be influenced, by their surroundings. Alienists advocated the replacement of imposing and monotonous architecture with an environment that stimulated recovery. By cultivating a cheerful atmosphere and providing more spacious accommodation it was hoped that patients would be encouraged to replace morbid feelings with positive thoughts. In the absence of cheerful optimism, the institution would remain counter-therapeutic and serve only to reinforce the patient's sense of confinement and feelings of despair. Security, surveillance and patient comfort were not always conducive to one another, but they had to be incorporated

⁴⁶⁴ Ibid., p.66.

⁴⁶⁵ Conolly, *The Construction and Government of Lunatic Asylums*, p.8.

⁴⁶⁶ A. Scull, 'A Convenient place to get rid of inconvenient people: the Victorian Lunatic Asylum', in A. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 1980), p.48.

in to the internal design of the asylum. The balance was inevitably a difficult and precarious one to maintain because suicide prevention demanded that security and surveillance prevail as a principal concern.

Efforts to create a secure environment resulted in the adoption of several, commonly used, approaches that aimed to protect suicidal patients. These techniques were often abundant but, according to Conolly, they should never become obtrusive. He was emphatic that no means of security should be omitted when caring for suicidal lunatics:

Well-devised doors and windows; knives of which the edges are so contrived as to prevent the infliction of serious or sudden injury; fire-guards, where most needed; the absence of all obvious or suggestive means of suicide...constitute the chief parts of the apparatus of safety required.⁴⁶⁷

An underlying concern for patient safety encouraged alienists and architects to incorporate preventative measures in to the design of furniture and the 'fixtures and fittings' of the institution. Patients frequently drew on their surroundings to facilitate suicide; examples being the use of gas burners or window handles. It became increasingly apparent that modifying the asylum's structure could prevent such acts.

⁴⁶⁷ Conolly, *The Construction and Government of Lunatic Asylums*, p.83.

Watson and Pritchett's design for the West Riding Asylum at Wakefield exemplified alienists' and architects' concern for patient welfare.⁴⁶⁸ They paid considerable attention to the construction of internal staircases. Watson and Pritchett stressed that 'all the staircases for the use of the patients, are formed round square brick pillars, to prevent the possibility of those accidents which have sometimes happened, from patients throwing themselves over the handrail'.⁴⁶⁹ The design of internal staircases was intended to assist patient surveillance and staff communication. It was important that attendants maintained a view of each level when moving between floors. The circular design adopted at Wakefield ensured that:

from a landing about half way between this and the next story, all that go up or down have a complete view, at the west end, of what is going on in the three galleries, the kitchen, wash-house, brew-house, and laundry; and at the east end, a similar view of the three galleries, of the men's kitchen, and the three day rooms for patients.⁴⁷⁰

The two circular staircases were positioned at the intersection of the wings to allow attendants to communicate with all parts of the building; importantly patients did not have access to them.

Windows were another aspect of internal design that received notable attention because they offered multiple opportunities by which a patient could commit suicide.

⁴⁶⁸ It is important to bear in mind that Watson and Pritchett based their design on Tuke's ideas. In his instructions, Tuke emphasised that the asylum should be designed with regard to inspection, security and a degree of cheerfulness.

⁴⁶⁹ Watson and Pritchett, *Plans, Elevations, Section*, p.29.

⁴⁷⁰ *Ibid.*, p.27. It was only the staircases at Wakefield that were circular in design. The asylum building itself was designed as an H shape.

Windows were commonly smashed, but often more for protest or destructiveness rather than self-harm. Nonetheless some patients proceeded to use the shards of glass to cut themselves. If cord formed part of the window's opening mechanism then hanging became an option, and finally there was the danger of a patient jumping from a window. Each method could be overcome by the imposition of wire guards and the avoidance of cord in the window mechanism. To protect the panes of glass from being broken the 'windows are guarded in the inside by a strong, but not too dense, wire grate placed before them'.⁴⁷¹ At Birmingham Borough Asylum the need for wire guards was acknowledged in the medical superintendent's monthly report of July 1851:

He begs to suggest the adoption of some plan to lessen the number of broken windows in the refractory courts and galleries. This may be accomplished either by a wire protection or by the use of very thick glass.⁴⁷²

Similar concern emerged at Gloucestershire County Asylum. Wire guards were not implicit within the asylum's original design, but following an act of self-destruction in 1851, modifications were recommended. The Reverend John James Halton, a second-class patient, committed suicide on 13 September 1851 by 'breaking through the window of his bed-room on the fourth floor of the Crescent and precipitating himself from it to the area below, a depth of forty feet'.⁴⁷³ This fatal incident prompted a reconsideration of the asylum's design. It was:

⁴⁷¹ Jacobi, *On the Construction and Management*, p.67.

⁴⁷² BCA, MS344/2/1, Medical Superintendent's Report Book, 1850-1853.

⁴⁷³ GA, HO22/1/1, General minutes, 1813-1851, p708-709.

resolved that in order to make the windows of the crescent secure, it is most desirable that wrought iron sash bars should be substituted for the present wooden ones, and that the size of the frames should be diminished.⁴⁷⁴

The response at Gloucester demonstrates a growing awareness amongst medical superintendents that internal design could assist suicide prevention and patient safety. Although omissions were made in the original design it was significant that measures were instituted in response to attempted or completed suicides.

In his discussion of the arrangement for melancholic and suicidal patients, Jacobi gave careful consideration to the validity of cord being used to operate the window's opening mechanism; in his classification such patients constituted the 4th division. He acknowledged that if the window could be opened by means of a cord then the attendant must 'take great care, however, that the part of the cord hanging down in the gallery, never descends so low, that any patient who may be there, may be able to seize hold of it and abuse it'.⁴⁷⁵ This instruction was applicable to all patients regardless of which division they belonged too since the cord could be abused by destructive and violent patients. Safeguards in the 4th division went beyond ensuring the cord did not extend into the patient's reach. Jacobi was adamant that the opening and shutting of the windows in this area should be affected in a more secure manner. He outlined the comprehensive design adopted at the Seigburg Asylum:

⁴⁷⁴ Ibid.

⁴⁷⁵ Jacobi, *The Construction and Management*, p.66.

To the lower margin of the window-frame is attached an iron bar one inch broad, an eighth of an inch thick, and two feet long, to correspond with the breadth of the window-sill on which it rests with its free end directed inwards, and furnished with a small projecting tooth. This bar is pushed out by means of a round, thin, iron rod kept by the attendant.⁴⁷⁶

Jacobi's insistence on removing cord demonstrated an intuitive recognition that suicidal patients could not be trusted. The most effective and simplest method of prevention was to remove the cord. Adjusting the design ensured that only the attendant could open or close the window thus denying the patient an opportunity to commit suicide.

Despite efforts to safeguard windows by way of design, patient ingenuity ensured window shutters and handles were still utilised. T.M. a pauper patient admitted to the Devon County Asylum in November 1869, was 'a violent and impulsive man, but not considered suicidal'. With no known indications of a suicidal propensity he was placed in a single room and 'hanged himself by his bed-sheet from one of the openings in the window shutter'.⁴⁷⁷ It was noted by the Commissioners in Lunacy that this was 'precisely the same means which had been successfully used by F.W., a fellow patient in the preceding month of August'.⁴⁷⁸ The examples taken from Devon are not exclusive. Suicides by hanging also occurred at Leicestershire County Asylum. James Palpreyman was admitted in November 1852 as 'a precautionary means against his frequent attempts at suicide'. After 'many elaborate attempts at

⁴⁷⁶ Ibid., p.84.

⁴⁷⁷ *Thirty-seventh Annual Report of the Commissioners in Lunacy*, PP 1883, p.83.

⁴⁷⁸ Ibid.

suicide' he 'succeeded on the 21st July [1855] in strangling himself by means of a strip of sheet fastened to the handle of his dormitory window'.⁴⁷⁹

In the previous year Francis Garfoot, a charitable patient, committed suicide 'by hanging himself to the window of his dormitory by means of a silk handkerchief which he had secreted about his person'.⁴⁸⁰ Similar circumstances surrounded the suicide of William Rice in July 1876. The deceased was found 'hanging by the neck by means of a towel fastened to the closet window'. Evidence at the coroner's inquest revealed that the patient had been left unattended but no blame was attributed 'to any of the officers'. The inquest verdict declared that Rice had committed suicide whilst in a 'state of temporary insanity'.⁴⁸¹ The cases outlined at Devon and Leicestershire reveal how patients often used components of the asylum's internal design to commit suicide. It is also apparent that the window only became useful if the patient first acquired a handkerchief, scarf or similar item. When prevention and surveillance faltered and the patient was able to secrete an item, then the design of the window became paramount; without a handle or shutter on which to attach the handkerchief or sheeting the patient's endeavours would be thwarted.

The position of gas burners courted significant discussion at Birmingham Borough Asylum. Recorded in Birmingham's annual report of 1850, John Randall made an attempt at suicide 'by suspending himself from the gas burner in the lavatory'.⁴⁸² Fortunately, Randall was seen by another patient and was prevented from

⁴⁷⁹ LCRO, DE3533/186, admitted 29 November 1852, admission no.1305.

⁴⁸⁰ LCRO, DE3533/83, Medical Superintendent's Journal and Report Book, 1854, p.13.

⁴⁸¹ LCRO, DE3533/194, admitted 12 May 1876, admission no.3656.

⁴⁸² BCA, MS344/2/1, Medical Superintendent's Monthly Report, 18 December 1850.

accomplishing his objective. During the following year another male patient attempted suicide in similar circumstances. Charles Barnett was discovered 'a little before 9 o'clock on the evening of Saturday last, he was found in the water closet of gallery no.5 suspended by his neck scarf to the gas burner'.⁴⁸³ Although attendant negligence was a contributory factor in Barnett's suicide, as he was temporarily allowed out of sight, the positioning of the gas burner came under scrutiny. Thomas Green, medical superintendent, stated in his annual report of 1851:

I must again beg leave to direct the attention of the visitors to the position of the gas burners; which are not only conveniently placed for the purpose of self-destruction, but are actually suggestive of it, especially those in the water closets and lavatories.⁴⁸⁴

Green raised additional concerns about the doors of the water closet, which opened inwardly. This design was deemed inappropriate because it allowed the patient to barricade himself in, 'which is easily done by placing the back against it, and the feet against the seat'. Once in this position he could 'with a strip from his shirt, or a bit of broken glass' inflict his purpose before an attendant could reach him and try to prevent the attempted suicide.⁴⁸⁵

At Worcestershire County Asylum, Elizabeth Berwich used a gas burner to facilitate her suicide. Admitted in December 1868, suffering from melancholia, Elizabeth had

⁴⁸³ Ibid., Medical Superintendent's Monthly Report, 5 September 1851.

⁴⁸⁴ Ibid.

⁴⁸⁵ Ibid.

previously threatened to stab her husband and 'destroy her own life'. Despite showing signs of improvement on the 17 April 1870 she was:

found by the attendant of her ward on entering the lavatory belonging to the gallery, suspended to the gas-bracket by means of a piece of twine and calico and chair placed in such a position as to enable the deceased to attach the string around her neck.⁴⁸⁶

An inquest was held three days later that concluded Elizabeth 'died from hanging herself whilst in a state of unsound mind'.⁴⁸⁷ The Lunacy Commission were subsequently informed of the incident and commented on the case in their annual report. They recognised that in many instances the positioning of gas brackets afforded 'facilities for patients hanging themselves'. In view of this conclusion they recommended that 'these brackets throughout the Asylum should be removed, and that other means of lighting the lavatories and bath rooms should be adopted' to prevent future incidents of suicide.⁴⁸⁸

Alienists recognised that institutional design could be utilised as a mechanism for managing patient behaviour regardless of its remedial benefits. Esquirol wrote in 1817 that 'whatever the strengths of the physician's prognostic or 'taxonomic impulse', architecture was of central importance to management and hence to

⁴⁸⁶ WRO, BA10127/18, admitted 18 December 1868, admission no.2206.

⁴⁸⁷ Ibid.

⁴⁸⁸ WRO, BA9665/1-3, Worcestershire County Asylum Eighteenth Annual Report (1871), p.13.

cure⁴⁸⁹. Institutional design was no longer perceived as a trivial matter and the sole domain of the architect. The task of supervising a large number of disruptive, suicidal and violent patients, in a confined space, encouraged architects and alienists to collaborate and establish security and surveillance as the cornerstones of asylum architecture. Attention to architectural arrangements was imperative if suicidal patients were to be prevented from indulging their propensity by making use of the surrounding environment. The scrutiny that doors, fire guards, windows, and gas burners came under demonstrates alienists' fear of suicide and their desire to overcome this by integrating function and security into the architecture of the institution.

Classification

Classification was a system that organised patients according to their diagnosis, behaviour and social class. Another significant element in classification was the separation of 'curables' and 'incurables' and the 'clean' from the 'dirty'. From a curative perspective, Tuke believed it was important to view the 'vacillations in each patient's disease'. Such close attention was not so well obtained 'when they are visited en masse, as when they are separated into smaller divisions, and arranged in suitable classes'.⁴⁹⁰ Models of classification did vary, but as a general rule patients were separated into classes according to nineteenth-century diagnostic categories. Behaviour, gender and social class were also taken into account so that:

⁴⁸⁹ Stevenson, *Medicine and Magnificence*, p.208.

⁴⁹⁰ Watson and Pritchett, *Plans, Elevations, Sections*, p.13.

the whole body of the patients of both sexes must be divided into certain chief classes, according to the greater or lesser degree of influence, which their disease has over their moral and social behaviour, and according to the degree, dependant upon the measure of this influence, of their ability or inability to conduct themselves in a quiet, cleanly, decent, and orderly manner, to observe prescribed rules, and to employ themselves usefully.⁴⁹¹

The character of the disease was of prime importance because it influenced the patient's behaviour and ability to exert self-control. Segregation, according to the disposition of the individual, was central to the pursuit of individualised treatment. When patients of a similar character were grouped together, treatment and management could, according to Scull, be adapted to the 'idiosyncrasies of the patients...the symptoms, the duration and the complications of the disease'.⁴⁹²

Asylum staff could use classification to induce patient conformity and self-restraint. If a patient behaved in a manner deemed unacceptable within his division then he was demoted to a different class where 'the available social amenities were sharply curtailed'⁴⁹³. Markus describes this practice as control through space. 'Re-formation' of an individual by the internal structures of a controlled space was central to the design of institutional buildings. Rules were 'built into space and its management; they define the location of persons and things, they control the paths of movement

⁴⁹¹ Jacobi, *The Construction and Management*, p.66.

⁴⁹² Scull, MacKenzie and Hervey, *Masters of Bedlam*, p.108.

⁴⁹³ Scull, 'A Convenient place to get rid of inconvenient people', p.46.

and the degree of choice'⁴⁹⁴. Markus concludes that the building and its management determined what patients were allowed to do, where and with whom.

Classification required the construction of dormitories and wards specially suited to each category of patient. To avoid the association of patients with conflicting behavioural or medical conditions, the various wards needed to be distributed methodically across the asylum. At Worcestershire County Asylum classification was viewed as a necessary tool for controlling behaviour and treating the patient's mental condition. It was suggested that:

those liable to sudden and violent paroxysms, and those suffering from acute attacks of insanity, should be separated from all the others, and provided with special arrangements of building, and be attended by a more numerous staff of attendants to ensure their safety and protect them from their own or others violent impulses.⁴⁹⁵

The call for 'special arrangements' and increased levels of staff demonstrate a preoccupation with protection and prevention. Alienists recognised that patient safety and surveillance were attainable if the two elements worked in conjunction.

The separation of epileptic and suicidal patients was also discussed at Worcestershire County Asylum. The behaviour and demeanour of epileptic patients was considered detrimental to the suicidal because 'the former are generally

⁴⁹⁴ Markus, *Buildings and Power*, p.97.

⁴⁹⁵ WRO, BA9665/1-3, Worcestershire County Asylum Annual Report (1871), p.57.

incurable, and in most of the latter prognosis is favourable'. It was acknowledged that suicidal patients required cheerful surroundings, and the 'presence of persons suffering from convulsions with excitement, with wild and maniacal derangement, would have a prejudicial effect on their relief and recovery'. There was concern that epileptics in the advanced stages of the illness 'become so degraded...and helpless in respect of themselves and sometimes so dangerous as regards others, that their proximity to suicidal cases...would be ruinous'.⁴⁹⁶ James Sherlock, medical superintendent, identified the dangers presented by both epileptic and suicidal patients and suggested that:

Classification of both these divisions of Patients is necessary, and will undoubtedly sooner or later be carried out especially where the construction of a new Asylum is undertaken, and in that case provision should be secured for the night attendance of such persons in their several wards by constructing proper dormitories and single rooms as would admit of their ready and constant supervision.⁴⁹⁷

Classification, particularly for the purpose of individualised treatment, encouraged a considered approach to the organization of institutional space. Assessing the needs and behaviour of different patient categories, and determining where and with whom they should be housed, affected both architectural plans and patient treatment. It was beneficial, for patient management and institutional organisation, to expand the boundaries of classification and arrange dormitories and wards in a segregated fashion.

⁴⁹⁶ WCRO, BA9665/1-3, Annual Report (1873), p.72.

⁴⁹⁷ Ibid.

Security and surveillance were foremost in the minds of architects and alienists, and were of great importance in the management and treatment of suicidal patients. By itself design was not a comprehensive solution to suicide or a replacement for observation; it became a useful adjunct to the vigilance of attendants and supported the principles of moral treatment. It was possible to use the asylum's interior space as a means of asserting control over the patient and the 'impressions' that acted upon his diseased mind. These advantages were brought to bear on all patients, but for the suicidal lunatic it was the incorporation of preventative measures, like window guards, into a specially designed institutional space that was most significant. Prevention, security and surveillance were imperative and required that function rather than remedial treatment was the prime intention and focus of the asylum's internal design and the expansion of patient classification.

Alienists acknowledged the influence that architecture could exert over the patient's mental well being and the organisation of the institution. Unfortunately, asylum expansion and the demise of moral treatment saw attention to design lessen. The pursuit of economy and overriding desire for custody rather than cure resulted in *ad hoc* additions being tacked onto existing buildings. Architecture ceased to function so dominantly as a remedial agent; it became increasingly bland and monotonous, reverting back to those elements which were reminiscent of prison or the workhouse. The creation of a cheerful and safe environment that promoted cure and aided suicide prevention was increasingly seen as an extravagance that local authorities were unwilling to subsidise. Architecture became another, very visible, example of

how financial concerns and the changing nature of the institution undermined the prevention of suicide and the general treatment of the insane. As Scull aptly argues, the *ad hoc* growth of institutional buildings displaced aesthetically pleasing and functional architecture so 'that the asylum was now a mere refuge or house of detention for a mass of hopeless and incurable cases'.⁴⁹⁸

Constant watching

nothing but a constant and lynx-eyed survey will prevent the self destruction of a large proportion of lunatics, when they have a wave of suicidal tendency passing over their minds.⁴⁹⁹

A discourse of prevention permeated contemporary literature and asylum practice throughout the nineteenth century. At its centre lay the absolute necessity of constant observation by the ever watchful attendant. Other means of patient management and suicide prevention emerged but the role of surveillance remained consistent. Attendant vigilance was listed, albeit briefly, in the rules and regulations of early public asylums. The rules for Nottingham asylum, were published in 1825, and stated that 'the assistants and servants be vigilant in preventing patients from injuring themselves or others'.⁵⁰⁰ In 1828 Suffolk County Lunatic Asylum published its rules and regulations, which included clear instruction on the importance of observing patients. It was required that:

⁴⁹⁸ Scull, 'A Convenient place to get rid of inconvenient people', p.57.

⁴⁹⁹ Wynn Westcott, *Suicide: Its history*, p.128.

⁵⁰⁰ NCA, *Rules, Orders, & Regulations, established for the management and conduct of the institution* (1825), p.61.

The keepers' utmost vigilance must be exerted to prevent Patients from obtaining possession of any knife, scissors, tool or instrument whatever, by which injury to themselves...may be attempted. In case any mischief shall arise from the neglect of this rule, strict and immediate investigation to be made by the Superintendent.⁵⁰¹

Constant watching was a principle that existed throughout the century, but it was more clearly defined after 1840. Gardiner Hill promoted observation as an essential substitute for mechanical restraint, and so it came to embody the very essence of patient management and, more specifically, suicide prevention. Constant watching was fundamental in its own right to the prevention of suicide, but it also contributed to the effectiveness of other forms of patient management. Efforts to safeguard medicine, razors and knives from the clutches of suicidal patients were largely ineffective, without the roaming eye of the attendant to act in support. This was particularly important during mealtimes and periods of outdoor recreation. In the dining room and the airing courts a host of new dangers existed, as patients came in to contact with implements and tools that could inflict self-injury. Constant watching had to embody the whole institution, so that attendants could cast their preventative gaze over every potential opportunity for self-destruction.

⁵⁰¹ SCRO, *Suffolk County Lunatic Asylum, Rules, Regulations, &c.*, p.14.

‘Responsibility for the safety of suicidal patients in the asylum fell on the attendants’.⁵⁰² Central to their role was the active prevention of suicides; ‘the public and the Commissioners look to the officers of asylums’ to ensure prevention of self-destruction.⁵⁰³ The success of constant watching depended on the expertise and calibre of attendants. During the nineteenth century, the majority of attendants embarked on their duties with insufficient training. Peter Nolan contends that ‘For the most part, more was expected of the attendants than their background and lack of training’ permitted them to deliver.⁵⁰⁴ Nancy Tomes, in her study of American asylum practice, concluded that, unremitting vigilance placed further demands on asylum staff as they were ‘expected to know exactly where their charges were at any time of the day or night’.⁵⁰⁵ When patients spent time in the privacy of their own room, the attendant was required to ‘find reasons for frequently calling to see how they were engaged’.⁵⁰⁶ If the patient went outdoors, to participate in exercise or employment, observation was maintained to prevent the secretion of a potential weapon of self-destruction. The attendant was expected to fulfil their duties with tremendous discipline and attention to detail, for the shortest lapse in concentration could be seized upon by the patient.

The consequences of neglecting one’s duty are evidenced by a successful female suicide at Rainhill Asylum in 1864; ‘the only one that has occurred during the last

⁵⁰² This opinion was expressed by Hayes Newington, medical superintendent at Ticehurst private asylum, during the mid-nineteenth century. A strong advocate of the need to emphasise prevention in suicidal cases, he devolved a great deal of responsibility to the asylum attendants for the prevention and safety of suicidal patients. MacKenzie, *Psychiatry for the Rich*, p.179.

⁵⁰³ Savage, ‘Constant Watching of Suicidal Cases’, p.17.

⁵⁰⁴ Peter Nolan, *A History of Mental Health Nursing* (London, 1993), p.47.

⁵⁰⁵ Nancy Tomes, *The Art of Asylum- Keeping: Thomas Story Kirkbride and the Origins of American Psychiatry* (Philadelphia, 1994), p.179.

⁵⁰⁶ *Ibid.*, p.180.

eight years'.⁵⁰⁷ The patient had made several suicide attempts previous to her admission, and 'it would appear that she only wanted an opportunity which was afforded by a temporary relaxation of vigilance on the part of the Attendant'. A lapse in concentration meant she was able 'to effect her purpose which she did by suspension by means of the strings of her flannel petticoat'.⁵⁰⁸ At Warwickshire County Asylum 'the neglect of an attendant' enabled Robert Dowding to attempt suicide in 1853. It was acknowledged that he had a 'strong disposition to suicide and has twice been detected endeavouring to strangle himself'. In response he was ordered to be constantly watched, but despite this intervention, he was found 'in the water closet' where he had 'tried to injure his throat with some edged scissors'. Fortunately he 'could do no more than lacerate the skin in a small spot'.⁵⁰⁹ A further example was discussed at length in Worcestershire County Asylum's annual report of 1873. It was noted that 'during the past year a suicidal wave has been perceptible' and some attempts 'of a most determined character' were made 'in the presence of their guardians'. These were all detected except in two cases where patients 'were allowed by their Attendants to separate themselves from the ever-present supervision spoken of...as essential for their safety'.⁵¹⁰

In both of these persons considerable apparent improvement had been obtained under Asylum care, but the culpable relaxation of our regulations by the Attendants in charge...resulted disastrously.

⁵⁰⁷ LRO, M614 RAI/40/2/30, Medical Superintendent's Annual Report (1864), p.111.

⁵⁰⁸ Ibid.

⁵⁰⁹ WCRO, CR1664/617, admitted 10 October 1853.

⁵¹⁰ WRO, BA 9665/1/2, Annual Reports 1869-1876, p.96.

In one of the above unfortunate cases life was not extinct, when the patient was, after a few minutes absence from observation, discovered strangling herself with the cord of a window blind of the dormitory which she occupied at night, and which she had been allowed to enter upon some seemingly rational pretence.⁵¹¹

In the latter case it was concluded that 'the Attendant in charge of the Patient was guilty of grave negligence in allowing the person to be out of observation for a considerable period'.⁵¹² These tragic results reinforce the insurmountable pressure and responsibility placed on the conduct and self-discipline of the individual attendant.

It should not be assumed that lapses in concentration occurred solely because the attendant carelessly shrugged the responsibility of their duties (although this may have been valid in specific cases). Even the most disciplined attendant faced distractions and complications beyond their own control; staffing infrastructure, patient-attendant ratio and an increasing patient population all threatened to undermine the role of the attendant. Frequently reported and criticised by the Lunacy Commission, inadequate staffing levels plagued nineteenth-century asylums. Constant watching of suicidal patients was one element of asylum practice that was particularly susceptible to a shortfall of attendants. The effectiveness of constant watching hinged upon a tightly structured staff of attendants, large in number, and free from distraction. Unfortunately, this ideal was endangered by an increasing

⁵¹¹ Ibid.

⁵¹² Ibid., p.101.

patient population that rapidly out-paced attendant recruitment and retention. Peter McCandless has observed that the nineteenth century witnessed a culture of 'build, build' 'which brought a skyrocketing in the number and scale of mental hospitals'.⁵¹³ The drive towards institutionalization brought overwhelming numbers of mentally afflicted individuals into asylums built to house far fewer lunatics. Asylums were also restricted by financial hardship and were unable to respond proactively to overcrowding by enhancing attendant numbers in direct correlation to the rising patient population.

Originally built in 1850 to accommodate three hundred patients, by 1869 Birmingham Borough Asylum was housing 632 patients; 'at which time the house was very crowded'.⁵¹⁴ Conolly recommended that the ideal patient attendant ratio was between thirteen to seventeen patients for each attendant.⁵¹⁵ Birmingham Asylum failed to match this and in the mid-nineteenth century operated with '22 to each nurse, or deducting the laundry and kitchen patients nearly 20 to each'.⁵¹⁶ Thomas Green, Birmingham's medical superintendent, and the Commissioners in Lunacy acknowledged that the number of attendants engaged at the asylum was too few. The Commission was quick to 'suggest for the consideration of the Committee whether it would be expedient to make some addition there to'.⁵¹⁷ Birmingham Asylum was not alone; a similar pattern of overcrowding was emerging throughout the English asylum system. Colney Hatch initiated a staffing restructure in 1859 to

⁵¹³ Peter, McCandless, 'Build, Build! : the Controversy Over the Care of the Chronically Insane in England, 1855-1870', *Bulletin of the History of Medicine*, vol.53 (1979), pp.553-574.

⁵¹⁴ BCA, MS344/2/2, Birmingham Borough Lunatic Asylum Nineteenth Annual Report (1869).

⁵¹⁵ Published in 1847, Conolly's work *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, made explicit the need for public asylums to strive for a ratio of 1:17, although 1:15 was considered a more preferable ideal, p.83.

⁵¹⁶ BCA, MS344/2/2, Nineteenth Annual Report (1869).

⁵¹⁷ Ibid.

compensate for a patient increase to 2,000. Extra attendants were drafted into the asylum so that 'no ward containing patients of a violent character had less than two nurses at any time'.⁵¹⁸

As Scull explains, the establishment of public asylums had a paradoxical effect on the number of insane people. Between 1844 and 1860 the population as a whole grew by 'just over 20 per cent', whereas the number of lunatics virtually doubled.⁵¹⁹ In their annual report of 1856, the Lunacy Commission expressed concern at the rapid increase. They noted:

the crowded state of nearly all the County Asylums, and the urgent necessity of making further immediate provision for the care and treatment of the Insane Poor...in nearly every County the accommodation provided in Asylums is, at present, or shortly will be, inadequate.⁵²⁰

The expansion of the asylum system appeared to create an increased demand for its own services. Attendants were responsible for a vast array of insane people, in asylums that had expanded on an immense scale far beyond expectation. Under these circumstances, asylums struggled to recruit a sufficient number of attendants who were capable of observing patients day and night.

⁵¹⁸ Colney Hatch Asylum had only opened eight years prior to this restructure and was forced to respond very quickly to the rapid population explosion it experienced. Hunter and Macalpine, *Psychiatry for the Poor*, p.93.

⁵¹⁹ Ibid., p.223.

⁵²⁰ Ibid., p.248.

Until the late nineteenth century, attendants were in receipt of limited formal training and relied on asylum regulations to inform and reinforce the expectations to which they should adhere. 'Special instructions are given in writing to the attendants in charge to keep them (suicidal patients) in constant view'.⁵²¹ The power of the written word was utilised by asylum superintendents to engrave on the minds of attendants the absolute necessity of unremitting vigilance and the significance this duty held within the rules and regulations of the asylum. Once in writing the attendant could not deny his knowledge of his duty to ensure the safety of suicidal patients. Individual asylum instructions were supplemented by the growth of published material outlining the duties of asylum staff. Attendants were made the subject of several handbooks; the most important was produced by the Medico-Psychological Association. In 1885 the MPA published *The Handbook for the Instruction of Attendants on the Insane*, in which they outlined in detail the expected duties and responsibilities of an asylum attendant.⁵²²

A milestone in the broader education and development of attendants, the MPA handbook was also a vehicle for reinforcing the importance of suicide prevention. After a suicide at Ticehurst private asylum in the early 1880s, Hayes Newington, medical superintendent, became an active proponent for greater suicide prevention. Newington's strong adherence to effective suicide prevention led to his involvement in the MPA handbook. In the handbook Newington fervently conveyed his belief in the 'need for watchfulness in suicidal cases'.⁵²³ By the end of the nineteenth century,

⁵²¹ StaCRO, Q/Alc/1/2/3-16, Staffordshire County Lunatic Asylum Seventy-first Annual Report (1889).

⁵²² Medico-Psychological Association, *Handbook for the Instruction of Attendants on the Insane* (1885).

⁵²³ MacKenzie, *Psychiatry for the Rich*, p.179.

asylum attendants could not avoid the plethora of written instructions and handbooks which outlined their role and reinforced their responsibility for ensuring patient safety.

'Watched, so long as it was deemed necessary, during the day, placed in rooms with other patients by night, and frequently visited'⁵²⁴, surveillance of suicidal patients did not remain static. The manner in which surveillance was conducted varied as both patients and attendants made the transition from day to night. Having passed through the night without causing concern, the threat from melancholic patients did not abate with the arrival of morning. 'Bear in mind that the morning is the time when all melancholics are at their worst, and most likely to do themselves harm'.⁵²⁵ Following a restless night, 'with little or unrefreshing sleep, he wakes in the deepest gloom, with all his morbid thought intensified, without hope in this world'⁵²⁶. Attendants needed to sustain constant watching during the early hours, but in reality they were often temporarily absent from the patient's room. It sometimes happened that an attendant 'gets up in the morning and goes to another room to dress or breakfast...leaving the patient quietly in bed at the very time of all the twenty-four hours that his presence is most needed'⁵²⁷. Leaving the patient alone as they awoke from their slumber provided an opportunity often too tempting for melancholic and suicidal patients to resist. A momentary lapse such as this provided an opportunity for the lunatic 'to act on his wish to end the pain of life by throwing himself out of the window or over the banister'.⁵²⁸

⁵²⁴ Conolly, *Treatment of the Insane*, p.198.

⁵²⁵ Blandford, *Insanity and Its Treatment*, p.209.

⁵²⁶ Ibid.

⁵²⁷ Ibid.

⁵²⁸ Ibid.

Surveillance during the night covered a smaller number of hours, most of which were passed in sleep, but it was this period of time that received significant attention from contemporaries and the Lunacy Commission. Observed by a small number of attendants, and their mind unoccupied, the suicidal patient was more likely to fixate on thoughts of suicide and find cunning ways of inflicting self-injury or destruction. The Commission was aware of the increased risk and discussed how to adequately staff wards at night time. Provision varied across the asylum system and rarely met with the expectations and requirements of the Lunacy Commission. 'On duty at night are eight men and thirteen women, which is by no means a strong staff for so large an asylum' as Colney Hatch.⁵²⁹ Equal criticism was levelled at Staffordshire County Asylum, where in 1877, 'no system of special night supervision for suicidal patients exists and it seems doubtful...one can be arranged unless wards are built for the purpose'.⁵³⁰

Conolly proposed three potential solutions to night watch arrangements.⁵³¹ First was a rotation system that would see 'a certain number of the attendants take the night-duty in turn, they of course enter on to take this duty at the close of their ordinary duties'.⁵³² This idea presented an immediate flaw that negated any advantage it potentially offered. Utilising the resources already at the asylum's disposal meant attendants drafted on to the night watch, albeit on a rota basis, would to embark on this task at the end of a full day. Exhausted from their daily duties, attendants immediately commencing constant watching at night would be 'more disposed to

⁵²⁹ Hunter & Macalpine, *Psychiatry for the Poor*, p.103.

⁵³⁰ SCRO, Q/Alc/1/2/3-16, Staffordshire County Lunatic Asylum Fifty-ninth Annual Report (1877).

⁵³¹ Conolly, *The Construction and Government of Lunatic Asylums*, pp.100-101.

⁵³² *Ibid.*, p.100

sleep than watch'⁵³³; weary eyes would be sure to close as the night dragged on and concentration lapsed.

Conolly's next suggestion was the introduction of a split shift. On first reflection this idea seemed to hold some merit. Each shift should have been capable of sustaining an adequate level of observation over what was a shorter period of time. However in reality, dividing the night duty into two watches denied double the number of attendants an entire night's rest. Conolly's final proposal offered asylums the most viable solution. He recommended that special attendants 'for the night-watch alone are introduced'.⁵³⁴ Night attendants would have no employment during the day and would be able to function proficiently under the demands of constant watching. Thomas Green of Birmingham Asylum agreed that 'the only way in which it can be effectually carried out is by separate attendance'.⁵³⁵ A night attendant on the male side was referred to in subsequent annual reports, indicating that Green's suggestion was acted upon. Having previously operated a roster system of two male and two female attendants 'who perambulated the wards'⁵³⁶, the decision was taken in 1857 to employ a specific night watch at Colney Hatch Asylum. The provision of a designated group of night attendants meant that patients were frequently monitored by alert and observant attendants.

To guarantee constant patient surveillance it was necessary for the skills of the individual attendant to be supplemented by mechanisms like the inspection plate and

⁵³³ Ibid.

⁵³⁴ Ibid., p.101.

⁵³⁵ BCA, MS344/2/1, First Annual Report, entry dated 23 October 1850.

⁵³⁶ Hunter and Macalpine, *Psychiatry for the Poor*, p.96.

tell-tale clock. Both were introduced to assist the attendant in their duties and make patient observation less intrusive. The inspection plate was accepted as an essential tool in the treatment of violent and suicidal patients, 'being a means of ascertaining, from time to time, the state of any patient'.⁵³⁷ Birmingham Borough Asylum put inspection plates on a 'few of the doors' during its opening year in 1850.⁵³⁸ Their appearance was 'very useful by enabling the attendant to examine the patients without disturbing them'.⁵³⁹ Discussed extensively in his work, *The Construction and Government of Lunatics Asylums and Hospitals for the Insane*, Conolly initiated the fitment of inspection plates on the doors of every bedroom at Hanwell. Placed at a convenient height on the door, the inspection plate 'may be looked through, if necessary, as the attendant passes along the galleries'.⁵⁴⁰ Made from iron, the plate appeared as a flat surface from the gallery with a small circular opening over which there was a cover. The cover could be moved or fastened when desirable and to minimize patient disturbance, it could be moved without creating a noise. To ensure all areas of the room could be viewed through the opening, the inside of the plate was of a concave design.

The tell-tale clock monitored attendant activity and regulated the periodic visitation of patients throughout the night. The dial-plate of the clock turned round once in twelve hours and each quarter of an hour, half hour or hour. To record the time of their visit, attendants depressed one of the forty-eight pegs situated at the top of the dial-plate. Before Birmingham Borough Asylum instituted a tell-tale clock frequent night visits

⁵³⁷ Conolly, *The Construction and Government of Lunatic Asylums*, p.26.

⁵³⁸ BCA, MS344/2/1, First Annual Report, entry dated 24 July 1850.

⁵³⁹ Ibid.

⁵⁴⁰ Conolly, *The Construction and Government of Lunatic Asylums*, p.26.

were undertaken by the medical superintendent. However, 'the necessity for these visits has been superseded by the use of the check clock'.⁵⁴¹ Offering proof that attendants made regular visits to suicidal patients, 'any neglect, to peg is at once made the subject of inquiry'.⁵⁴² As a mechanism for regulating attendant activity, the night clock was extremely advantageous to the medical superintendent. When the eyes of the attendant were firmly fixed on suicidal patients, the night clock acted as the observant eye of the medical superintendent.

George Savage's work 'Constant watching of Suicidal Cases' appeared in *The Journal of Mental Science* in 1884. In his paper he called for caution in the use of constant watching and posed the question 'Is it for the patient's good?'.⁵⁴³ Savage argued that prolonged and intense periods of constant watching could have an adverse affect on the patient's frame of mind. 'When constantly watched they felt as if they were being dared to do a thing, and naturally set themselves to evade their tormentors'.⁵⁴⁴ Irritated by the distrustful and constant gaze of the attendant, he believed that suicidal patients languished under feelings of persecution. In Savage's opinion, constant watching cultivated unnecessary intrusion and increased patient anxiety, which could intensify the individual's suicidal propensity. Savage was also critical of the inspection plates supposed benefits. Rather than utilise the inspection plate to spy on the patient during seclusion, Savage suggested a more radical approach. 'Part of a gallery should have the doors taken off, and the patients be

⁵⁴¹ BCA, MS344/2/1, Second Annual Report, entry dated 30 July 1851.

⁵⁴² Harry A. Benham, 'Some Remarks on Suicides in Public Asylums', *The Journal of Mental Science*, vol.49, (1903), p.450.

⁵⁴³ Savage, 'Constant Watching of Suicidal Cases', p.19.

⁵⁴⁴ Ibid.

allowed to sleep in the doorless rooms while the attendant walks about the ward'.⁵⁴⁵

This approach would bring the patient in to the view of the attendant without the noise of the inspection plate being opened and the eyes of authority peering intrusively into the patient's room.

Savage was also adamant that suicidal patients should be sequestered in a single room where they would find relief from further indulgence in the thought of suicide. 'The persecuted man is generally more at peace if in a room by himself...I have one man who is very suicidal, who would certainly attempt to murder the night attendant or any patient who coughed, or moaned...he would consider the action was done to annoy him'.⁵⁴⁶ Residence in a single room would bring the patient a degree of privacy, tranquillity and feeling of trust that encouraged self-control. Savage acknowledged that a single room brought more risk but he stood firm in his conviction that 'some risk must be run if good is to result, and we must be considerate to each other when accidents do happen'.⁵⁴⁷

Constant watching underpinned suicide prevention; it was the most basic and fundamental response to the risk of self-destruction. Observation formed part of all patient management, but in suicidal cases it was implicit from the moment of admission. The premise of constant watching was simple, unremitting vigilance day and night, but this ideal was not easily managed as broader institutional change altered the context in which it was practised. The asylum's most essential tool was also the biggest obstacle to the effectiveness of patient surveillance. Attendants bore

⁵⁴⁵ Ibid., p.18.

⁵⁴⁶ Ibid.

⁵⁴⁷ Ibid., p.19.

the brunt of responsibility for patient safety and suicide prevention, but they were neither equipped nor sufficiently supported in their endeavours. Attendants were certainly handicapped in their work, and, the potential for lapses in concentration increased as they could be distracted by other duties and patients. Constant watching was sustainable, but it had to be conducted in a pragmatic manner that responded to the changing nature of the institution and the resources available to attendants. Despite the challenges it faced from overcrowding and inadequate staffing, constant watching remained the cornerstone of suicide prevention and was actively promoted and enforced throughout the nineteenth-century.

Mechanical restraint

Proper instruments of restraint, judiciously and humanely employed, are not ignominious manacles and fetters, as the vain claimants of a pseudo-humanity love to represent.⁵⁴⁸

Physical restraint was common place in the armoury of eighteenth century 'mad-doctors' and continued to be prevalent until the mid-nineteenth century. It was portrayed as a necessary tool in the management and treatment of patients, offering both curative assistance and protection against injury or violence. The methods adopted were various, differing between institutions, but the primary objective was

⁵⁴⁸ S. Hadwen, 'Remarks on the Necessity of Restraining Certain Lunatics', *The Lancet*, vol.II (1840), p.907.

the restriction of patient movement as an intervention against 'the immediate impulse of his will, uncontrolled by reason'.⁵⁴⁹

The use of mechanical restraint was about balancing control and protection which raises the question whether asylums used protection as an excuse for over use of control. W.A.F Browne suggested that restraint was often applied after careful consideration 'and from a conviction that I was doing that which was calculated to promote the comfort and cure of my unfortunate patients'.⁵⁵⁰ Browne's benevolence was often apparent in the decision to impose restraint in suicidal cases. In the debate that surrounded the use of restraint, patients disposed to suicide were frequently described as 'special', 'exceptional' or 'extreme' cases in which it was difficult to avoid recourse to restraint for the patient's own safety. The imposition of restraint usually masqueraded behind claims of protection, but its use in the management of suicidal cases was often, legitimately, concerned with patient welfare. Mechanical restraint was in this 'exceptional' case intended to limit bodily movement in order to break the patient's habits, subdue violence and prevent acts of suicide.

Attitudes towards restraint, and the boundaries that dictated its use, underwent a profound change throughout the nineteenth century. This transition effected changes in the institutional environment and innovations in management techniques. It thus becomes important to differentiate between practices in the pre and post non-restraint period. Prior to 1840 'mechanical restraint formed the rule of practice rather than the

⁵⁴⁹ Haslam, *Considerations on the Moral Management*, p.24.

⁵⁵⁰ W.A.F Browne, 'The Humane System of Treating the Insane', *The Lancet*, vol. I (1841), p.682. Browne was medical superintendent at the Montrose Asylum and the first Scottish Lunacy Commissioner.

exception'.⁵⁵¹ This dictated that the risk threshold used to determine the imposition of restraint remained low. Risk threshold was primarily concerned with preventing self damage and, where few alternatives existed, restraint remained the instinctive response rather than a last resort. Scull views the continued use of restraint in early asylums to be the outcome of the authorities' concern with security and the preservation of institutional discipline. This was compounded by the structural deficiencies of institutions and the shortcomings of available management techniques. As long as alternative methods of patient management were not fully utilised and the order of the institution was threatened then 'the cruelties of the madhouse keeper were, in fact, functionally necessary'. The absence of better techniques meant that restraint was the only intervention that could guarantee at least a minimum level of order.⁵⁵²

The non-restraint movement of the 1840s changed this situation. Firstly, its emergence was connected to a change in the 'cultural meaning of madness' and a shift in the boundaries of moral acceptability. Mechanical restraint, like many other practices, was accepted by early reformers on the recommendation of those who claimed expertise in the treatment of the insane. Yet a few decades later such treatment was considered unnecessarily cruel and devoid of a fixed place in the asylum's treatment repertoire. In Scull's opinion this transition came from a change in 'the world view of the person who is doing the perceiving'.⁵⁵³ The reform process encouraged a change in the moral boundaries of society, by raising in the public consciousness the issue of lunacy provision. There was, in addition to cultural changes, a shift within the psychiatric

⁵⁵¹ Hill, *A Concise History of the Entire Abolition*, p.102.

⁵⁵² Scull, *Museums of Madness*, pp61-63.

⁵⁵³ Ibid.

profession. Alienists adopted a paradigm of insanity that viewed the madman as lacking self-restraint and order, but who was not devoid of all reason. If the madman had not lost the essence of his humanity, then he no longer needed to be managed by fear and coercion.

Adherence to non-restraint affected the management of suicidal patients and changed the criteria for determining appropriate use of restraint. Restraint had been second nature, but its use was scrutinised and extremely rare during the non-restraint era. Adoption of the 'non-restraint' policy signified the progressive advancement of an institution. The risk threshold was raised and breaches of an institution's 'non-restraint' policy were few and usually resulted from extreme circumstances. When restraint was used for suicidal patients it could signify a degree of desperation by attendants unable to counter the patient's behaviour and prevent self destruction by more acceptable means.

Fennell and Mellett see the increased use of restraint by the late nineteenth century as an issue influenced by changes in the nature of the institution. The early optimism of the 1830s and 1840s waned because the wholesale practice of non-restraint was prevented by over-populated asylums, suffering a shortage of attendants. Restraint's reintegration is attributed to the growth of asylums and the increasingly prevalent notion that insanity was an intractable problem. It was feared that asylum and staff resources were inadequate to deal with the increased number of insane patients. Mellett states that under these circumstances 'doctrinaire acceptance of non-restraint

was being challenged'.⁵⁵⁴ Restraint was reinstated out of necessity as a means of overcoming the institutional inadequacies that had once dogged early asylums.

From the opening of this Asylum in the year 1816, mechanical restraint appears to have been extensively employed; and at the time our Officers took charge they found twenty-nine persons wearing either handcuffs, leg locks or strait waistcoats...moreover during the night-time all the epileptic and violent patients were chained or otherwise secured in bed.⁵⁵⁵

Lancaster Asylum's extensive use of restraint was not exceptional during the early to mid nineteenth century. In February 1823 a directive was given in preparation for the opening of Gloucestershire County Asylum 'that Mr Poynder order the instruments of restraint according to his list from Stafford, or Birmingham'.⁵⁵⁶ At this time coercion was accepted as common practice in the treatment of the insane on the premise that its use was minimal and not hastily adopted. Haslam stated, 'the term coercion has been understood in a very formidable sense and not without reason'⁵⁵⁷, but in suicidal cases it was justified to ensure patient welfare. The overriding ethos in contemporary literature and institutional practice was that mild restraint should be applied with the intention of preventing self-harm and bringing benefit to the patient. Importantly, restraint was not to be imposed as a form of punishment. Adherence to

⁵⁵⁴ Mellett, *The Prerogative of Asylumdom*, p.39.

⁵⁵⁵ LRO, QAM 5/38, Report of the Lunatic Asylum for the County of Lancaster (1841), p.4.

⁵⁵⁶ GA, HO22/1/1, First County Asylum: general minutes 1813-1851 (February 13th 1823).

⁵⁵⁷ Haslam, *Observations on Madness and Melancholy*, p.283.

this is borne out in the 1844 Metropolitan Commissioners in Lunacy's report.⁵⁵⁸ In Jones' work on the history of mental health services, attention is drawn to the arguments given in favour of moderate coercion. The consensus of opinion, drawn from evidence submitted to the report, was that 'experience showed that the best approach to the insane was that in which kindness was mingled with a show of authority'.⁵⁵⁹

The decision to impose restraint also had to take account of the patient's underlying mental condition. Management of the body was often a vital objective in cases of mania when the patient's violent excesses had to be repressed. Joseph Mason Cox acknowledged that maniacs were generally responsive to 'kindness and tenderness' but:

in cases of absolute necessity...where there are symptoms of high excitement, and the natural disposition and temper are mutually altered; where audacity, indelicacy, and fury alternate, with raving, vociferation, and impatience of control, we must have recourse to the best methods of restraint.⁵⁶⁰

Containment of unpredictable maniacal excitement was the principle objective of restraint, but it was also stressed that the patient should be subject to the least inconvenience and that protection should not negate all liberty. In the case of melancholy patients the balance between protection and liberty was considered to be less equal. Cox identified that the 'management of melancholics turns principally

⁵⁵⁸ *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor* (1844).

⁵⁵⁹ Jones, *A History of the Mental Health Services*, p.141.

⁵⁶⁰ J. Mason Cox, *Practical Observations on Insanity* (London, 1806), p.47.

upon the prevention of injury to themselves⁵⁶¹; it was the presence of a suicidal disposition that determined the need for restraint. He declared that 'with patients of this description coercion is seldom necessary, excepting with the above intention'.⁵⁶²

The terms under which restraint was sanctioned and removed aimed to prevent the indiscriminate use of coercion as control or punishment. It was the medical superintendent who authorised restraint or 'in his absence, one of the Assistant Medical Officers, who shall have been left in charge by him'.⁵⁶³ To monitor the frequency with which restraint was employed in an institution, it was necessary that 'every direction for mechanical restraint shall be entered in an Order Book...the precise time at which and the period for which restraint is directed'.⁵⁶⁴ Rule 28 of the Salop and Montgomery asylum dealt with this issue. It stated that:

Whenever Mechanical Restraint is used...the Patient shall be placed under continuous observation, both by night and by day, by a qualified Attendant, and be visited during the day, at intervals not exceeding four hours, by the Medical Superintendent or one of the Assistant Medical Officers.⁵⁶⁵

This practice became a legal requirement under the 1828 Madhouse Act⁵⁶⁶, and was applicable to both public and private institutions. During the Lunacy Commission's

⁵⁶¹ Ibid., p.50.

⁵⁶² Ibid.

⁵⁶³ SRO, 6175/C/1/1, *Rules and Regulations of the Salop and Montgomery Lunatic Asylum*, 1855, p.8

⁵⁶⁴ Ibid.

⁵⁶⁵ Ibid.

⁵⁶⁶ 9 Geo. IV, Cap. 41, *An Act to Regulate the Care and Treatment of Insane Persons in England*, 1828.

annual visit, records of restraint were inspected and feedback was given in the Commissioner's report. In his discussion of mechanical restraint, Mellett notes that the Commissions' reports reflected their abhorrence when restraint was recorded.

Observation was equally relevant when the decision was made to remove restraint. Cox declared that 'it is only by close observation and long experience that we can ascertain when a part or whole of the coercion should be discontinued...the liberation must, in all cases, be gradual'.⁵⁶⁷ This was particularly important for suicidal patients, since it was vital that their destructive behaviour had subsided and they were capable of exerting self-control. Gradual removal of restraint allowed careful assessment of the patient's behaviour as their mind and body readjusted to its liberation. Furthermore, it gave asylum staff time to judge whether restraint had successfully subdued the patient's destructive or harmful tendency.

The term 'mechanical restraint' conjures up images of a beast-like lunatic manacled or chained, but in practice nineteenth-century asylums drew on a more extensive and less brutal array of instruments. When determining the form of restraint to be used Tuke, in 1813 stressed that 'the mode of it ought to be subject to consideration of its effect on the mind of the insane'.⁵⁶⁸ There was an increasing awareness that restraint, if used judiciously, could extend beyond control and actually aid the patient's recovery. If this was to be achieved and benefit brought to the patient then 'the degree of coercion, when employed, should be uniformly proportioned to that of

⁵⁶⁷ Cox, *Practical Observations*, p.49.

⁵⁶⁸ Tuke, *Description of the Retreat*, p.164.

the disease'.⁵⁶⁹ The most commonly employed form of restraint tended to be the strait waistcoat. In his work of 1817 Haslam described it as the 'usual contrivance' it 'confines his arms and hands, which are crossed over the region of the stomach, and it is secured by being tied behind...as far as his hands are concerned, he is certainly prevented from doing mischief'.⁵⁷⁰ As with all methods of restraint, its effectiveness was dependent on the manner in which it was imposed and 'provided it [strait waistcoat] fits the shape of the patient, and is properly put on it is a good safeguard'.⁵⁷¹ The strait waistcoat was open to cruelties but, according to Burrows, this was the fault of those 'who put them on' rather than the design of the waistcoat itself.⁵⁷² If applied incorrectly:

drawn so tight across the shoulders, that it brings them forward too much, narrows the capacity of the chest, and impedes respiration...The strings of it also are often fastened too tightly round the arms, so as to check the circulation, and the sleeves are sometimes tied improperly in a knot on the back, so as to gall the patient exceedingly.⁵⁷³

Restraint, as with many aspects of patient care, was largely dependent upon the attendants who imposed it. Regardless of the intention behind using restraint, its success was unavailing unless the medical superintendent was 'judiciously surrounded by able attendants' capable of following his instruction.⁵⁷⁴

⁵⁶⁹ Cox, *Practical Observations*, p.50.

⁵⁷⁰ Haslam, *Considerations on the Moral Management*, p.26.

⁵⁷¹ Burrows, *Commentaries on the Causes*, p.692.

⁵⁷² Ibid.

⁵⁷³ Ibid.

⁵⁷⁴ Ibid., p.694.

Despite these limitations medical superintendents did not shy away from the strait waistcoat, as proven in the case of Eunice Richards, a suicidal patient at Birmingham Borough Asylum. Her behaviour was characterised by destructive actions and repeated suicide attempts. In May 1872 it was recorded in the asylum's monthly report that 'Eunice Richards, has been under restraint for 4 hours by means of a strait-waistcoat'. This was a response to her breaking '60 panes of glass' and her declaration that 'she will smash them all as soon as she is at liberty; she has also made several attempts to destroy herself'.⁵⁷⁵ Eunice's behaviour persisted and the use of restraint was again documented on 20 December 1872:

On the night of the 13th, she cut her throat with a pair of scissors which she had managed to conceal in her bed, as she threatened to destroy herself in that, or some other way, I placed a leather waistbelt on her to which the wrists were secured.⁵⁷⁶

She was kept under restraint 'by this means first, and afterwards by a strait waistcoat until the afternoon of the 18th'. It was only 'upon her promise to behave better for the future [that] the restraint was removed'.⁵⁷⁷ This promise proved difficult to keep and Eunice continued to attempt suicide. In October 1880 she 'tried to cut her throat with a piece of glass'; in November she 'made several attempts to strangle herself, and her habit of smashing panes of glass persisted. She was 'violent and abusive' on 11 May 1882 and was placed in the 'strait jacket from 6pm to 11pm'. When Eunice displayed

⁵⁷⁵ BCA, MS344/2/2, Twenty-second Annual Report, entry dated 17 May 1872.

⁵⁷⁶ Ibid., 20 December 1872.

⁵⁷⁷ Ibid.

similar behaviour on 22 May, she was unmanageable only 'until she saw that the strait-jacket would be put on her if she continues'.⁵⁷⁸ This singular example is not proof in itself that restraint always deterred patients and broke their destructive and suicidal habits. It does, however, demonstrate the importance of restraint when behaviour was persistent and demanding of asylum resources.

In addition to the strait waistcoat, medical superintendents had at their disposal leather straps, muffs, long leather or canvas sleeves and the traditional method of manacling patients. 'The simplest and cheapest means was by the use of chains'...but...'handcuffs, and leather muffs and straps, have been much relied upon'.⁵⁷⁹ Haslam considered manacles to be an 'effectual and convenient mode of confining the hands'. This was because patients frequently endeavoured to liberate themselves but 'the friction of the skin against a polished metallic body may be long sustained without injury'.⁵⁸⁰ These observations were recorded by Haslam in 1809; they are reflective of a time when mechanical restraint, in its crueller forms, was still an accepted norm in the treatment of insanity. The utilisation of chains and manacles became much less prevalent after non-restraint was adopted.

With manacles and chains out of favour, alternatives were employed such as wrist bands, which were applied to John Webb at Birmingham Borough Asylum in 1862. When admitted he had 'a large gaping wound at least 4 inches long' under his jaw which was 'loosely held together by sutures'. During the day he repeatedly 'tried to tear open the wound but was prevented from doing so by two persons being with him

⁵⁷⁸ BCA, MS344/12/41, readmitted 10 October 1880.

⁵⁷⁹ Conolly, *Treatment of the Insane*, p.16.

⁵⁸⁰ Haslam, *Observations on Madness*, p.290.

holding either arm'. Later that evening 'he got his hands up to the throat and tore out the stitches. I therefore put him in a waistbelt and wrist bands'.⁵⁸¹ Extreme behaviour forced a breach of the 'Non-Restraint' policy at Warwickshire County Asylum when in 1875 the hands of a female patient, S.L. were restrained. The asylum's annual report stated that the medical superintendent was 'obliged...to have her hands restrained by night, and a special extra attendant to take charge of her by day' because of 'continual attempts to gouge out her eyes with her thumbs'. The use of restraint at night was justified because:

By incessant care this could be guarded against by day: but would not have been so easily accomplished by night if there were ever a temporary relaxation of vigilance on the part of her watcher that I unhesitatingly adopted the precaution of mechanical restraint, just as I should do in the case of surgical disease did circumstances appear to demand it.⁵⁸²

Restraint was intended to prevent acts of suicide, but it was also valuable following infliction of an injury. Patients often picked their wounds, so to prevent this and allow the wound time to heal it was necessary to restrain the patient's hands. In the case of S.L. it was noted that 'fortunately the restraint was not irksome, but an evident relief to the patient who, though eminently suicidal, did not entirely lose the sense of danger, or perhaps the physical pain, to which this propensity might expose her'.⁵⁸³

⁵⁸¹ BCA, MS344/12/2a, admitted 14 September 1862.

⁵⁸² WCRO, CR 1664/30, Warwick County Asylum Annual Reports 1858-1883 (1875 Report, p16-17).

⁵⁸³ Ibid.

The most suitable method of restraint was the source of divided opinion. Medical superintendents based their preference on practical experience. Writing in 1827, Slade Knight declared that the 'best mode of securing a violent lunatic was the long sleeves'.⁵⁸⁴

It simply consists of two large strong leather sleeves, closed at the bottoms, and fastened across the shoulders by a strap, and staple lock; and again in the same manner across the back of the elbows, the sleeves being attached in front by a broad short belt across the upper part of the breast.⁵⁸⁵

Knight stated that 'patients have worn these sleeves for months, without sustaining the slightest injury from them'.⁵⁸⁶ Unlike other methods of restraint 'if at any time they [long sleeves]...are found too warm, small holes may be easily punched in them so as to admit ventilation' and prevent discomfort.⁵⁸⁷ Long sleeves were eventually used to restrain James Blackwell after waist belts and wrist locks were removed. Admitted to Birmingham Borough Asylum in April 1855 James was 'considered dangerous to himself' and several times 'dashed his head against the wall with a view to destroy himself'. To prevent him tearing his wound 'a leather belt was placed loosely around the body and the wrists' but 'he pointed to his testicles, with the remark that he could still reach them; but surely I said, you would not mutilate yourself, he replied I certainly shall if not prevented'. In response to this threat the belt was removed and replaced by 'one of our strong ticking jackets with lengthened sleeves so as to act like a strait

⁵⁸⁴ Ibid., p.115.

⁵⁸⁵ Ibid.

⁵⁸⁶ Ibid., p.116.

⁵⁸⁷ Ibid., p.115.

waistcoat'. Further precautions were taken with the ordering of opium and the presence of an attendant to watch over him day and night.⁵⁸⁸

Although restraint brought some benefit to patients and assisted asylum staff, there still existed limitations in its practice and criticisms continued to be levelled at those who favoured restraint even in 'extreme' cases. The role of the attendant and the skills they needed were markedly different under restraint. Bucknill summarised the lack of involvement attendants could exert when they had coercion at their disposal. It was possible under restraint that:

management of the insane could be conducted by a small number of attendants, without calling upon them to exercise either self-control, intelligence, or humanity; there was little need of medical skill, or employment, or recreation; it was found that the easiest plan of controlling the lunatic was by appeals to his lowest motives, especially to the most debasing of all motives, to fear.⁵⁸⁹

Critics of restraint argued that it was the creation of fear and 'the degrading sense of shame, which constituted the true virus of mechanical restraint'⁵⁹⁰ regardless of the context in which it was applied. They were concerned that restraint hindered the attendants' ability to develop humanity towards those they cared for. Alienists were also concerned that 'the system of restraint tends to render the attendants less

⁵⁸⁸ BCA, MS344/12/2a, admitted 21 April 1855.

⁵⁸⁹ Bucknill and Tuke, *A Manual of Psychological*, p.524.

⁵⁹⁰ *Ibid.*, p.524.

watchful'.⁵⁹¹ Not only was the attendant 'apt to be much more careless' but the latter [the patient] was also 'much less disposed to yield to his good-will to one who day by day adjusts his straps or strait-waistcoats'.⁵⁹²

Perhaps mechanical restraint's biggest limitation was its inability to fully guarantee patient safety. Gardiner Hill was foremost amongst the critics of restraint and was quick to highlight that 'mechanical contrivances did not prevent accidents or destruction to property'.⁵⁹³ He attributed this to a lack of adequate surveillance which in many cases accounted for 'broken windows, strangling in strait-waistcoats, accidents by burning'.⁵⁹⁴ Drawing on evidence from Lincoln Asylum, Gardiner-Hill stated that 'up to July, 1835, there had been seven cases of suicide'. In one case the patient was 'strangled in a waistcoat' and another 'used the belt in which she had been restrained, to hang herself'.⁵⁹⁵ Smith's study of early nineteenth-century public asylums provides further examples of how mechanical restraint sometimes failed to overcome the dangers it was intended to safeguard against.⁵⁹⁶ At Nottingham in 1818 a male patient was secured to the bed by one hand but still managed to tear his sheet and subsequently strangle himself. At Wakefield in 1822, a patient was 'held in a refractory cell and tightly restrained with leather straps and belts, his hands tightly locked into leather pouches' yet he was able to hang himself 'after gnawing through one of the pouches to get his fingers out and then unbuckle a strap'.⁵⁹⁷ Successful suicides reveal both the limitations of restraint and the adverse effect it could have on

⁵⁹¹ Gardiner Hill, *A Concise History of the Entire Abolition*, p.129.

⁵⁹² *Ibid.*, p.129.

⁵⁹³ *Ibid.*, p.81.

⁵⁹⁴ *Ibid.*

⁵⁹⁵ Gardiner Hill, *Lunacy; its Past and Present*, p.24.

⁵⁹⁶ Smith, *Cure, Comfort and Safe Custody*, p.257.

⁵⁹⁷ *Ibid.*, p.257.

the patient's mentality. Thurnam believed that the suicidal propensity was 'generally aggravated by the adoption of personal restraint' so that the patient was likely to commit suicide 'by the aid of the instruments of coercion themselves' or react to its imposition with increased violence.⁵⁹⁸

The rationale for mechanical restraint was to restrict bodily movement, thereby controlling the patient's mobility, but in suicidal cases it is fairer to conclude that protection and prevention outweighed the desire for control. Restraint was predominately enforced as a last resort designed to curb destructive and violent behaviour. The case notes surveyed in this study indicate that by the mid-nineteenth century restraint was not extensively used or abused as an easy solution to containment of suicidal behaviour. Where imposed it was not for a prolonged period of time and generally only the patient's hands were restricted by means of straps or wrist locks. If control was the overriding motivation for using restraint, then it could be expected that the inherent danger associated with suicidal patients would have encouraged over-use, but instead it remained minimal. Haslam declared that coercion should be 'used only as a protecting and salutary restraint' and for suicidal patients this was the general rule of application. Mechanical restraint diminished following the non-restraint campaign, but in the management of suicidal behaviour it remained relevant as a substitute for the loss of self control. In these circumstances it was not used for its ability to control, but more rightly as 'a protecting and salutary restraint' that primarily yielded benefit to the patient.

⁵⁹⁸ Gardiner Hill, *A Concise History of the Entire Abolition*, appendix G p.108.

Seclusion

Seclusion was not a new technique that emerged in the non-restraint era as a substitute for coercion. It was common-place and, like restraint, it operated with a dual purpose. Placing a patient in a darkened room was intended to bring therapeutic benefit and act as a containing mechanism for unmanageable behaviour. Seclusion was often employed as an alternative or supplement to mechanical restraint, but within the context of non-restraint attitudes towards the use of seclusion changed. Bucknill declared that when 'restraint is not employed, everything which is employed is liable to be called a substitute for it'.⁵⁹⁹ Alienists were apprehensive and fearful that, in the absence of restraint, seclusion might be used more extensively to contain and isolate patients than was previously the case.

Seclusion was intended to reduce a patient's scope for destructive or violent behaviour. It was not attributed a distinct or specifically unique therapeutic benefit for patients with a suicidal propensity. The therapeutic rationale for seclusion was to remove the patient from the external stimuli that aggravated their state of excitement and 'give him the benefit of continued tranquillity'.⁶⁰⁰ The quietness of his own room 'instead of sitting exposed to a crowd of patients'⁶⁰¹ was considered soothing. Furthermore, 'as light is often a source of irritation, so darkness is a powerful auxiliary in obtaining quiet, and preventing the renewal of raving'⁶⁰², hence seclusion in a darkened room. Temporary isolation was advocated in the treatment of insanity because it calmed the patient and alleviated their 'paroxysm'. Bucknill did admit 'the

⁵⁹⁹ J.C. Bucknill, 'On the Employment of Seclusion in the Treatment of the Insane', *The Asylum Journal*, vol, 1 (1855), p.186.

⁶⁰⁰ Conolly, *Treatment of the Insane*, p.42.

⁶⁰¹ *Ibid.*, p.43.

⁶⁰² Burrows, *Commentaries on the Causes*, p.690.

existence of a few exceptional cases, in which it is sometimes needful, for short periods, for the protection and security of other patients, rather than for the medical treatment of the individual selected'.⁶⁰³ This was often the underlying motivation for depriving suicidal lunatics of their full liberty. It was necessary to remove lunatics with dangerous tendencies from 'the society of their fellow patients' and the opportunity to fulfil their desire for self-destruction.⁶⁰⁴

The removal of suicidal patients from external stimuli differed from that of the general inmate population. Quietness and the soothing nature of a darkened room were still relevant, but of greater benefit was the restriction seclusion placed upon the patient's movements. It limited patient access to instruments which they could use against themselves. Restricted movement also meant it was harder for patients to evade observation because they were contained in a defined space. Rather than removing the stimulation of light or noise, seclusion was valuable for its ability to extract a suicidal patient from the temptation of a knife at the dining table or the desire to smash a window. The seclusion of suicidal patients was not an indiscriminate means of getting rid of troublesome individuals. It facilitated containment that allowed the patient to be protected and managed within a controlled environment.

Seclusion was thought to be of remedial benefit, but this was often secondary in the decision to isolate destructive and suicidal patients. It was the opportunity to reduce the risk of dangerous behaviour that was most advantageous. Conolly advised that 'the best security against such accidents [self injury] is quietness, or the temporary

⁶⁰³ Bucknill, 'On the Employment of Seclusion', p.187.

⁶⁰⁴ Bucknill and Tuke, *A Manual of Psychological*, p.525.

isolation of excited patients, in other words seclusion'.⁶⁰⁵ This was particularly relevant when alternative methods of behaviour management were hindered by overcrowding and under-resourced attendants. In his annual report of 1887 Dr Spence, medical superintendent of the Staffordshire Asylum at Burntwood, raised issue with this dilemma. He was concerned about how the institution was 'to provide facilities for the continuous day and night supervision of patients with Suicidal tendencies...owing to the number of those who are returned by the Relieving Officers'.⁶⁰⁶ In the absence of sufficient numbers of attendants recourse to seclusion helped to relieve the pressure of constant watching. Seclusion did not free the attendant completely from their duty of observation, but it did mean respite and only periodic checks to monitor patient behaviour.

As previously stated, the concept of seclusion was not new but it underwent a later refinement of its practice in the form of the padded room. It can be argued that the padded room was the real substitute for mechanical restraint because it was specifically intended to manage the asylum's most difficult patients; among them were the suicidal. In his discussion of the *Treatment of the Insane without Mechanical Restraints*, Conolly declared that:

if the padded rooms, the real substitutes for restraint in very violent cases, were not of the highest importance – offering, indeed, an auxiliary, without which it is questionable whether or not restraints could be entirely dispensed with in any large asylum.⁶⁰⁷

⁶⁰⁵ Conolly, *Treatment of the Insane*, p.44.

⁶⁰⁶ D. Budden, *A County Lunatic Asylum: the History of St. Matthew's Hospital* (Walsall, 1989), p.35

⁶⁰⁷ Conolly, *Treatment of the Insane*, p.42.

The padded room differed from seclusion in a patient's bedroom because it was purposely constructed with protection and safety in mind. Padded rooms were 'made with strong waterproof ticking properly stuffed, or lined with Kamptulicon - a composition of cork and caoutchouc'.⁶⁰⁸ The padded rooms at Hanwell Asylum consisted of:

a thick soft padding of coir (cocoa-nut fibre), enclosed in ticken, fastened to wooden frames, and affixed to the four walls of the room – the padding extending from the floor to a height above the ordinary reach of a patient.⁶⁰⁹

Additional protection was afforded by the whole of the floor being padded, 'or covered with a thick mattress, of the same material as the padded walls, so that it makes a complete bed'.⁶¹⁰ Safety was intrinsic to the design of the padded room so that 'the most furious lunatic might be let loose, like a beast in a den, without doing harm to himself or to any one'.⁶¹¹ This statement underpinned the premise of the padded room, but the most determined and destructive patients were on occasion able to subvert it. Burrows noted that 'some maniacs unrestrained and so situated would tear away all padding, and beat their brains out, or soon become beasts in reality'.⁶¹² Alfred Freeth was admitted to Birmingham Borough Asylum in July 1851. He stated he was 'afraid of doing injury to others- doesn't feel himself safe- that he

⁶⁰⁸ H. Labatt, 'On the Use and Abuse of Restraint in the Treatment of the Insane', *The Journal of Psychological Medicine*, vol.2 (1849), p.259.

⁶⁰⁹ Conolly, *Treatment of the Insane*, p.45.

⁶¹⁰ *Ibid.*, p.45.

⁶¹¹ 'The History and Present State of Lunatic Asylums', *The Journal of Psychological Medicine*, vol.3 (1850), p.441.

⁶¹² *Ibid.*

has not control over his own actions'. On the 15 November he 'became suddenly violent – being placed in the padded room he tore it to pieces and tried to strangle himself with a bit of string he found behind the padding'. Alfred was again removed to the padded room on the 8 February 1852 in consequence of his excited and quarrelsome behaviour. He 'managed to tear' the first padded room 'with his nails' and 'the other with a bit of brass off the shutters'.⁶¹³ At Warwickshire County Asylum Mary Cashmore, admitted July 1857, was ordered to sleep in a padded room. Before her admission, she had 'attempted to hang herself and beat her head against the wall'. Case note entries describe Mary exhibiting 'much restlessness of manner' and 'had little sleep'. In recognition of the patient's dangerous behaviour, directions were given 'to the nurse about her sleeping in a padded room, being frequently visited at night and for precautions being taken against her reported disposition to be both suicidal and dangerous to others'. She was placed in the padded room at approximately 8pm and frequently monitored:

seen by the nurse on evening duty and reported to me at 10pm...she was visited again by the night nurse about 11 and 12 and each time she was awake and comfortable. On going to her room a little after 1am she found her excited and restless...on going into her room they found her extremely excited, talking incoherently, rubbing her hands and face up and down on the pads...some blood was smeared on the pad where she had been rubbing.⁶¹⁴

⁶¹³ BCA, MS344/12/2, admitted 28 July 1851.

⁶¹⁴ WCRO, CR1664/619, admitted 21 July 1857.

Mary's behaviour suggests that despite its intended purpose, and efforts to guard against harm, the padded room was unable to guarantee patient safety on every occasion. Sometimes the patient's determination and the ferocity of their actions were too strong even for padded walls and floors. These examples demonstrate that for some suicidal patients the padded room had only limited effect, but they were in the minority.

Patient case notes reveal frequent use of the padded room at night time. This pattern was observed at Leicestershire County Asylum and is demonstrated by the case of George Harrison, admitted in March 1847. He arrived at the institution in an exhausted state 'produced by loss of blood, the consequence of a wound in the throat extending from ear to ear and inflicted by himself during a fit of melancholy despondency'. It was noted that 'the present attack was preceded by great restlessness, and depression of spirits'. He was 'not subjected to personal restraint' but was 'placed in bed in a padded room' and to be 'kept perfectly quiet'.⁶¹⁵ At Rainhill Asylum the same action was taken in the case of Thomas Bickerstaff. Afflicted with mania and subject to delusions, Thomas became a patient at the asylum in June 1875. He was 'very excitable' and at 'night he is obliged to be put in the padded room by himself'. This action was justified because 'he walks about shouting and singing and because he pulls his bed to pieces'. He also 'occasionally got out of bed to examine the other patients in the dormitory'.⁶¹⁶ The padded room was required for James Lucas, who was admitted to Rainhill in August 1880. His background history revealed that he threw 'himself head forward if not prevented and

⁶¹⁵ LCRO, DE3533/185, admitted 29 March 1874, admission no.785.

⁶¹⁶ LRO, M614 RAI/11/6, admitted 22 June 1875.

attempts to bite'. James was a threat to himself and potentially to his fellow patients and attendants, whom he may have tried to bite. 'On admission he was very wild and excited' and 'was placed in the padded room at night'.⁶¹⁷

There are several possible reasons that may account for the frequent use of the padded room at night. Firstly, it was common practice for asylums to employ a small body of night attendants to care for and monitor patients. As these attendants were fewer in number than their daytime counterparts, it was difficult to maintain constant watching of patients. The padded room was a useful resource that protected the patient and relieved the pressure placed on attendants. Once contained in the padded room it was sufficient for the attendant to observe the patient periodically. Secondly, night time brought with it difficulties in procuring sleep. An inability to sleep was often accompanied by restlessness which could agitate the patient's temperament and induce destructive or violent behaviour. Lack of sleep also left suicidal patients free to fixate on their self-destructive propensity. Without any distractions and frustrated by an uncomfortable night the patient become even more disgruntled and melancholy. The tranquilising effect of a darkened padded room helped to induce sleep by removing the stimuli of light. If this failed, at least the confines of the padded room contained the patient's restlessness and limited the means by which suicide could be attempted.

The padded room was also employed in response to specific forms of behaviour. Gardiner Hill found the padded room 'exceedingly effective in cases where patients

⁶¹⁷ LCA, M614 RAI/11/7, admitted 23 August 1880.

are bent upon injuring themselves', notably by 'knocking their heads against the wall'.⁶¹⁸ This pattern of behaviour prompted William Kitley to be placed in the padded room at Worcestershire County Asylum. Suffering from acute mania, William was admitted to the institution in December 1860. He was considered suicidal and 'at times will strike his head against the wall'. Once admitted he 'was restless and fond of wandering about. He slept but little at night, and on account of his trying to injure himself by striking his head against the wall, he was put in the padded room'.⁶¹⁹ Thurnam agreed with Hill, recommending that in violent cases 'where efforts to check or soothe the...patient are unsuccessful' seclusion was advisable 'for those requiring it, in a room the walls and floors of which are padded, in order to prevent bodily injury'.⁶²⁰ This procedure was followed in the case of Mary Walker, an acute maniac admitted to Worcestershire Asylum in January 1868. After admission she was 'noisy, sleepless and agitated – her mind is occupied with various delusions of a religious nature'. Mary falsely believed that 'she had been deserted by God, will be damned and tormented; that she has been guilty of the greatest crimes and will be hanged'. As a result of her behaviour it was 'found necessary to place her in a padded room as during her attacks of excitement she is in the habit of smashing windows'. Furthermore she 'attempted to injure herself declaring that she wishes to put an end to her existence'.⁶²¹ Mary was unable to continue her pattern of destructive behaviour, presumably because the padded room limited both her movements and access to objects that could cause damage or self injury.

⁶¹⁸ Gardiner Hill, *A Concise History of the Entire Abolition*, p.74.

⁶¹⁹ WRO, BA10127/15, admitted 3 December 1860.

⁶²⁰ Cited in Conolly, 'Second Notice of the Eighth Report of the Commissioners in Lunacy', *The Asylum Journal*, vol.1 (1855), p.147.

⁶²¹ WRO, BA10127/18, admitted 27 January 1868, admission no.2061.

When a dangerous patient was secluded additional precautions were sometimes required so that seclusion could be enforced with due consideration to the dangers of suicide. Hanwell's padded rooms contained:

In general...no furniture except bolsters or pillows, also covered with strong ticken. The window is guarded by a close wire-blind, which admits light and air, but prevents access on the part of the patient to the glass or window frames.⁶²²

At Shropshire County Asylum, 'Regulation no.12' stipulated the use of similar precautions. It was warned that the 'window shutters must be closed, and if the Patient is destructive, his or her shoes must be taken off, and the Bedding and other moveable articles must be removed'.⁶²³

These basic and most obvious of precautions were supplemented by the use of ticking in patient's clothing. 'If the patient is disposed to suicide' it was advised that 'the clothing he uses is of a strength and consistence resisting his efforts to tear it into strings to effect his purpose'.⁶²⁴ Conolly instructed that the blankets should also be 'enclosed in strong ticken cases'.⁶²⁵ These measures were not vastly different from standard methods of suicide prevention, but in the context of seclusion they took on greater significance. In the absence of an attendant, the suicidal lunatic could not be isolated in an environment that failed to take account of his propensity. It was essential

⁶²² Conolly, *Treatment of the Insane*, p.45.

⁶²³ SRO, 6175/C/1/1, *Rules and Regulations of the Salop and Montgomery Lunatic Asylum*, 1855, p.30.

⁶²⁴ Conolly, *Treatment of the Insane*, p.45.

⁶²⁵ Ibid.

that seclusion of suicidal patients operated on separate guidelines in accordance with Conolly's recommendations.

Although the isolation of suicidal patients required additional preventative measures, there was within the general framework of seclusion a preoccupation with patient safety and welfare. This concern was apparent throughout the process of seclusion, particularly the monitoring of patients. When in temporary isolation patients had to be 'visited from time to time...and an accurate knowledge of the state of the secluded patient' obtained by 'means of an inspection-plate or covered opening in the door of the room'.⁶²⁶ The patient was monitored for reasons of safety and to ensure that their basic needs were still met. Once secluded the patient was not 'left to suffer from thirst or hunger, nor are his personal state and cleanliness unattended'.⁶²⁷

In a bid to distance seclusion from the associated abuses of restraint alienists, such as Bucknill, expressed their 'disapproval of seclusion in the old fashioned manner, by harsh and negligent attendants'.⁶²⁸ It was advised that any struggle should be avoided. In Conolly's opinion:

The seclusion itself, which is merely putting the patient out of the gallery, or airing court, into his bedroom, or into a padded room, and locking the door should be effected without violence; and in cases of difficulty, by the united and prompt aid of many attendants, by whose conjoined exertions danger is best prevented, and the patient best overcome, without any

⁶²⁶ Ibid.

⁶²⁷ Ibid.

⁶²⁸ Bucknill, 'On the Employment of seclusion', p.187.

doubtful, dangerous, and irritating contest between the patient and any one or two attendants.⁶²⁹

Conolly suggested that it was possible, in some cases, for seclusion to 'be effected by persuasion alone, the patient having generally some consciousness of the desirableness of being quiet and alone'.⁶³⁰

It was not only alienists who endeavoured to effect seclusion with minimum disruption and irritation to the patient. The Lunacy Commission advocated the merits of seclusion and monitored its use in public asylums. They defined the parameters under which seclusion was appropriate and detailed the manner in which its use should be recorded. The Commission became more vocal on the subject after the abolition of non-restraint. In its annual report of 1858, the Lunacy Commission declared that all seclusion, 'defined as any amount of compulsory isolation...whereby a patient is confined in a room and separated from all associated, was required to be recorded in the medical journal'.⁶³¹ The Commissioners made it clear that they were concerned with securing 'a strict record of every instance where it is resorted to'.⁶³² At Hanwell 'a written report of each instance of seclusion, and of its duration' was made and subsequently sent to the 'physician at the close of each day, and copied by him into a book which is inspected at every meeting of the Committee'.⁶³³ Conolly believed that by keeping a strict record, 'thus are obtained all the advantages of

⁶²⁹ Conolly, *The Construction and Government of Lunatic Asylums*, p.115.

⁶³⁰ Ibid., p.115.

⁶³¹ Ibid., p.33.

⁶³² NA, *Thirteenth Annual Report of the Commissioners in Lunacy*, PP 1859 xiv, p.68.

⁶³³ Conolly, *Treatment of the Insane*, p.45.

seclusion, without any abuse of it'.⁶³⁴ Failure to record seclusion was a serious matter because the Commission wanted to 'prevent it being adopted not from medical reasons but from motives of economy, and as a substitute for the watchfulness...of properly qualified attendants'.⁶³⁵

Seclusion was often compared to mechanical restraint because both aimed to calm a patient's behaviour by means of containment. Though seclusion was not a direct substitute for restraint, it was resorted to for the same reasons of providing protection and security. Containment in a relatively small, and controlled, space withdrew patients from sources of irritation and limited opportunities to inflict self-injury or attempt suicide. The patient was unable to hide from attendants or source implements to use against himself. This level of protection was not obtainable by the standard form of secluding a patient in their bed room. It was necessary for seclusion to evolve into the padded room, particularly in the post abolition period, so that additional safety measures could be implemented. To a certain extent the padded room compensated for the loss of restraint and was crucial for the safe housing of suicidal patients when 'the patient cannot be at large with benefit to himself or with safety to others'.⁶³⁶ Seclusion in itself was not a guaranteed solution to the safety of suicidal patients. The thick padding of the walls and floor of the room were on their own not sufficient to safeguard the patient, as was shown in the cases of Alfred Freeth and Mary Cashmore. That is why attended seclusion was preferable and patient observation could not be fully dispensed with.

⁶³⁴ Ibid., pp.45-46.

⁶³⁵ NA, *Thirteenth Annual Report of the Commissioners in Lunacy*, PP 1859 xiv, p.68.

⁶³⁶ Conolly, *Treatment of the Insane*, p.42.

Suicidal patients were among the most significant groups within the asylum population. Their often dangerous behaviour demanded specific attention and required careful consideration. In this chapter it has been demonstrated that the management of suicide was dominated by the issue of protection and prevention. The asylum was obligated to treat patients in a secure environment that was capable of providing protection and remedial care. Alienists and architects recognised this and sought to overcome dangers within the institutional structure by incorporating preventative measures directly in to the asylum's internal design. It is evident that asylum architecture operated on two levels. Firstly, it had to be functional to ensure security and surveillance, and secondly, if properly designed, it could be an agency for remedial treatment. Anderson describes suicide prevention as the creation of a safe environment by 'proper arrangements' and 'due vigilance'⁶³⁷. This encapsulates the meaning of management when applied to suicidal lunatics, and was the leading objective of asylum architecture and design.

Suicide management was less concerned with the question of cure versus custody and more about the effectual containment of difficult behaviour and the safeguarding of patient welfare. The use of constant watching, mechanical restraint and seclusion was predominantly about effective management rather than control, order and routine. The focus was on restricting patient movement and preventing opportunities for self-destruction. Most asylum patients required the behavioural manifestations or symptoms of their insanity to be managed. For suicidal lunatics this was coupled with

⁶³⁷ Anderson, *Suicide in Victorian and Edwardian England*, p.403.

the need to manage and prevent suicide as an episodic event alongside mental suffering. There existed a genuine safety risk that had to be guarded against, so constant watching, mechanical restraint and seclusion were employed with the express desire to: 1. limit bodily movement; 2. restrict access to potential instruments; 3. intervene when self-control was lost.

Constant watching, restraint, and seclusion did not prevent self-destruction in every instance, but they did, on the whole, successfully minimise the number of completed suicides. It was no straight forward task to guard against suicide in asylums of vast proportion, but the use of management techniques meant it was conducted with some success. Constant watching was a proactive response to the risk of suicide and was utilised as a matter of course following admission. Mechanical restraint and seclusion are better perceived as reactive responses, triggered by a suicide attempt or extreme behaviour. Regardless of quite when, and on what basis, each technique was employed, the over-riding fact remains that the management of suicide afforded constructive intervention when the patient was unable to exert self-control and internal reasoning. Management demanded that asylum staff 'do what is best for the individual'⁶³⁸ because their own protection and safety was more important than doctrinaire acceptance of non-restraint and the criticisms levelled at seclusion. As D.H. Tuke declared they were 'a necessary evil' in the pursuit of protection and security.⁶³⁹

⁶³⁸ Ibid., p.404.

⁶³⁹ Tuke, *Chapters in the History in the British Isles* (1882), p.141.

THE STRUGGLE BETWEEN CONTROL AND THERAPY

The foundation of the asylum rested on its responsibility to provide cure and custody in equal measure. However, in the years following the 1845 Lunatics Act, the prospect of maintaining a healthy equilibrium greatly diminished. The gradual oscillation between cure and custody became increasingly apparent within the practices of moral treatment, non-restraint and towards the end of the century 'chemical restraint'. Moral treatment and non-restraint offered the prospect of restoring the asylum's curative ideal in a time of reform and therapeutic optimism, but in reality both fell short of expectation in large-scale, overcrowded institutions. Changes to the asylum's structure and operational environment caused alienists' initial intentions to falter. What was conceived in theory, based on a small-sized asylum, proved unrealistic when practised in the vast institutions that subsequently emerged.

Medical superintendents came to accept that the asylum's primary responsibility had changed; out of circumstance, and necessity, alienists resigned themselves to the pursuit of custodial containment. The innovation promised by moral treatment and non-restraint was replaced by a period of stagnation and a return, by the latter stages of the century, to restraint in both mechanical and chemical form. The changing dynamic between custody and cure, in the post 1845 period, raised one dominant question: Was control or therapeutic intervention the underlying intention of moral treatment, non-restraint and chemical restraint? The ensuing chapter explores the

intended benefits and conduct of each treatment, focusing on the implications for institutional organisation, asylum staff, and the care of suicidal patients. It becomes clear that the transformation of asylum conditions placed constraints on the effectiveness of each approach, compromising the position of attendants and suicidal patients alike.

Moral treatment

The chief reliance in the cure of insanity must be rather on management than medicine. The government of maniacs is an art, not to be acquired without long experience, and frequent and attentive observation.⁶⁴⁰

William Pargeter's reference to the importance of management was written in 1792 before Tuke and Pinel publicly advanced the merits of moral treatment. Both played an important role in the advancement of psychological approaches to the treatment and management of insanity. Importantly, this development should be seen as an extension of a trend borne out of the therapeutic optimism of the late eighteenth-century. Driven by William Battie and John Locke's reformulation of the nature of insanity, a new-found faith in the potential for cure and the possibility of new treatments emerged.⁶⁴¹ Locke argued 'that madness was a form of disordered reasoning in which random associations of ideas led to false judgements and thus to

⁶⁴⁰ W. Pargeter, *Observations on Maniacal Disorders* (Oxford, 1792; reprinted London, 1988), introduction xxvii.

⁶⁴¹ W. Battie, *A Treatise on Madness* (London, 1758); J. Locke, *An Essay Concerning Human Understanding* (London, 1695) The ideas of eighteenth- and early nineteenth-century writers, like Battie and Locke, made not only a significant contribution to the understanding of insanity when originally published but continued to be highly influential throughout the nineteenth century. Their work permeated much of the discourse and literature of their successors as well as influencing the treatment methods adopted in public asylums.

erroneous actions'.⁶⁴² Suffering from a deluded imagination, the insane person was perceived as not completely devoid of reason; in principle their behaviour and mental state were capable of remedy. From this optimistic perception of the madman, the traditionally harsh and indiscriminate methods of chaining and brutalizing the individual were exchanged for strategies of treatment based upon restoring reason and self-control. This transition manifested itself in the form of 'moral treatment', a broadly constructed approach that included all non-medical techniques, but more specifically endeavoured to target the mind and affect the patient's psychology via distinctly therapeutic methods.

Moral treatment was not a specific technique. It concentrated on rational and emotional, instead of organic, aspects of insanity. Madness, viewed as a breakdown of internal rational discipline, required direction of the individual's moral and psychological faculties, so that self-control could supplant external restraint. Tuke stressed that 'if we adopt the opinion, that the disease originates in the mind, applications made immediately to it, are obviously the most natural, and the most likely to be attended with success'.⁶⁴³ This aetiology of insanity inferred that the mind housed both the source of the affliction and its potential recovery. The madman was recognised as a moral subject whose intellectual and moral 'powers' were perverted, not obliterated. By cultivating awareness within the healthy part of the mind that the other part was diseased, the patient could recognise their own state of confused perception. Moral treatment required patients and asylum attendants to actively contribute to the recapture of reason and the restoration of 'a healthful

⁶⁴² Cited in Digby, *Madness, Morality and Medicine*, p.33.

⁶⁴³ Tuke, *Description of the Retreat*, p.131.

equilibrium in patients' lives, which would minimize their vulnerability to mental imbalance' in the future.⁶⁴⁴

The restorative ideal emphasized the notion of a free, rational, self-determining individual who could be roused to regain self-esteem and a desire to return to normal life. Scull argues that moral treatment rejected the traditional modes of managing and treating the mad, together with the rationales that underlined them.⁶⁴⁵ Rather than continuing to tame madness via external coercion, emphasis fell upon directly targeting the origins of insanity. This approach did not lead to the complete abandonment of mechanical restraint. Even within the practices of moral treatment restraint was a given. Coercion was still accepted as a last resort once moral treatment had 'failed' or been incorrectly conducted, thereby providing no benefit to the patient's mind. Restraint was only deemed improper when imposed for a purpose other than preventing injury.

Moral treatment actively sought to transform the lunatic from within and successfully remodel him as a person 'approximating the bourgeois ideal of the rational individual'.⁶⁴⁶ Lockean theory was central to the optimistic assertion that the madman, like any individual, was malleable. Locke believed that the formation of character was influenced by education and environment. He presumed that malleability of demeanour and behaviour was possible if the lunatic's environment was changed and re-education commenced. Porter suggests that Locke's doctrine 'encouraged expectations of 'reform' and pointed to the asylum as the site where, by

⁶⁴⁴ MacKenzie, *Psychiatry for the Rich*, p.27.

⁶⁴⁵ Scull, *The Most Solitary of Afflictions*, p.100.

⁶⁴⁶ *Ibid.*, p.89.

breaking the chains of adverse circumstances, minds could be reformed'.⁶⁴⁷ The indulgence of gloomy thoughts, and their perpetuation by the strains of life in the outside world, needed to be broken and the mind redirected to a happier status quo.

Moral causes were either blamed for the emergence of insanity or classified as a contributing factor. Haslam identified the negative effect certain moral causes had upon a person's state of mind:

Such are, the long endurance of grief; ardent and ungratified desires; religious terror; the disappointment of pride; sudden fright; fits of anger; prosperity humbled by misfortunes: in short, the frequent and uncurbed indulgence of any passion or emotion, and any sudden or violent affection of the mind.⁶⁴⁸

An incorrect association of ideas formed in the mind, accompanied by an implicit belief in its reality. Slade Knight argued that the mind became fixated upon absurd ideas 'to the truth of which it will perniciously adhere, in opposition to the plainest evidence of its fallacy, and the individual is always acting upon that false impression'.⁶⁴⁹ Fixed ideas and delusions were often deeply rooted in the mind of suicidal lunatics, either upon or shortly after admission to the asylum. The patient's despair and despondency was driven by an inability to escape, mentally, from their established train of thought. Suicidal lunatics commonly thought that they had committed a gross sin and were to be punished.

⁶⁴⁷ Porter, *Mind-Forg'd Manacles*, p.208.

⁶⁴⁸ Haslam, *Observations on Madness*, p.210.

⁶⁴⁹ Slade Knight, *Observations on the Causes, Symptoms and Treatment*, p.16.

Fear and guilt dominated the false impressions present in melancholic delusions. They induced a state of anxiety, despair and self-loathing that added to the patient's already fragile mental condition. Alfred Freeth, admitted to Birmingham Borough Asylum in July 1851, fancied 'that he is under the influence of magic or the devil: says that he is afraid of doing injury to others'.⁶⁵⁰ Admitted in November of the same year, Susan Harwood 'fancies she has done some great mischief to her Friends for which she is to be punished but converses rationally upon all points'.⁶⁵¹ To unseat these fixed ideas, which in many cases perpetuated suicidal tendencies, the principles of moral treatment advocated that the medical superintendent did not try to convince the lunatic that their delusions were false. Influenced by Battie and Locke's work, Slade Knight argued that:

It will be found most prudent, most conducive to the patient's recovery, to permit the accuracy of these insane perceptions and morbid ideas to be unquestioned, and perfectly unheeded, to carry the lunatic's attention to a very different subject, and to fix it, as much as possible, on that which has no relation to the hallucination.⁶⁵²

Slade Knight's recognised the psychological origins of the affliction and encouraged the re-direction of patient thought in a bid to establish equilibrium in the mind. Distraction and the means by which patients' reason was to be strengthened would be found in the utilisation of employment, recreation, religion and the intensification

⁶⁵⁰ BCA, MS344/12/2, admitted 28 July 1851.

⁶⁵¹ BCA, MS344/12/2, admitted 6 November 1851.

⁶⁵² Slade Knight, *Observations on the Causes, Symptoms and Treatment*, p.71.

of personal contact between the patient and medical superintendent; each of which held their own limitations and risks when applied to suicidal patients.

Some have been afraid to trust working implements in the hands of lunatics, less they should convert them into weapons of offence. But the fear is unfounded, as is proved by the rarity of any accident.⁶⁵³

I do not hesitate, with proper precautions, to entrust him with tools, even where an inclination of suicide or violence exists.⁶⁵⁴

It was natural and justifiable for medical superintendents to express concern at the prospect of exposing suicidal patients to the associated risks of employment and recreation. Asylum superintendents found themselves in the paradoxical position of adhering to a method of management that actively prescribed patient interaction with potentially dangerous objects. Under these conditions, suicidal patients required greater assessment of their mental state and general conduct to determine the appropriateness and beneficial effect of employment and recreation. Burrows argued that it was possible to trust patients and avoid accidents, but only if the time was taken to assess the patient and direct their 'moral treatment' based upon an informed, individualized approach. Determining a patient's willingness and suitability to engage in employment, recreation and communal living was a precautionary measure for themselves and the wider asylum community. If a patient had failed to develop an adequate degree of self-control over their desire for self-destruction then

⁶⁵³ Burrows, *Commentaries on the Causes*, p.707.

⁶⁵⁴ Ellis, *A Treatise on the nature*, p.197.

the ability to place trust in them was flawed, placing themselves and those around them in a vulnerable and dangerous position.

According to Bynum, psychologically-based causes and symptoms of disease are by definition a deeply individual matter, thus making it a vital requirement of moral treatment that the 'therapist' knows his patient 'far more intimately than most medically-orientated physicians apparently ever bothered to do'.⁶⁵⁵ Alienists recognised that universal cures were no longer viable in the treatment of an individual condition. This created a therapeutic doctrine that espoused the need for an intensification of personal contact between the physician and patient. Haslam, like Battie and Monro in the eighteenth century, claimed that greater patient knowledge was necessary to inform patient treatment. The precise details of the patient's demeanour, disposition and ideas had to be observed, digested and translated into methods of management appropriate to each case. To achieve a comprehensive understanding, Haslam stated that 'intercourse, frequent observation of the patient, detailed and protracted examination of the state of his mind' were needed since this 'can alone furnish the practitioner with any certain and useful knowledge of this difficult disorder'.⁶⁵⁶

The introduction of employment as a therapeutic agent and promoter of routine in the lives of asylum patients was advanced by the adoption of moral treatment methods. Ellis stated that 'nothing is found so efficacious as employment' to divert the patient's

⁶⁵⁵ W.F. Bynum, 'Rationales for Therapy in British Psychiatry 1780-1835', *Medical History* vol. 18 (1974) p.327.

⁶⁵⁶ Haslam, *Considerations on the Moral Management*, p.80.

thoughts and relieve the monotony of asylum life.⁶⁵⁷ Ellis was the first to implement and praise the benefits of a large-scale, work-based regime at Wakefield asylum in 1818. He instituted a wide variety of activities that allowed patients to work in and outside of the asylum building. Patients with specific trades were also encouraged to reacquaint themselves with their previous occupation. The cultivation of a working community offered therapeutic gain and social rehabilitation for the patient and provided discipline and economic advantages for the institution.⁶⁵⁸

Distraction of the mind and productive occupation of the hands were constructive aids in breaking the behavioural habits of the suicidal. Suicidal patients who were prone to pulling out hair, picking their face or fingers, or tearing up clothing needed to have their conduct counteracted by employing the hands in an alternative task. Vital to the prevention of self-destruction was not allowing the patient time to idle away weeks and months in their rooms or airing courts. The theory of distraction was considered most appropriate for melancholics whose mental state was characterized by deeply rooted ideas. Unconvinced of the falseness of their delusions, Haslam stated, the primary objective for melancholics should be the diversion of the mind from its favourite and accustomed train of ideas by occupying it with different activities.⁶⁵⁹ Employment was also considered beneficial in relieving the ‘paroxysms’ of maniacal lunatics. For the restless, irritable and often sleepless patient, manual labour, particularly agricultural work, had the advantage of tiring the body and provoking sleep via exhaustion. Maudsley and Hack Tuke stressed that, for maniacs,

⁶⁵⁷ Cited in Smith, *Cure, Comfort and Safe Custody*, p.229.

⁶⁵⁸ For a more extensive discussion of William Ellis’s achievements at Wakefield asylum see Smith, *Cure, Comfort, and Safe Custody*, chapter 7.

⁶⁵⁹ Haslam, *Observations on Madness*, p.43.

the therapeutic value of active employment acted as a sedative more efficaciously than the administration of drugs.⁶⁶⁰

Employment also instituted regularity to asylum life and infused the patient with a sense of gratification for their labours. The regularity of labour, the need for attention from the patient, and the obligation to complete a task placed the lunatic in a position of responsibility. The patient was not only conforming to an ordered routine, he was being rehabilitated for his return to working-class society. Slade Knight perceived employment as a valuable source of indulgence for 'happier thoughts' and a reward for the self-motivation and regulation of the patient's behaviour:

It is therefore of the utmost importance in the cure of the insane, that ample means be provided for every gradation of exercise and labour...the contemplation of our labour, when we see it is useful, is pleasing and healthful to the mind; it never fails to produce a certain degree of gratification and content.⁶⁶¹

An opportunity for idle contemplation, which tended to weaken the vitality of the mind, was removed by the provision of varied and extensive programmes of patient occupation. Warwickshire County Asylum's programme of occupation outlined the customary pursuits that were replicated across the English asylum system as curative agents:

For men, garden or agricultural work is the most desirable occupation, whilst some are advantageously engaged in different

⁶⁶⁰ Maudsley, *The Pathology of Mind*, p.563', D.H. Tuke, *Chapters in the history of the insane in the British Isles* (London, 1882), p. 489.

⁶⁶¹ Slade Knight, *Observations on the Causes, Symptoms, and Treatment* p.90.

trades, such as shoemaking, tailoring, carpentering, assisting the engineer, baker or painter, or in making themselves useful in the wards...among the females, the laundry and kitchen, needle and domestic work, afford an ample source of employment.⁶⁶²

Traditional gender division was evidenced by the tasks awarded to patients, with females involved in domestic roles and men employed in outdoor and manual labour. The asylum very much mirrored the employment model of the outside world. The nature of the work undertaken depended on social status, gender, physical strength and intelligence. Upper-class patients were not expected to descend to manual labour; employment for them meant regular bodily exercise. Walks in the garden and intellectual occupation of the mind through the study of new languages, mathematics and literature were more suited to the refined habits of private patients. By contrast, lower-class patients were expected to assist in manual or domestic chores because they held 'no inclination for works of taste...music, cards, billiards and similar pursuits'.⁶⁶³ Subject to different modes of occupation, and with them different environments of practice and equipment, upper and lower-class patients required varied methods of management and attention. Manual and domestic work exposed lower-class, suicidal, patients to an environment laden with tools and greater liberty. The conditions of the kitchen, garden or workroom provided greater opportunities for destructive or injurious incidents than the study of literature or music. Class division of labour dictated that the activities of lower class patients required greater vigilance and precautionary measures to guard against self-destruction.

⁶⁶² WCRO, CR1664/30A, Annual Report (1856).

⁶⁶³ Burrows, *Commentaries on the Causes*, p.455.

Caution, prevention and vigilance were, however, vital in some degree for all patients entrusted with either manual or intellectual pursuits. It was important to attain the right balance between freedom and constraint when granting patients the liberty to work. Testing a patient's returning self-control with increased freedom and exposure to risk was dependent on the work-master exercising the same vigilance as the attendants in the wards. Conolly drew attention to the importance of continued vigilance during employment and recreation. At Hanwell Asylum, 'the attendants are required to be so placed as to maintain a continual observation of the whole of the ground, and of every patient'.⁶⁶⁴ Constant care and surveillance of suicidal patients was expected and enforced without question for fear of the tragic outcome if ignored. The suicide of a male patient at Nottinghamshire County Asylum in 1857, following the adoption of a system of out-door exercise, demonstrated the consequences of inadequate vigilance.⁶⁶⁵ The failure to supervise closely the activities of a suicidal patient points to two differing conclusions: (1) supervision was correctly prescribed during outdoor employment or recreation, but inadequate conduct of this practice by attendants allowed the briefest of opportunities to be seized upon by the patient; (2) an incorrect assessment of the patient's state of mind and behaviour placed the individual in a situation they were unprepared for. If the patient had failed to develop an adequate degree of self-control then the ability to place trust in him was greatly impaired.

The case notes of Leicestershire County Asylum patients provide further evidence of a cautionary approach to employment. Suicidal patients were engaged in

⁶⁶⁴ Conolly, *The Construction and Government of Lunatic Asylums*, p.57

⁶⁶⁵ NA, SO/HO/1/6/1, Nottingham General Lunatic Asylum Annual Report (1856).

employment following signs of an improvement in their mental state and general conduct. A male patient committed to the asylum in 1845, described as 'a case of melancholy despondency with a suicidal tendency', was granted employment following an improvement in his condition:

He soon manifested symptoms of amendment and shortly afterwards requested me to allow him out of door employment...I concluded that such an occupation would be beneficial to him, and having cautioned him...I have sent him into the garden...and for nearly three months he worked...and rapidly recovered his health and strength.⁶⁶⁶

The patient was presumed capable of being given the responsibility of handling tools and materials because his mind was under greater control. It can also be concluded that employment's curative benefits were most effective in the recovery stage, because the patient was preparing for his return to 'normal society' and wished to re-engage with the routine and gratification derived from occupation.

Worcestershire County Asylum adhered to the same practice, employing suicidal patients once a significant improvement in their mental and bodily health was exhibited. John Hancox entered the asylum in March 1859 suffering from imbecility. He had 'twice attempted to throttle himself' and exhibited violence towards his parents, 'who found much difficulty in controlling him'. During the course of his stay, John 'made several attempts to escape', but once his behaviour was judged to be 'not nearly so vicious and violent in his manner as when admitted', he was allowed to

⁶⁶⁶ LCRO, DE3533/185, Male and Female Casebook, January 1845 – August 1848.

work at the shoemaker's shop.⁶⁶⁷ Admitted in April of the same year, Emma Stockley was afflicted with acute mania and 'said to be suicidal having attempted to make away with herself both by drowning and jumping through a window'. She displayed restless and violent behaviour as well as the refusal of food and was 'destructive of her clothing and bedding'. By October of 1859, six months after her admission, Emma 'continued steadily to improve...she has for some time past diligently employed herself in assisting in the duties of the ward and was at this time deemed fit to be discharged.'⁶⁶⁸ The approach adopted at Leicestershire and Worcestershire County Asylums demonstrate the caution shown by medical superintendents when allowing suicidal patients to undertake employment. Despite the obvious therapeutic benefits, it was imperative to firstly consider the safety of the patient and ensure their mental condition had significantly improved and an adequate degree of self-control was established.

Not all patients were willing or indeed capable of undertaking work as a means of distraction and stimulation. By the mid-nineteenth century, increasing emphasis fell upon the utilisation of recreational activities as an alternative or supplementary source of therapeutic amusement. As Slade Knight suggested, patient recreation 'affords a gentle stimulus to the mind, without exciting the passions; and from frequent observation...many lunatics are capable of playing excellent games'.⁶⁶⁹ To maintain stimulation and avoid repetition, medical superintendents introduced a diverse range of activities. At Ticehurst private asylum, as in other well run private institutions, 'rational mental recreations' were characterised by drawing, sewing,

⁶⁶⁷ WCRO, BA10127/14, Male and Female Casebook, May 1858 – May 1860.

⁶⁶⁸ Ibid., admitted 7 April 1859, admission no.808.

⁶⁶⁹ Slade Knight, *Observations on the Causes, Symptoms and Treatment*, p.82.

writing and even the playing of the harpsichord and violin in some cases.⁶⁷⁰ Outdoor activities were characterised by fishing, bowls and hunting and, for those who were physically weak, carriage rides were taken so that 'benefit from the air and varied scenery' could be enjoyed.⁶⁷¹

Indoor pursuits were plentiful in county asylums, with skittles, cards and dominoes commonly available to patients. The value of music and literature was also recognised by most public asylums, one example being Leicestershire County Asylum. In his annual report of 1854, the medical superintendent recorded that:

the books in the library purchased by the Committee of Visitors in August last have been...circulated and to the more intelligent of the patients the use of these books is a source of amusement and gratification. Books of history seem to be most in request by them.⁶⁷²

In September of the same year a brass band was introduced. The creation of 'a small brass band amongst the attendants and patients' was founded on the belief that 'music of this kind as an appropriate amusement for outdoor recreation'. Four months after the medical superintendent's initial enquiries it was noted that 'the band has now become sufficiently organised to furnish us with music to which the patients frequently dance with evident enjoyment'.⁶⁷³

⁶⁷⁰ MacKenzie, *Psychiatry for the Rich*, p.43.

⁶⁷¹ *Ibid.*, p.141.

⁶⁷² LCRO, DE3533/83, Medical Superintendent's Journal and Report Book, September 1853-June 1862.

⁶⁷³ *Ibid.*

Outdoor activities were also numerous in county asylums and required slightly more energetic involvement, with sports such as bowls, tennis, shuttlecock and cricket commonly available. Slade Knight highlighted the merit of nine-pins, since it afforded exercise for the body and disciplined the mind. The need to guard against self-injury was evident in Slade Knight's cautionary advice that 'the pins and bowl should be made of strong leather stuffed with horse-hair, by which contrivance they cannot be used to effect personal violence'.⁶⁷⁴ Prevention strategies had to be enforced during recreation because it was necessary to avoid activities that were capable of being turned to mischievous purposes by suicidal patients.

To alleviate the monotony of asylum life and make constructive use of patient time, the simplistic and traditional nature of earlier pastimes was surpassed by more adventurous and comprehensive provision. At Norfolk Lunatic Asylum land was hired, in 1853, for the purpose of holding cricket matches, involving 50 male patients.⁶⁷⁵ At the York Retreat, Digby notes, by the 1850s music came to play an increasingly important role as patients played the piano, violin and accordion.⁶⁷⁶ The therapeutic benefit derived from these amusements is evidenced by the case of a female patient at Birmingham Borough Asylum. Susan Prescott was admitted in May 1853 suffering from melancholia and having previously attempted suicide. Susan was rewarded for her improved conduct by attending the asylum ball; she was 'more cheerful and was at the ball on Monday and danced twice'.⁶⁷⁷ The introduction or withdrawal of recreational activities, under a system of reward and punishment,

⁶⁷⁴ Slade Knight, *Observations on the Causes, Symptoms, and Treatment*, p.82.

⁶⁷⁵ Cherry, *Mental Health Care in Modern England*, p.66.

⁶⁷⁶ Digby, *Madness, Morality and Medicine*, p.45.

⁶⁷⁷ BCA, MS 344/12/2, admitted 26 May 1853.

offered additional therapeutic leverage by which the suicidal patient could be induced to control his tendencies and take benefit from their inclusion in rational amusements. John Burdett Steward, physician to Droitwich Asylum, acknowledged the moral basis on which reward and punishment operated. He wrote that:

Association affords the means of rewarding good conduct and checking violence; for, the removal of a patient from the society of the orderly acts often, as a moral influence upon his future conduct. It is considered by inmates an evil and privation; and frequently, they will exercise self-control rather than be subject to it.⁶⁷⁸

When trying to modify individual behaviour by reward, William Ellis stressed the need for medical superintendents to familiarise themselves with the patient's likes and dislikes. The patient's preferred indulgences could then be granted or withheld according to the behaviour he displayed.⁶⁷⁹ The beneficial effects of employment and recreational activities were capable of extending beyond distraction and stimulation. They could serve as an inducement for improved patient conduct, which in the case of suicidal lunatics saw patient self-control rewarded with attendants' trust.

Moral management

W.A.F Browne recognised that the therapeutic rationale underpinning moral treatment was imprecise. He asserted that 'there is a fallacy even in conceiving that

⁶⁷⁸ J. Burdett Steward, *Practical Notes on Insanity* (London, 1845), p.82.

⁶⁷⁹ Smith, *Cure, Comfort and Safe Custody*, p.212.

Moral Treatment consists in being kind and humane to the insane'.⁶⁸⁰ Moral treatment marked a distinct rupture with the brutal coercion and fear of the older asylum regime, but its milder approach had the potential for imposing conformity and a gradual deterioration into a repressive system of moral management. Joan Busfield argues that the transformation of moral treatment into a repressive system of management was always latent within its construction. She contends that by the second half of the nineteenth century many medical superintendents were not even paying lip-service to the principles of moral treatment. Scull draws attention to the ironic nature of moral treatment and its evolution into moral management. He argues that 'the reason for its [moral treatment] immediate appeal, was the way it demonstrated that the most repellent features of existing madhouses were actually unnecessary cruelties'.⁶⁸¹ The asylum's cruder features had been removed only to be replaced by a more comprehensive method of control.

The mid-nineteenth-century public asylum experienced a transformation in its structure that forced the overt use of mechanical restraint to be substituted with more pervasive techniques of patient management. Digby rightly identifies that, 'to a much greater extent the patient was slotted into a fixed environment rather than a social context being created for the individual'.⁶⁸² Individualized treatment, informed by good patient knowledge (which was crucial for suicidal patients) was sacrificed with the emergence of an overtly rigid routine that expected patients to obey bureaucratic rules rather than those intended to aid recovery. Conformity to institutional rules brought mixed reactions from patients. For some suicidal patients it bred increased

⁶⁸⁰ W.A.F. Browne, 'The Moral Treatment of the Insane: A Lecture', *JMS*, vol.10 (1864), p.312.

⁶⁸¹ Scull, *The Most Solitary of Afflictions*, p.172.

⁶⁸² Digby, *Madness, Morality and Medicine*, p.76.

feelings of anxiety, but others found order, structure, and security reassuring. Moral management rested upon the patient's individual responsibility to regulate his behaviour in order to maintain the rules of the asylum. This placed further pressure and emotional strain upon the mind of the suicidal, which acted antagonistically with the negative thoughts that already existed. Digby provides an example that makes clear the adverse impact of such anxiety. A melancholic patient at the Retreat lost her nerve because she felt incapable of regulating her behaviour in line with the demands of the institution's regulations. She left a suicide note explaining:

I...constantly feel that I am greatly out of place amongst all the unblemished moral characters in this house and fear that my having been here at all will bring much trouble on you. I therefore feel compelled to take this desperate and dreadful step.⁶⁸³

Patients were encouraged to feel guilty about their inability to maintain order; an emotion that suicidal patients were likely to struggle with. Moral management acted divisively since anxiety caused some patients to develop suicidal tendencies under the strain of guilt or inadequacy, whilst it exacerbated feelings of gloom among the already suicidal. The latter occurrence was a particular concern when delusions were present. It was common for melancholic patients to consider themselves inferior or to feel that their mere existence was detrimental to society. If patients already felt guilty for failing to conform to the social structures of the outside world, then expectations to obey institutional rules and the patient's perceived failure to do so, served to compound delusional feelings of low self-worth and deepen suicidal desires.

⁶⁸³ Ibid., p.77.

The ascendancy of moral treatment gave those afflicted with a suicidal tendency an opportunity to re-assert control over their own behaviour. Suicidal patients could find recovery in the distraction and stimulation of employment and recreation. The risk of exposing suicidal patients to new environments, equipment and greater liberty did not undermine the efficacy of moral treatment. It was the ever growing size of the asylum, and the high patient to staff ratio that reduced individual patient attention and care. The unique conditions of the nineteenth-century asylum could not maintain the liberal ideal of moral treatment as it had been perceived by early exponents in the late eighteenth century. In seeking a more viable alternative, appropriate to institutional rather than patient needs, the suicidal lunatic was forced to exchange the benefits of therapeutic optimism for anxiety and conformity.

The challenge of non-restraint

Until the close of the eighteenth century it was generally accepted that troublesome lunatics should be restrained by various physical or 'mechanical' means. The latter were of many kinds and included chains, handcuffs, leather straps, strait jackets and specially designed coercion chairs. As the nineteenth century dawned attitudes to the care and treatment of the insane became more closely aligned to Enlightenment thinking. This was heavily influenced by a shift in the cultural meaning of madness and was illustrated by the increased reformist zeal that surrounded lunacy provision. The seventeenth-and eighteenth-century paradigm of insanity viewed the madman as no better than a beast. In relinquishing his reason, the lunatic had lost the essence of his humanity (and become crazed). Nineteenth-century reformers, and much of wider society, were in the process of abandoning this view of the madman.

In a consciously reforming age the efficacy and justification for mechanical restraint was called into question. Once considered as 'useful, even essential adjuncts to the attempt to compel right thinking', chains and other forms of mechanical restraint were increasingly portrayed as inhumane and open to abuse.⁶⁸⁴

The image of Philippe Pinel unchaining the shackled inmates at the Salpêtrière hospital in Paris achieved mythical status and contributed to the wave of enlightened humanitarianism that spread across Europe. In England, scandalous stories of neglect and abuse of patients, most famously the image of William Norris restrained at Bethlem, encouraged growing opposition to the excessive use of restraint. Cases such as Norris did much to discredit the use of restraint and gave reformers moral leverage against established approaches to the treatment and care of the insane.⁶⁸⁵

The publication of Samuel Tuke's *Description of the Retreat* (1813) also played a significant role in promoting a milder approach to patient treatment and more lenient use of restraint (Tuke did not advocate the total abolition of coercion). The Retreat provided an institutional model for the efficacy of milder treatment and laid the foundation for the later abandonment of mechanical restraint.⁶⁸⁶ Restraint remained in use until the 1830s and beyond, but examples of patient abuse, reformist agitation and the work of Tuke cultivated growing sympathy in favour of modifying the treatment of insanity.

⁶⁸⁴ Scull, *The Most Solitary of Afflictions*, p.65.

⁶⁸⁵ Donnelly, *Managing the Mind*, p.35.

⁶⁸⁶ Digby, *Madness, Morality and Medicine*, p.82.

Lincoln Lunatic Asylum was the first institution to lay claim to the total abolition of mechanical restraint.⁶⁸⁷ Making this remarkable declaration in 1838, Robert Gardiner Hill, House Surgeon at Lincoln, asserted 'that in a properly constructed building, with a sufficient number of suitable attendants, restraint is never necessary, never justifiable, and always injurious'.⁶⁸⁸ The birth of the English non-restraint system is most commonly attributed to the innovative achievements of Robert Gardiner Hill, but this narrow focus denies the important foundation that was laid at Lincoln by Dr E.P Charlesworth, one of the physicians to the asylum. In his article, 'Non-Restraint and Robert Gardiner Hill', Justin Frank draws attention to the precipitous decline in instances of restraint evident in the years immediately preceding Hill's appointment. By 1829, Charlesworth cited diminished cases of restraint and coercion throughout the asylum. He cultivated a new found awareness for the patient's well-being that was reflected in the asylum's annual report of 1831:

Heretofore it was conceived that the only intention of a receptacle for the Insane, was the safe custody of the unhappy objects, by any means however harsh and severe. These views are now passing away, and the fair measure of a Superintendent's ability in the treatment of such patients, will be found in the small number of restraints which are imposed.⁶⁸⁹

By the time Hill arrived at Lincoln, Charlesworth had exercised greater control over attendants, decreased the frequency with which restraint was used, and ameliorated

⁶⁸⁷ Lincoln was a voluntary, public subscription asylum with a predominantly pauper clientele.

⁶⁸⁸ R.Gardiner Hill, *Total Abolition of Personal Restraint in the Treatment of the Insane* (London, 1839) p.22.

⁶⁸⁹ J. Frank, 'Non-Restraint and Robert Gardiner Hill', *Bulletin of the History of Medicine*, vol. 41 (1967), p.144.

the most severe coercive techniques. Total abolition was a piecemeal process that commenced with Pinel, Tuke and Charlesworth before culminating in Hill's 1838 declaration and John Conolly's publicised claims of success at Hanwell Asylum in 1840.

To control patient violence, the non-restraint system advocated first and foremost an increased reliance upon surveillance, manual restraint and temporary seclusion. Underpinning the very essence of the non-restraint system was the need for unrelenting preventative, almost parental, observation of patients. The attendant was never to allow a patient from their sight, especially those harbouring ideas of self-harm and suicide. In extreme cases of violence, patients were held by attendants and removed to a safe room or padded cell, where they remained until the rage passed; if it continued, sedation was used in the most severe cases. Alienists preferred these measures on both moral and medical grounds, as it was thought that patients found it less degrading to be held by attendants and put in isolation than be placed in a strait-jacket.

The adoption of non-restraint was not universally embraced by the emerging psychiatric profession and lay community. Distinctly different opinions emanated from within each camp. Those opposed to non-restraint could not reconcile the needs of suicidal and violent patients with the liberty that non-restraint advocated. They considered it inappropriate to remove restraint and depend on constant vigilance by the attendant. G.P. Button, superintendent of Dorset County Lunatic Asylum, and W. Lauder Lindsay of the Murray Royal Institution for the Insane, claimed it was necessary to subdue and shorten the violence of patients using restraint as the

quickest and most effective means.⁶⁹⁰ This mood of scepticism saw some contemporaries take even more scathing swipes at Gardiner Hill's advocacy of non-restraint. The system's most vehement critics reviled its principles as 'a piece of contemptible quackery, a mere bait for the public ear'.⁶⁹¹ Prejudice against 'every improvement in science or practice'⁶⁹² was deemed by Gardiner Hill as unwillingness in some quarters to accept an innovation that challenged deeply rooted practices in lunacy provision. Nancy Tomes identifies and develops the argument that professional division and practical limitations prevented the total abolition of mechanical restraint. Tomes argues that mechanical restraint was undoubtedly stigmatized, but even at the height of enthusiasm for this new innovation, most superintendents were unwilling to endorse the concept of total abolition.⁶⁹³

Opposition to non-restraint was driven primarily by the fear that relinquishing the restrictions of restraint placed suicidal patients and attendants in a position of vulnerability to the impulses of self-destructive behaviour. Some medical superintendents perceived suicidal patients as an extreme case where the imposition of mechanical restraint was justified to protect the patient. Bucknill advocated restraint for those:

⁶⁹⁰ G.P. Button, 'On the Treatment of the Insane, Cases to illustrate the propriety of partial restraint', *The Lancet*, vol.1 (1841), pp.727-729.

W. Lauder Lindsay, 'The Theory and Practice of Non-Restraint in the Treatment of the Insane', *Edinburgh Medical Journal*, vol.23 (1878), pp.887-899, 1092-1103.

⁶⁹¹ Hill, *A Concise History of the Entire Abolition*, p.13.

⁶⁹² *Ibid.*, p.24.

⁶⁹³ N. Tomes, 'The Great Restraint Controversy: a comparative perspective on Anglo-American psychiatry in the nineteenth century', in Bynum, Porter and Shepherd (eds.), *The Anatomy of Madness* vol.III (1988), pp.190-225.

suicidal patients who have endeavoured to effect their purpose, by thrusting articles of clothing and other substances, down the throat, by beating the head against the wall, and other means, which are scarcely capable of being obviated by any watchfulness on the part of the attendants.⁶⁹⁴

Strict allegiance to non-restraint prevented restraint being utilised when it was truly needed and removed a large degree of autonomy over patient treatment and management. James Huxley, medical superintendent at Kent Asylum, complained that in the non-restraint movement the grounds of dispute had been narrowed to the single proposition, all or none.⁶⁹⁵ He insisted that the doctor's motivation had to be considered in judging the appropriateness of restraint; if mechanical restraint was used not to punish but to treat the patient, it was legitimate. In the case of suicidal patients legitimacy was obtained by the emphasis placed on successful prevention. Where the impulse for self-destruction was strong and desperate, modified restraint was safer and much kinder to the patient than allowing the patient full liberty or trusting the vigilance of attendants.

At Ticehurst private asylum, the therapeutic benefit of restraint was embraced by Samuel Newington and Charles Hayes. MacKenzie reveals that the Newingtons approached the use of mechanical restraint with a degree of self-consciousness, but this emanated from their awareness that the Lunacy Commissioners and some

⁶⁹⁴ Bucknill and Tuke, *A Manual of Psychological*, p.502.

⁶⁹⁵ Nancy Tomes deals extensively with the practice and politics of the non-restraint movement in her discussion of 'The Great Restraint Controversy'. She draws on contemporary opinion, including that of James Huxley, to demonstrate the contention that existed between non-restraint's proponents and opponents.

patients' families were opposed to restraint. At Ticehurst, the limited employment of restraint emanated from external pressure as well as the proprietor's disdain for the use of coercion. The Newingtons found restraint useful in a practical capacity, but more importantly, they retained its use because they believed it was therapeutic in some instances. Newington and Hayes believed that:

the value of mechanical restraint was not only that it prevented physical depletion or damage through...violence, but that used continuously over a period of time it broke established patterns of behaviour, and created a new habit of abstinence.⁶⁹⁶

When mechanical restraint was employed to break long-established patterns of behaviour it could be perceived as a legitimate component of medical therapy. Restraint was capable of instituting change physiologically rather than being deployed for its disciplinary or punishing merits.

Conolly argued that in asylums where restraint was not employed, patients disposed to suicide were rarely found to inflict self-injury. He claimed that 'there is great reason for believing that a disposition to commit suicide prevails most, and becomes most inveterate where restraints are most employed; and is even created in many cases by their use'.⁶⁹⁷ Following the adoption of non-restraint at Gloucestershire County Asylum, it was recorded that, 'all the patients are as securely managed and are governed with much less difficulty and disturbance, WITHOUT than WITH

⁶⁹⁶ MacKenzie, *Psychiatry for the Rich*, p.143.

⁶⁹⁷ Conolly, *Treatment of the Insane*, p.257.

mechanical restraint'.⁶⁹⁸ At Lincoln, an apparent change in suicidal behaviour, as a consequence of non-restraint, was evident in the case of a female lunatic admitted in 1838. The patient was admitted to the asylum in a state of immense excitement and was restrained by a strait-waistcoat. Subject to sudden and violent outbursts, she had attempted self-destruction prior to admission by jumping into a stone pit. The strait-waistcoat was replaced by constant surveillance after which she became quiet and orderly. Six days after admission, she was described as 'so far recovered as to have lost all disposition towards any inordinate action...she has herself stated, that the irritation of personal restraint had occasioned the excitement she at first exhibited'; the patient was eventually removed to the convalescent ward and employed in needlework.⁶⁹⁹

Non-restraint brought a new found freedom that affected a change in the behaviour and demeanour of suicidal patients. Hill recognised that under the physical confinement of restraint the suicidal patient was encouraged, by (their) inactivity, to focus on gloomy thoughts and delusions which fed suicidal tendencies. In general, restraint was recognised as having counter-productive attributes to the patient's condition. It frequently exasperated patient irritability and confirmed existing delusions. When freed from restraint, the patient was afforded freedom of movement and the opportunity to undertake occupation of the mind as a distraction from its gloomy fixation.

⁶⁹⁸ GRO, HO22/8/1, Annual Report (1841).

⁶⁹⁹ Gardiner Hill, *A Concise History of the Entire Abolition*, p.152.

Alienists, who were unwilling to commit themselves to the total abolition of mechanical restraint, advocated the concept of partial abolition. Patient liberty was welcomed, but when extreme violence or self-destructive behaviour became problematic, restraint should be imposed as a means of protection. The rationale for restraint had after all operated on two grounds: 'either with a view to prevent them from doing injury to others, or to hinder them from doing violence or mischief to themselves'.⁷⁰⁰ Removing the option of mechanical restraint withdrew the medical superintendent's ability to evaluate the suitability of restraint in suicidal cases. The ideal scenario, according to Browne, was 'as much liberty as is consistent with the safety of the whole community, and just as much restraint as is consistent with the happiness and recovery of each of the members'.⁷⁰¹ Browne thought the rhetoric of enlightened humanity was not to be strictly adhered to for suicidal lunatics; 'Many establishments have been condemned and ruined, by the occurrence of a case of suicide within their walls'.⁷⁰² James Wilkes, medical superintendent at Stafford Asylum, and Thomas Green, at Birmingham Borough Asylum, were unprepared to comply with the idea 'that it [restraint] is in all instances injurious'.⁷⁰³ Wilkes and Green, together with a select number of medical superintendents, reached the conclusion that cases may occur in which 'its temporary employment may be both necessary and justifiable'⁷⁰⁴; no more so than in the case of suicidal patients.

⁷⁰⁰ J. Crawford, *Observation of the Expediency of Abolishing Mechanical Restraint in the Treatment of the Insane in Lunatic Asylums* (Glasgow, 1842), p.6.

⁷⁰¹ W.A.F. Browne, 'What Asylums Were, Are and Ought to Be' in A. Scull (ed.), *The Asylum as Utopia: W.A.F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry* (London, 1991), p.203.

⁷⁰² *Ibid.*, p.204.

⁷⁰³ F. Winslow, 'On Non-Mechanical Restraint in the Treatment of the Insane', *The Journal of Psychological Medicine and Mental Pathology* (1854), p.555.

⁷⁰⁴ *Ibid.*, p. 554.

The rationale for partial abolition was not supported by Gardiner Hill. He considered 'the mere partial mitigation of restraint is not in itself a safe system, suicides not having diminished under it...it would appear on the contrary that there is not any safety, when the attendants are not compelled to rely wholly upon inspection'.⁷⁰⁵ As long as restraint was available it was thought that attendants would devolve much of their responsibility to mechanical coercion. In Gardiner Hill's opinion, only when restraint was completely removed and the focus fell upon the attendant as the primary overseer of patient management would the risk of self-destruction diminish.

The omnipresent risk and unpredictability of suicidal behaviour had encouraged a reliance on restraint as the primary source of management against successful acts of self-destruction. Restraint offered an easily imposed method of controlling violent and destructive excesses without consuming the attention of attendants. Alternative methods of management and prevention already existed, like seclusion, but their use remained minimal because restraint was a more convenient method. The removal of restraint placed a new found emphasis on several alternative, more proactive methods of patient management. Patient management shifted from a policy of restraining violent and destructive 'paroxysms' to a comprehensive scheme of awareness, foresight and direct attendant involvement.

According to Shepherd and Wright, asylum doctors responded to the transition in patient management by instructing attendants to adopt a variety of strategic measures designed to prevent suicides.⁷⁰⁶ These measures manifested themselves as strict surveillance, protective clothing, force-feeding, manual restraint and drugs.

⁷⁰⁵ Gardiner Hill, *A Concise History of the Entire Abolition*, p.129.

⁷⁰⁶ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p. 179.

Active prevention against suicidal behaviour gained considerable impetus during the non-restraint era. It marked a period of greater preoccupation with prevention that permeated approaches to patient management in the mid-nineteenth century. The removal of mechanical restraint made it even more important 'to foresee everything that the patient may devise in the way of self-destruction, so that his intentions can be frustrated'.⁷⁰⁷ The removal of every potential instrument of danger was a prime concern:

staff should be instructed to lock up all medicines, never allow patients to handle them and never serve out more than the exact dose...any loss of keys or razors should be reported immediately...knives and forks are only to be used in the presence of attendants.⁷⁰⁸

The rules and regulations of the Salop and Montgomery County Asylum demonstrate the importance attached to these duties. Regulation 11 informed attendants that immediately after each meal they were to:

count the knives, forks, spoons, and other utensils, lock them up, and afterwards have them properly cleaned under their own personal supervision. Should any be missing a strict search must be made, and the Head Attendant informed of the loss.⁷⁰⁹

⁷⁰⁷ Craig, *Psychological Medicine*, p.457.

⁷⁰⁸ Dr H. Sutherland, 'The Prevention of Suicide in the Insane', *The Lancet* (1892), p.1267.

⁷⁰⁹ SA, 6175/c/1/1, *Rules and Regulations of the Salop and Montgomery Lunatic Asylum*, 1855, p.30.

Attention was paid to other potentially dangerous objects that, if ignored, could have fallen into the hands of suicidal patients. The rules and regulations of Fishponds private asylum clearly stipulated that 'No hat-pins are permitted to be worn by nurses when on duty. In the wards [at Fishponds] the uniform cap is only permitted to be fastened with a safety pin'. Each attendant and nurse had a 'locked receptacle provided in his or her room in which any sharp instrument, such as razors, scissors, etc, can be placed; a special key being provided for the officer in each instance, thereby leaving no excuse for dangerous articles to be left unguarded'.⁷¹⁰ Preventative measures, such as locked receptacles, were a vital component of the asylum environment that aided the attendant in their strict adherence to a policy of suicide prevention. The removal of patient clothing was another important means of preventing suicide. Browne observed that 'it is a general rule in some asylums, that the clothes of the patients should be taken out of their bedrooms at night, and wrapped up'.⁷¹¹ This stopped suicidal patients tearing their clothing to aid hanging and strangulation. To ensure prevention during the day, Conolly advocated that 'the clothing he wears is of strength and consistence resisting his efforts to tear it into strings to affect his purpose'.⁷¹²

Non-restraint prompted a reappraisal of patient management strategies. Seclusion, sedation and surveillance come to the fore of asylum care. In the absence of restraint, they afforded effective, 'therapeutic' methods of handling disruptive behaviour, but in time the ethics of seclusion and sedation were scrutinized and questioned. Seclusion was, like many of the substitutes for restraint, subject to

⁷¹⁰ H.A. Benham, 'Some Remarks on Suicides in Public Asylums', *JMS* (1903), p.450.

⁷¹¹ Scull (ed.), *The Asylum as Utopia*, p.204.

⁷¹² Conolly, *Treatment of the Insane*, p.48.

misrepresentation by opponents of the non-restraint system. They considered the confinement of patients in seclusion cells or padded rooms, for prolonged periods of time, to be an act of cruelty and liable to abuse. Lauder Lindsay and T.O. Wood, the medical superintendent of Dunston Lodge private asylum, called for the abolition of seclusion. Wood stated that 'air and exercise, with good food and careful attention during the day, and sleep at night, will do more for the cure of insanity than all the seclusion in the world'.⁷¹³ In its place he advocated separate airing courts so that excitable patients could be removed from the stimuli that produced or maintained their excitement, without being denied exercise and fresh air.

Conolly defended seclusion, stressing the care with which confinement was imposed and the therapeutic benefits it offered:

But it is overlooked that with us seclusion is only employed when the patient cannot be at large with benefit to himself, or with safety to others...he is abstracted from noise, from the spectacle of a crowd of lunatics, from meeting those who are almost as violent as himself, and from every object likely to add to his irritation.⁷¹⁴

Seclusion aimed to alleviate the irritations and symptoms of the patient's suicidal behaviour; curing the patient's 'paroxysm' was its primary objective. At Gloucestershire County Asylum, patient records evidence the use of seclusion as a response to destructive behaviour, with the duration ranging from one to ten hours. A female patient, Mary, was placed in seclusion for a period of ten hours after

⁷¹³ T.O. Wood, 'The Abolition of Seclusion', *Journal of Mental Science*, vol. 18 (1872), p.60.

⁷¹⁴ Conolly, *Treatment of the Insane*, p.43.

exhibiting very excited behaviour and being destructive to her clothing. Demonstrating similar behaviour and threatening to break the windows several days later, Mary was placed in seclusion for most of the day.⁷¹⁵ Under the system of non-restraint, seclusion offered an alternative method of subduing the temporary 'paroxysm' of violent excitement without the need for direct bodily coercion.

In the absence of mechanical restraint continual surveillance was considered the greatest substitute. Gardiner-Hill stressed that an attendant should always be present for the purpose of preventing self-harm and that suicidal patients should, without question, be placed in an open dormitory under the constant watch of a night attendant. In 1857, he boldly claimed that 'not a single instance of suicide has occurred in the asylum [Lincoln] since the adoption of this system...proving that ...nothing but constant surveillance by day and night can prevent suicide under any system whatever'.⁷¹⁶ Constant watching of suicidal lunatics was an accepted and comprehensively conducted substitute to restraint. Its practice underpinned the system of non-restraint as a direct mechanism for prevention as well as supporting the practice of seclusion and the removal of potential weapons.

The implementation of non-restraint had a profound impact on the practices of suicide prevention. It shaped broader institutional practice in the mid-nineteenth century and re-directed traditional approaches to the management of suicidal behaviour. Non-restraint ushered in a greater emphasis on prevention, placing consideration for the welfare and treatment of suicidal patients higher on alienists'

⁷¹⁵ GRO, HO22/65/1, *Medical Journal*, 1860-1871. The patient is referred to by her Christian name because it was not possible to accurately decipher her surname.

⁷¹⁶ Gardiner Hill, *A Concise History of the Entire Abolition*, p.58.

agenda. The positive affects of the system brought greater patient liberty, drew attention to the need for night attendants, and marked a watershed in the transition from custodial to curative care. The patient was set to gain much benefit from the abolition of mechanical restraint, but implementation of the system meant that a labour-intensive style of asylum management was required to overcome initial transitory problems. Non-restraint had been developed by practitioners, but it was asylum attendants who had to deal directly with the destructive and violent behaviour of suicidal patients and they often did so in a pragmatic way. The management and treatment of suicidal patients became a more practical, hands-on task, which hinged on the vigilance and skills of an under-resourced body of attendants who increasingly conducted their duties according to human nature rather than particular theories.

Chemical restraint

Following the 1845 Lunatic Asylums Act, which made the erection of county asylums compulsory in England, there was a series of significant developments in both the operation of the institution and the treatment methods it adopted. The first of these, as already discussed, was the abolition of mechanical restraint in favour of therapeutic endeavours aimed at restoring the patient to health. The system of non-restraint was a significant catalyst for the growth of drug treatment. It forced a greater 'reliance on pharmacological interventions' to control difficult behaviour and prevent acts of suicide.⁷¹⁷ Alongside non-restraint was a dramatic explosion in the patient population, which saw nineteenth-century lunatic asylums under-staffed and overwhelmed by chronic cases.

⁷¹⁷ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p.179.

By the latter stages of the nineteenth century, these conditions proved the catalyst for an increased reliance on sedatives and narcotics to control those patients most at risk of inflicting self-injury or acts of 'self-destruction'. With chains and fetters out of favour and seclusion treated with some scepticism, sedation became a more appealing alternative. According to Lauder Lindsay 'if a superintendent administer morphia, or any other preparation of opium largely, he may boast of his rare cases of mechanical restraint and seclusion'.⁷¹⁸ Unlike chains and manacles, the introduction of drugs could masquerade behind a therapeutic rationale, making it acceptable to the psychiatric profession, the Lunacy Commission and wider society.

In violent and suicidal cases an element of restraint remained necessary and it seemed that chemical restraint offered a less overtly forcible approach. Sedatives and narcotics, such as chloral hydrate and opium, were utilised to calm patients, procure sleep and maintain order in the wards of the asylum as mechanical restraint had once done. For some alienists this was a questionable alternative; was there truly any difference between restraining a patient with sedation or the imposition of shackles? Motivation for the administration of drugs emerged as the most contentious aspect of 'chemical restraint'. Alienists debated whether drug treatment flourished in the latter half of the nineteenth century as a means of re-asserting control and prevention over the suicidal or dangerous, or was genuinely intended to provide medicinal and therapeutic benefit. Before exploring the role drug treatment played in the prevention and management of suicidal lunatics, it is first necessary to briefly examine the reasons why drugs rose to prominence.

⁷¹⁸ Lauder Lindsay, 'The Theory and Practice of Non-Restraint', p.1095.

The burgeoning patient population and increased dependency on the skills of attendants gradually compromised the ideal of non-restraint and made the regulation of those disposed to violence and self-destruction more and more complex.⁷¹⁹ The low number of attendants, usually one per ward, and the failure in many asylums to provide sufficient night staff were intrinsically connected to the pursuit of economy. Local authorities were unwilling to spend additional money to recruit more attendants; they strove to keep the costs of institutionalisation low. Medical superintendents were charged with managing a micro-economy that maximised the asylum's income. Their performance was judged on the successful control of expenditure as well as their medical contribution. Asylums were never rich in finances or resources and the failure of alienists to achieve high cure rates discouraged future investment and allowed economy to prevail. Moderate funds ensured that the asylum could only achieve a moderate level of care. Economic concerns undoubtedly contributed to the custodial character of public asylums and encouraged the increased use of drugs to control patients as a substitute for attendants.

The asylum's impending drift toward regimentation and routine was also detrimental to the practice of 'moral treatment'. The high patient to staff ratio meant medical superintendents found it increasingly difficult to maintain regular contact with patients and keep abreast of individual cases. A comprehensive knowledge of patients was sacrificed with the emergence of a system of management primarily concerned with institutional efficiency and order. The difficulty of applying the principles of moral

⁷¹⁹ Scull, *Museums of Madness*, chapter 6.

treatment, in a large monolithic institution, was a further erosion of the asylum's curative ideal and hastened the need for a more custodial approach.

Non-restraint and moral treatment exerted considerable influence over asylum practice, but they should be perceived as secondary contributors in the emergence of extensive drug treatment. Overcrowding of large-scale institutions represented the underlying catalyst for the shift from cure to custody and, as a bi-product, the increased use of drugs in the treatment of the insane. A substantial number of annual admissions remained in the institution as long-stay patients, rapidly filling the asylum with an overwhelming population of incurable cases. This trend forced medical superintendents to re-evaluate and adjust their approach to patient care in light of the practical realities they faced. The innovation promised by moral treatment and non-restraint was replaced by a period of stagnation that stifled hopes of recovery and cure. The asylum's operational objective became the maintenance of discipline and order. Outbursts of disturbed or destructive behaviour needed to be flattened by short-term sedation rather than lengthy periods of tranquilisation.

Throughout the 1860s and 1870s, drugs became a more appealing 'medical treatment'. Chloral hydrate, opium, bromide of potassium, morphia and digitalis were the most commonly employed sedatives and narcotics. Opinions were divided about the efficacy and motivation for their use in the general treatment of insanity and suicidal patients. Henry Maudsley gave reference, in his work *The Pathology of Mind*, to the level of division that existed among his contemporaries:

Opinion is yet divided as to the value of this [chloral hydrate] and other sedatives, and while one physician at the head of a large asylum denounces them earnestly, another who has had as large a field of practice cannot speak too well of them.⁷²⁰

Without consensus of opinion it was exceptionally difficult to 'dogmatise upon the good effected by pharmaceutical remedies'.⁷²¹ Much of the discourse hinged on the motivation for administering drugs. Sedation was deemed acceptable if given with the intention of subduing a violent and suicidal patient for their own and others' benefit but, if prescribed on a routine basis with the sole objective to make the duties of attendants easier, then this was unjustifiable. Although medical superintendents were required to record the use of drugs in asylum casebooks, it remains difficult to determine from these entries whether medical or punitive reasons were the main motivating factors.

Alienists' lack of knowledge about the medicinal and therapeutic value of drugs was evident throughout contemporary discourse. Maudsley was acutely aware that alienists needed exact information about the benefits of drug treatments. Clouston shared this opinion and undertook observations and experiments on the use of opium and bromide of potassium in 51 cases of both curable and incurable conditions. He declared that:

⁷²⁰ Maudsley, *The Pathology of Mind*, p.551.

⁷²¹ Hack Tuke, *Chapters in the History*, pp.486-487.

At best we can only work very empirically. But our empiricism may be founded on a rational and scientific examination of the effects of the drugs we use...the following observations were undertaken almost entirely with the view of obtaining a little more accuracy in my knowledge of the effects of certain medicines.⁷²²

Clouston's observations suggest that when bromide and cannabis indica were combined it produced good effects on the patient's condition by the end of the first day of its use. He noted that patients commonly became less restless, violence abated and they slept more easily at night.⁷²³

The psychiatric profession had yet to develop a detailed and extensive knowledge of the effects drugs had on insanity. Only limited investigations had been conducted on the level of improvement that was derived from sedatives and narcotics. What then did alienists hope to achieve by the increased use of drugs in the treatment of suicidal lunatics? In the debate that surrounded drug treatment, alienists focused on the procurement of sleep and the attainment of quieter wards as the underpinning justification for, and intended results of, drug treatment. This was exemplified in the work of Joseph Williams, published in 1845, entitled *An Essay on the Use of*

⁷²² T.S. Clouston, 'On the Use of Certain Drugs in Insanity', *The British and Foreign Medico-Chirurgical Review*, vol. 46 (1870), pp.493-494.

⁷²³ T.S. Clouston, 'Observations and Experiments in the Use of Opium, Bromide of Potassium and Cannabis Indica in Insanity', *The British and Foreign Medical-Chirurgical Review*, vol.47 (1871), pp.205-206.

Narcotics and other Remedial Agents.⁷²⁴ Rather than purposely targeting the mental affliction, it was intended that drugs would subdue the restless and violent physical manifestations of the illness. This allowed the patient's bodily and general health to improve and for cure hopefully to follow. Care and control were after all two sides of the same coin, since calm patients were a necessary prerequisite to the beneficial administration of therapeutic treatments. The use of drug treatment could be motivated by one of three possibilities: (1) chemical control; (2) therapeutic intervention; (3) a combination of the two. The methods of treatment adopted by alienists were driven as much by the desire and increasing necessity to maintain order as well as to effect cure.

Sedatives and narcotics were considered particularly effective in producing a quiet ward at night. This was a crucial time period in the care of the suicidal because the maintenance of adequate surveillance and management was compromised by insufficient staffing levels. Observed, during the night, by a small number of attendants and his mind unoccupied, the patient was deemed more likely to fixate on thoughts of suicide and find cunning ways of inflicting 'self-injury' or 'destruction'. This period of time caused considerable anxiety for attendants and received significant attention from alienists and the Lunacy Commission.

Chloral hydrate was the sedative of choice for patients disposed to restless nights. Hack Tuke asserted that alienists employed it without discrimination because it was 'regarded as a talisman in insomnia and excitement'.⁷²⁵ For a brief period, chloral

⁷²⁴ J. Williams, *An Essay on the Use of Narcotics and other Remedial Agents Calculated to Produce Sleep in the Treatment of Insanity* (London, 1845).

⁷²⁵ Hack Tuke, *Chapters in the History*, p.486.

hydrate was 'the spoilt child of psychological medicine'.⁷²⁶ It was routinely prescribed as a natural course of treatment when patients were unable to sleep. Chloral hydrate was administered to Martha Widdowson, a patient of the Leicestershire County Asylum, in an effort to overcome the difficult behaviour she displayed at night. She was admitted to the asylum in January 1875 as a 'case of melancholia with a suicidal tendency'. Observations of her behaviour revealed that 'the appetite is very poor and the patient is very restless at night'. In consequence of her sleeplessness it was considered necessary to prescribe a 'chloral draught every night'. Martha responded well to the treatment; she slept better and her appetite improved.⁷²⁷

Similar behaviour prompted the use of chloral hydrate in another case at Leicestershire County Asylum. Mary Sutton was admitted in December 1870, suffering from melancholia with a suicidal predisposition; 'she had attempted self-destruction by taking poison before admission'. She was repeatedly 'sleepless at night and disturbs the other patients'. To counteract her behaviour, chloral hydrate was regularly administered at night and she 'improved considerably under its use'.⁷²⁸ Selina Bloomfield was committed to Warwickshire County Asylum in October 1870 in a 'low and desponding' state. She had 'attempted to hang herself' and asked 'for poisons to destroy her life'. Selina experienced difficulty sleeping and was 'ordered Chloral 3g at night'. The chloral proved effective and it was recorded that she 'sleeps well now'. The medical superintendent instructed that attendants 'diminish the Chloral and in a few days stop it altogether'.⁷²⁹ Despite a marked improvement in the

⁷²⁶ Ibid.

⁷²⁷ LRO DE3533/194, admitted 30 January 1875, admission no.3531.

⁷²⁸ LRO DE3533/193, Male and Female Casebook, January 1870-August 1873.

⁷²⁹ WCRO, CR1664/622, admitted 31 October 1870.

condition of each patient, the use of chloral hydrate was initiated primarily to induce sleep and subdue difficult behaviour rather than provide any overtly therapeutic benefit.⁷³⁰

Advocates of drug treatment rested much of their argument on the ability to procure sleep, thereby relieving the pressure placed upon night attendants. When drugs were administered for this purpose they were perceived as assisting suicide prevention, but for Maudsley the grounds of justification were not so black and white. He questioned the true benefit of narcotic-induced sleep when compared to that of natural sleep. The two were considered very different conditions, leading Maudsley to declare that 'what is wanting is the knowledge that in either of these or other artificial states the same sort of repair and restoration of nerve-element takes place which takes place in natural sleep'.⁷³¹

By inferring that the patient gained little curative benefit from drug-induced sleep, Maudsley challenged the therapeutic grounds on which some alienists sought to legitimize their use of drugs. It is logical to conclude that the one major benefit sleep provided, whether natural or narcotic, was temporary respite from the patient's despondent thoughts or delusions. It was asylum attendants who gained far more from a ward of sleeping patients. An inadequate number of night attendants posed a significant threat to the practice of constantly watching the activities of suicidal patients. Without recourse to mechanical restraint, control of patients depended on

⁷³⁰ Chloral hydrate was administered primarily for its ability to sedate patients, but sleep was considered to be of great therapeutic benefit in itself.

⁷³¹ Maudsley, *The Pathology of Mind*, p. 551.

close observation. If attendants were to succeed in their duties and maintain order in vast asylums they needed patients to conform to the rules of the institution. Sedative-induced sleep offered a practical solution to the management of suicidal behaviour at night. It was the needs of the institution and its attendants that came to the fore and took precedence over those of patients; custodial rather than curative consideration dictated.

Night time was a particularly dangerous period for suicidal patients, but it should not be perceived that the hours when they were awake were any easier. The emotional state of the patient and the intense mental suffering they experienced proved the catalyst, according to German psychiatrist Wilhelm Greisinger, to certain 'impulses and directions of the will which are manifested in external actions'.⁷³² The internalization of negative emotions and ideas manifested itself, outwardly, in the form of hostile and destructive actions towards both the individual himself or those around him. The behaviour of suicidal patients was dangerous and often unpredictable, but of equal concern was its impact on the quietness of the wards and the disturbance it caused to other patients. Alienists' divided loyalty to serve the needs of the institution and the patient were summarised by Dr Pritchard Davies, medical superintendent of Kent Asylum. He wrote, 'I believe that very few medical officers used powerful drugs purely and simply as restraints, yet I am sure many used them as means of controlling, with the hope that quiet being established cure would follow'.⁷³³

⁷³² Greisinger, *Mental Pathology*, p.252.

⁷³³ Cited in G. Savage, 'The Use of Sedatives in Insanity', *The Practitioner*, vol. xxxvii (1886), p.181.

Despite Davies' inference that the patient's condition and cure were of concern, it remained a secondary consideration that was still to be achieved by means of restraint. The primary motivation rested upon the need to control demanding behaviour and violence beyond that presented by suicidal lunatics. There were different manifestations of difficult behaviour and other types of patients that may have required 'chemical control'; drug treatment was not exclusive to the management of suicidal patients. Some alienists tried to justify sedative use in this scenario as a curative aid to stifle difficult or suicidal behaviour and produce quiet, but for the majority of the profession it was an unconvincing argument. The underlying fact remained that sedatives, such as chloral hydrate, were used to keep turbulent patients quiet in the way mechanical restraint had once done.

In his discussion of the uses and abuses of sedatives, George Savage declared that alienists who drugged patients into submission 'were neither better nor worse than the physicians who restrained mechanically with the same object in view'.⁷³⁴ Sceptics believed that drug treatment did not represent significant progression from mechanical coercion; it simply became the old enemy under a new guise, hence it rapidly acquired the apt label of 'chemical restraint'. Pritchard Davies believed that there was very little difference 'in the reasoning which made our ancestors keep their patients quiet by means of rope and chains...and the modern practitioner's administration of powerful drugs for the same purpose'.⁷³⁵ He regarded each 'period

⁷³⁴ Ibid., p.181.

⁷³⁵ F. Pritchard Davies, 'Chemical Restraint and Alcohol', *JMS*, vol.26 (1881), p.526.

of quiet' produced by chemical restraint as a detrimental blow 'to the already enfeebled organism', which inevitably led to its destruction.⁷³⁶

Concern about the true motivation for drug treatment led many to be critical of 'chemical restraint', but not all alienists were as bleak about the efficacy of drugs. Encouraged by empirical evidence, a small number of alienists concluded that the administration of opium and morphia could deliver an improvement in the patient's condition and alleviate the suicidal propensity. Opium acted primarily as a tranquiliser and was administered to 'treat all those types of madness which were characterized by insomnia and restlessness'⁷³⁷. Fielding Blandford claimed that opium 'allays the terrible feeling of depression which melancholic patients endure, especially in the morning'.⁷³⁸ It often afforded only temporary relief and brought with it dangers of addiction and a loss of appetite. Despite these risks, the positive effects of opium were believed to be beneficial when a persistent suicidal impulse existed and the lunatic patiently planned an opportunity to effect their desire for self-destruction. Maudsley noted that 'in one instance of the kind, after its use had been continued for a long time without any marked effect, the patient got quite well'.⁷³⁹

Similar results were recorded for a female patient at Birmingham Borough Asylum. Susan Prescott was admitted in May 1853 suffering from melancholia with a suicidal tendency. Described as 'discontented' and 'more and more crazy and restless at night', she was prescribed opium and hyoscyamine for a month. Following this

⁷³⁶ Ibid., p.530.

⁷³⁷ L. Sueur, 'The Use of Sedatives in the Medical Treatment of Insanity in France from 1860-1870', *History of Psychiatry*, vol.8 (1997), p.97.

⁷³⁸ Blandford, *Insanity and its Treatment*, p.439.

⁷³⁹ H. Maudsley, 'On Opium in the Treatment of Insanity', *The Practitioner*, vol. 2 (1869), p 5.

course of treatment, she became 'much quieter in her manner...more cheerful', her suicidal propensity receded.⁷⁴⁰ Benjamin Rowley, a patient of Worcestershire County Asylum in 1861, also 'began to make some improvement' after taking opium. He was said to be suffering from monomania of fear and had attempted suicide by poisoning and cutting his throat. His behaviour was characterised by restlessness and refusal of food. Following the use of opium, he began taking food and slept much better at night.⁷⁴¹ In both of these cases it is impossible to determine whether the recovery was due to opium or other factors. To profess that opium alone was capable of removing a suicidal desire, or overcoming difficult behaviour, was dubious when knowledge of the treatment was in its infancy. It is, however, plausible that the tranquilizing effect a large dose of opium had on the mind and body was capable of subduing suicidal thoughts.

The administration of morphine also appeared to act beneficially on suicidal patients. It controlled the excitement of mania and lifted the depression of melancholia and weakened delusions. Dr Seymour, physician to St George's Hospital and later a Metropolitan Commissioner, favoured the use of morphine acetate in the treatment of suicidal patients.⁷⁴² Over a period of seven years, Seymour tested the efficiency of acetate in eighteen cases of mania characterized by a gloomy despondency, and a strong disposition to suicide. He considered 'those suicidal cases to be where the acetate is the most indicated: it seems to exercise an irresistible influence over them in preventing them from doing mischief'.⁷⁴³ The influence exerted presumably came

⁷⁴⁰ BCA, MS344/12/2, admitted 26 October 1853.

⁷⁴¹ WCRO, BA10127/14, admitted 25 March 1861, admission no.1057.

⁷⁴² Seymour classified acetate as the first preparation of morphine.

⁷⁴³ Williams, *An Essay on the Use of Narcotics*, p.62.

from morphia's ability to allay the patient's depression and delusions, both of which acted as triggers for suicide. Seymour's confidence in morphine was undermined by the experience of Harriet Jones at Rainhill Asylum and John Waters, a patient of Birmingham Borough Asylum. Harriet Jones was admitted to Rainhill Asylum in February 1851 having been diagnosed with mania. Yet, strangely, her case notes recorded that 'on admission she appeared to be suffering from great depression of spirits with a very strongly marked tendency to self-destruction'. She refused food and was found wandering 'about the dormitory nearly the entire of the first two nights'. In accordance with Seymour's thinking, Harriet 'was ordered...acetate of morphia every night'. In addition 'attempts were made to induce her to take beef tea'. Her condition eventually improved but this was not attributed to her course of morphia. It was found that she 'suffered much from accumulation of milk but on the subsidence of this she steadily and rapidly improved'.⁷⁴⁴

The case notes of John Waters provide further evidence that discredits the efficacy of morphine. John was admitted to Birmingham Borough Asylum in 1851. He was suffering from partial insanity of three weeks duration and was classified as 'dangerous to himself and others'. Soon after his admission, John fell into a state of bewilderment and repeatedly caused 'a disturbance in the ward by getting out of bed and dragging his bedclothes about the floor'. Morphine was administered and 'kept him quiet for a few hours but he became restless afterwards'. The morphia 'having partly lost its influence' was exchanged for doses of opium. John's disruptive and excited behaviour was not overcome by morphine or opium. He only experienced

⁷⁴⁴ LRO, M614 RAI/8/1, Female Casebook, January, 1851- June 1853.

‘much quieter nights’ once the shower bath was regularly employed.⁷⁴⁵ This suggests Seymour’s confidence in the therapeutic benefits of morphine was a little premature. Although morphia brought some benefit it should be remembered that Seymour only tested and observed the positive effects of morphine on eighteen patients. Drawing a causal link between the administration of morphine and any subsequent abatement of a suicidal desire was precarious when validated by inadequate quantitative evidence. Morphine may have offered limited therapeutic benefit for a small number of patients, but it was not a panacea for suicidal behaviour *per se*.

By the late nineteenth century, alienists’ declaration that British asylums were free from mechanical restraint was an ambiguous claim that was increasingly met with dubious acceptance. Robert Cameron, medical superintendent of the Midlothian District Asylum in Scotland, encapsulated this sentiment in his article on the philosophy of restraint. He asserted that ‘there is a very general impression among...the medical profession abroad that it is only by the free use of stupefying drugs that British alienists are able to dispense with the use of mechanical appliances’.⁷⁴⁶ The use of drugs in the treatment of insanity remained largely akin to mechanical restraint; it targeted the body and not the mental affliction. Sedatives and narcotics merely restricted the potential for acts of self-destruction rather than removing the suicidal propensity by psychological and therapeutic endeavours. The potential for abuse was as latent in the administration of drugs as it had been in the shackling of patients. It remained possible for suicidal patients to be chemically restrained under the pretext of medical treatment, yet registers of restraint and

⁷⁴⁵ BCA, MS344/12/2, admitted 10 March 1851.

⁷⁴⁶ R. Cameron, ‘The Philosophy of Restraint in the Management and Treatment of the Insane’, *Journal of Mental Science*, vol.28, (1881-1882), p.519.

seclusion presented the asylum as the very model of a therapeutic institution. J.M. Granville considered the therapeutic rationale for drug treatment to be a perversion of medical techniques. His opposition was rooted in a belief that the 'pretence of curative treatment was a sophistry' because the 'real object was to secure quiet wards'.⁷⁴⁷

This paradoxical situation left the majority of alienists, even by the 1880s and 1890s, to question whether putting the patient's brain into 'chemical restraint' did him any benefit? Inadequate knowledge and empirical evidence stimulated an on-going debate about the moral and medical justification for drug treatment. Based on his own experience, Cameron confessed that he had 'seen no beneficial results to follow the continuous use of sedative drugs that could fairly be attributed to those drugs'.⁷⁴⁸ Conflicting accounts prevented alienists from making a direct correlation between the administration of drugs and the improved condition of suicidal patients. A lack of definitive evidence meant that the therapeutic benefits presented by a small number of alienists, like Dr Seymour, could not be discounted. As long as the majority of the psychiatric profession failed to actively and extensively develop their knowledge via experimentation and case observation then no clear distinction could be drawn between 'chemical control' and 'therapeutic intervention'. It was difficult for alienists (and remains the case for historians) to determine the underlying motivation for the administration of sedatives and to decide whether any improvement in the patient's condition could be directly attributed to drug treatment. The grounds of clarification were a 'grey area', but the evidence presented infers that drugs were largely a

⁷⁴⁷ House of Commons, *Select Committee on the Operation of the Lunacy Law*, 1877, p.397 (evidence of J.M. Granville) cited in A. Scull, *The Most Solitary of Afflictions*, p.290.

⁷⁴⁸ Cameron, 'The Philosophy of Restraint', p.520.

vehicle of disciplinary power that allowed alienists to reassert control over suicidal patients, whilst masquerading behind a more subtle therapeutic approach. The justification of curative treatment was a plausible, but often misleading, argument as medicinal or therapeutic benefit remained secondary to institutional needs.

* * * * *

When originally conceived, both the asylum and its treatment methods were primarily concerned with humanitarian and curative care. Over time, changes in the institutional environment and structure meant a reversal of these priorities. Therapeutic pessimism gained ascendancy and placed the asylum's custodial and protective functions at the forefront of provision. Innovation was stunted and eventually replaced by a policy of containment that secured institutional efficiency. The asylum had always operated as a Janus-faced institution combining cure and custody, but the implementation of moral treatment and non-restraint allowed the concealment of a more systematic and custodial regulation of patients' lives to evolve under the guise of therapeutics. A labour-intensive style of management was required to ensure the success of both systems, but ironically this secured their eventual demise. Attendants became the lynch-pin of the asylum, but the pursuit of economy prevented the recruitment of additional attendants and served to encourage an increased reliance upon sedatives and narcotics to fill the void and guarantee control over difficult behaviour. 'Chemical restraint' represented the final chapter in the demise of therapeutics and the asylum's failed attempt to operate efficiently and humanely without the need for controlling methods.

In a less benevolent environment, suicide management and prevention was forced to adapt. In the asylums studied, the changing nature of the institution did not translate into a dramatic increase or decrease in the number of completed suicides during the latter half of the nineteenth century. The decline of therapeutic intervention did make an impression on the practices of suicide prevention, but it bore more heavily on the institutional surroundings that influenced the patient's emotional and mental state. The advancement of custodial care undermined management techniques, made attendants remote and fostered greater regulation of asylum life which, when conjoined, made patients feel more isolated and the prospect of recovery uncertain. When this external pressure and the pain of their illness converged, the suicidal ideation already present in the patient's mind was strengthened and a suicide attempt was perhaps encouraged as a strategy of escape.

6

THE LUNACY COMMISSION AND SUICIDE PREVENTION

The Lunacy Commission was one of several inspectoral bodies established during the first half of the nineteenth century. Changing notions of the role of government encouraged the growth of central agencies that were responsible for supervising the implementation of social and economic policies at a local level. Benthamite ideals such as economic efficiency, uniformity, and professionalism also influenced and helped to create the role of the inspectorate. In the area of lunacy provision, the Commissioners in Lunacy were the representatives of the state, replacing visitation by local magistrates or asylum governors which had been the norm until 1845. The work of the Lunacy Commission has received only marginal attention within the broader historiography of nineteenth-century psychiatry. There has, as Mellett acknowledged in 1981, been 'little attempt to analyse the organisation and function of the Commissioners'.⁷⁴⁹ Subsequent work has attempted to rectify this omission. Indeed in his own work, Mellett explored the effectiveness of the Commission as an innovative policy-making body and concluded that the composition and structure of the Commission gave it little room for effective intervention. Bartlett's *The Poor Law of Lunacy* also concentrated on the administrative workings of the Commission.⁷⁵⁰ It considered the bureaucratic relationship that existed between the Poor Law Officials and the Lunacy Commission. Bartlett concluded that, apart from inspection and the publication of annual reports, the Commission lacked any practical mechanism for

⁷⁴⁹ D. Mellett, 'Bureaucracy and Mental Illness: the Commissioners in Lunacy 1845-1890, *Medical History*, vol. 25 (1981), p.222.

⁷⁵⁰ Bartlett, *The Poor Law of Lunacy*, chapter 6.

enforcing the improvements it suggested. In his opinion the Commissioners in Lunacy were reactive, with their response to situations frequently determined by pragmatic considerations.⁷⁵¹

Both Bartlett and Mellett emphasised the bureaucratic and structural deficiencies that hindered the Commission in its efforts to regulate the asylum system. An in-depth analysis of the Commission's composition, function and implementation of policy did not occur until Hervey's notable contribution. Hervey's thesis was not just a work about the bureaucratic responses adopted by the Commission. It was instead a comprehensive study that framed the emergence of the Commissioners in Lunacy within the changing conceptualisations of mental illness, and the Victorian pre-occupation with the role of the inspectorate. In contrast to the 'normal view',⁷⁵² Hervey argued that the Commissioners in Lunacy succeeded in making a 'systematic and very considerable inroad into the gross malpractices with which it was faced'.⁷⁵³ He recognised the progress made by the Commission in creating a uniform system of inspection that helped to establish basic standards and monitor bad practice.

This chapter is concerned with the Commissioners' attempt to monitor and raise standards in the area of suicide prevention. By considering the Commission's role as an inspectorate and the process of investigation that followed a suicide, it will be possible to determine how active it was in promoting stringent prevention techniques. Hervey suggests that basic standards were improved but he does not give any

⁷⁵¹ Ibid., p.208.

⁷⁵² The normal view, exemplified by Mellett and later adopted by Bartlett, interpreted the Lunacy Commission's implementation of policy as a pragmatic response to issues as they arose day by day. Hervey details this view in direct contrast to his own argument.

⁷⁵³ N. Hervey, *The Lunacy Commission 1845-1860, with special reference to the implementation of policy in Kent and Surrey*, (PhD thesis, University of Bristol, 1987), p.184.

indication as to whether suicide prevention featured within this improvement. Therefore, this chapter will look at how the Commission utilised its powers of inspection and regulation to improve the standard of care for suicidal patients. It will question whether asylum staff were held accountable when suicides occurred and if any specific guidelines were laid down by the Commission. This assessment of the Commission's work will judge whether standards were significantly improved and, if so, whether it was the result of a pragmatic or systematic approach to suicide prevention.

The Lunacy Commission was established in 1845 as a permanent central regulatory body responsible for the inspection and monitoring of all English asylums. Prior to its creation, institutional inspection was undertaken by the Metropolitan Commissioners in Lunacy created under the 1828 Madhouse Act.⁷⁵⁴ The Metropolitan Commission was part-time, consisting of five doctors and up to fifteen lay Commissioners.⁷⁵⁵ Its activities were limited to the London metropolitan region and its primary role was the licensing and inspection of private asylums within this catchment area. By comparison, the 1845 Lunatics Act established a more comprehensive inspectorate that was responsible for monitoring lunacy provision for all insane persons except Chancery lunatics. Eleven Commissioners were appointed, six of whom were professional inspectors (three physicians and three lawyers) and five honorary Commissioners. The Commission's composition was diverse, consisting of former asylum superintendents, private medical men and lay individuals of an evangelical

⁷⁵⁴ Under the 1774 Act for Regulating Madhouses, inspection of provincial institutions was conducted by local justices. L. Smith, 'The Keeper Must Himself be Kept': Visitation and the Lunatic Asylum in England, 1750-1850', in G. Mooney and J. Reinartz (eds.) *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (Amsterdam and New York, 2009), pp.201.

⁷⁵⁵ Hervey, *The Lunacy Commission*, p.74.

persuasion.⁷⁵⁶ This led to a lack of uniformity in the Commission's approach to lunacy provision. Bartlett argues that there was no apparent consensus amongst the Commission on how insanity was to be understood. Unlike the Poor Law Central authority, the Lunacy Commission never established a coherent ideological base. The Commission's view of the asylum itself was subject to variation. According to Bartlett, on occasion it adopted a medical approach in which the asylum was fundamentally about cure, or at least medical care, whilst at other times 'it was an institution to control the behaviour of the inmate'.⁷⁵⁷

The powers of the Commission were primarily concerned with inspection. The Commissioners were initially to visit 21 county asylums, 96 provincial licensed houses, 48 metropolitan licensed houses, approximately 750 workhouses, 20 gaols and any single patients brought to their attention.⁷⁵⁸ County asylums were visited annually, during which every patient was seen and certificates of insanity and medical casebooks were examined. Beyond its powers of inspection the Commission's authority was fairly limited. Melling, Forsythe and Adair detail the confines of this power, noting that it could criticise institutional provision in its annual reports, it could make recommendations regarding plans for new asylums or any extension plans, and it could prosecute asylum staff where breaches of law were identified.⁷⁵⁹ This lack of authority was exacerbated by the subordinate position of the medical commissioners, who until the 1840s did not recruit any men with asylum

⁷⁵⁶ Bartlett, *The Poor Law of Lunacy*, p.201.

⁷⁵⁷ Ibid.

⁷⁵⁸ Hervey, *The Lunacy Commission*, p.165.

⁷⁵⁹ J. Melling, B. Forsythe and R. Adair, 'Politics of Lunacy: Central State Regulation and the Devon Pauper Lunatic Asylum, 1845-1914' in Melling and Forsythe (eds.) *Insanity, Institutions and Society*, pp.68-92.

experience. The incipient lunacy profession therefore welcomed the appointment of former medical superintendent Samuel Gaskell in 1849. However, in Hervey's opinion Gaskell only began to fulfil his potential as a medical commissioner following the appointment in 1856 of another former superintendent, James Wilkes of Staffordshire County Asylum. Their combined practical experience, together with their commitment, made a significant difference to the thoroughness of the Commission's inspection regime. According to Hervey, Gaskell and Wilkes 'provided the catalyst for a more interventive approach from the medical Commissioners',⁷⁶⁰ particularly in relation to treatment regimes.

The Lunacy Commission and suicide prevention

We have the satisfaction of stating that the deaths by suicide, during the last year have amounted to only eight in number. Considering that the total number of lunatics in Asylums in this country is not less than 15,000 and that the ancient system of mechanical restraint has in many institutions been altogether abandoned...we cannot but consider that the number of deaths by suicide is smaller than might have been anticipated, and that the fact is highly creditable to the Superintendents, Medical Officers and Attendants.⁷⁶¹

This declaration of success appeared in the Commission's fifth annual report, and resulted from evidence gathered during their yearly inspections. County asylums were generally visited by two Commissioners, but due to the limited size of the

⁷⁶⁰ Hervey, *The Lunacy Commission*, p.149.

⁷⁶¹ *Fifth Annual Report of the Commissioners in Lunacy*, PP 1851 xxiii, p.13.

inspectorate visitations could sometimes be infrequent and superficial. During their visit Commissioner's paid attention to the use of restraint and seclusion, they observed the general conditions of the asylum, noted any incidents of suicide and made recommendations for future improvement. Their findings were then documented in annual reports, the format and content of which quickly adopted a pro-forma character. When reading the Commission's annual reports the regularity of certain words and phrases becomes apparent. The content remained equally repetitive, with the same aspects of institutional care receiving attention and the Commission expressing their satisfaction or dissatisfaction with what they saw.

The section of the report that commented on suicide management and prevention also assumed a pro-forma style. It usually commenced by stating the number of suicides for that particular year and the modes used. If any of the suicides had taken place whilst the patient was on trial leave then this would also be detailed. The specifics of the suicides were then summarised. Relatively brief details were given about the patient's condition, and the circumstances preceding and following the act. Where an inquest had been held the verdict would also be recorded, together with any criticism or reaction given by the Commission. As well as expressing their opinion in relation to specific incidents, the Commission utilised its annual reports and visits to criticise inadequate provision as a whole and to recommend improvements that would help to prevent future suicides. They were critical when institutions failed to adopt or maintain basic prevention techniques, and made good use of their reports to highlight these shortfalls in practice. The Commission did not issue its own rules of practice for asylums. Instead it used annual reports to discuss

matters relating to suicide prevention and tried to raise standards by publicly criticising asylums and reinforcing the importance of techniques such as constant watching, written instruction and night attendants.

Night attendants, as discussed in chapter four, were vital to the prevention of suicide. The Commission recognised this and placed great emphasis on the importance of 'proper care of the Insane during the night'.⁷⁶² They acknowledged that the welfare of all patients depended on the constant vigilance of night attendants, but drew particular attention 'to the very inadequate means at present employed for this purpose in many of the public and private asylums of the country'.⁷⁶³ Although the Commission identified this problem in the 1850s, and made efforts to reverse the trend, it remained an area of concern until the 1880s. Despite the employment in most county asylums of special night attendants, the Commission still found that 'in the generality of cases they have also some duties to perform during the day'.⁷⁶⁴ Of greater concern was the admission that in some asylums the older practice of 'employing, in rotation, the Day Attendants either for a part or the whole of the night', was still in operation.⁷⁶⁵

Following their annual visit to Worcestershire County Asylum in 1857, the Commissioners drew attention to the institution's night watch arrangements. They stated 'there is no regular Night-watch, but the Attendants take it in turns to sit up until 12 o'clock at night; after that hour there is no Night-watch except in cases of

⁷⁶² *Thirteenth Annual Report of the Commissioners of Lunacy*, PP 1859 xiv, p.63.

⁷⁶³ *Ibid.*

⁷⁶⁴ *Ibid.*, p.64.

⁷⁶⁵ *Ibid.*

severe sickness'.⁷⁶⁶ In the Commission's next report, of 1858, it was noted that in response to previous criticism:

there is a night nurse on the female side, but we think that her time should be exclusively devoted to this duty. We hope that a similar watch will be placed on the male side as soon as practicable; at present the system is imperfectly carried out.⁷⁶⁷

It is apparent from this comment that the Commission did not compel the institution to modify its night watch. Instead, its use of language was conciliatory and cautious, lacking any great sense of authority or conviction. By using phrases such as 'we think' and 'we hope', the Commission weakened its own position as a regulatory body. They adopted a suggestive approach which relied on gentle coercion and the powers of persuasion, rather than assertively demanding that asylums follow their recommendation.

Despite the Commission's lack of authority, Worcestershire Asylum responded to repeated calls for a more extensive night watch, but it was a very slow and gradual process of improvement. It was not until 1861 that a male attendant was 'engaged for that exclusive duty, thus in that respect assimilating the two divisions'.⁷⁶⁸ However, by 1873 there had been little else done to extend the number of night attendants. In response the Commission repeated their recommendation made during previous visits, that a second permanent night attendant be engaged in each

⁷⁶⁶ WCRO, BA9665/1, Fourth Annual Report (1857), p.9.

⁷⁶⁷ Ibid., Fifth Annual Report (1858), p.7.

⁷⁶⁸ Ibid., Eight Annual Report (1861), p.12.

division.⁷⁶⁹ This was acted upon and the following year the Commission was able to report that a second male attendant had been appointed.⁷⁷⁰ Having been subject to prolonged scrutiny, the asylum was eventually praised by the Commission in 1876. A second female attendant had been employed, 'and the supervision of the wards by night divided, so as to ensure more constant attendance of the patients, and more especially of the epileptic and suicidal cases'.⁷⁷¹

In the early 1870s Rainhill came under repeated criticism for its inadequate night watch. The Commission stated that:

we regret still to have to observe that the second night watch in each division is still supplied by a male and female patient respectively. We do not think that for a continuance, such important service should be so applied; and keeping in view what has been said of the character of a large part of the population of this Asylum, we think that each division should have two paid night attendants.⁷⁷²

This situation was rectified, but the night watch continued to fall far below the standards expected. In 1874 the Commission drew attention to this problem, declaring that 'the system of night attendance here [Rainhill] differs from that in most County Asylums'. Attendants were not exclusively appointed for the night watch, but were 'taken from the ordinary body, and perform the work for a period of two months, when they are replaced by others selected in rotation'. The Commission expressed

⁷⁶⁹ Ibid., Twentieth Annual Report (1873), p.10.

⁷⁷⁰ Ibid., Twenty-first Annual Report (1874), p.12.

⁷⁷¹ WCRO, BA9665/2, Twenty-third Annual Report (1876), p.10.

⁷⁷² LCA, M614 RAI/40/2/2, Annual Report (1871), p.109.

their dissatisfaction and made it clear that 'in our opinion the very difficult and responsible duties of night watching cannot be satisfactorily executed in this manner'.⁷⁷³

It was crucial that patients were visited during the night, so many asylums made use of the tell-tale clock to monitor the frequency with which this was conducted. In its 1883 annual report the Commission commented that 'in general, mechanical or electric apparatus of some kind is in use, and in this direction there has been much improvement of late'.⁷⁷⁴ The frequency with which the night attendants were required to record their visits in the 'special wards' varied considerably. The Commission's observations revealed that:

in some Asylums every ten minutes, or a quarter of an hour, in others every half hour, or even every hour. The latter is certainly too long an interval, and every half hour would probably be sufficient unless in special cases.⁷⁷⁵

The tell-tale clock was designed to monitor attendant activity and regulate patient safety. With this dual purpose in mind, the Commission promoted the tell-tale clock as a valuable tool in the prevention of suicide. Following an assessment of the night watch at Nottingham Asylum in 1877, the Commission strongly recommended 'the immediate introduction of tell-tale clocks to test the watchfulness' of attendants in the women's division.⁷⁷⁶ In 1874 it was recommended 'that Dent's Tell-tale Clocks be

⁷⁷³ Ibid., Annual Report (1874), p.120.

⁷⁷⁴ *Thirty-seventh Annual Report of the Commissioners in Lunacy*, PP 1883 xxx.1, p.63.

⁷⁷⁵ Ibid., p.64.

⁷⁷⁶ NRO, SO/HO/1/6/1, Nottingham Lunatic Asylum Annual Report (1877), p.14.

introduced' at Rainhill asylum. This was deemed necessary because 'at present there is no security that the night rounds are duly made'.⁷⁷⁷

The Commission's attention was not confined to constant watching at night. It understood and promoted the need to maintain patient observation at all times. Insufficient vigilance could, and in some cases clearly did, provide the opportunity for a patient to commit suicide. The Commission recognised the consequences of such a failing and reminded asylum authorities that:

In spite of all precautions taken, by depriving them of instruments or other means of self-destruction, by protecting window bars or by other mechanical expedients, such patients as these adverted to, who are ever on the watch for opportunities, will sometimes effect their purpose unless kept constantly in sight, actually under the eye of the attendants.⁷⁷⁸

Despite this warning, a number of suicides continued to be facilitated by a lax approach to constant watching. The Commission's minute book records the suicide of Ann Flynn at Staffordshire County Asylum in 1865. As required, the medical superintendent forwarded the notice of death particulars and 'the depositions at the inquest in the case'. In response the Commission ordered that a letter be sent to the asylum 'stating that the Board did not think the attendance on the patient had been sufficient'. The Commission recommended that 'the recurrence of such cases is to be

⁷⁷⁷ LRO, M614 RAI/40/2/2, Annual Reports 1871-1874 (1874), pp.120-121.

⁷⁷⁸ *Twenty-second Annual Report of the Commissioners in Lunacy*, PP 1867-1868 xxxi, p.73.

prevented...by a due supervision of attendants'.⁷⁷⁹ A similar opinion was expressed to the authorities at the 'West York Asylum',⁷⁸⁰ after the suicide of Eleanor Midgley in 1867. A letter was directed to 'Dr Browne conveying the opinion of the Commissioners, that blame could not properly be attached to the attendants in charge'. Having reviewed the particulars of the case, it was concluded that this incident 'suggested the necessity of exercising a more prolonged special surveillance over suicidal patients'.⁷⁸¹

For constant watching to be effective, attendants needed to be fully informed of the patient's mental state. This was normally conveyed by means of verbal instruction. However, it was increasingly felt that a written statement should be issued to supplement verbal communication. The Commission was keen to stress that written notice would help to keep suicidal patients under more effectual observation. In their annual report of 1869 they suggested that:

a written statement setting forth the suicidal propensity of the patient, should be given to the attendant first taking charge of him, and that this document should be sent with the patient to any other ward to which he subsequently might be moved.⁷⁸²

This comment followed an earlier admission, in 1867, that in some instances 'Medical Superintendents appear to have so far disregarded the statements of

⁷⁷⁹ NA, MH50/13, *Commissioners in Lunacy Minute Book*, vol.13, July 1864-June 1866, p.246.

⁷⁸⁰ It is likely that the Commissioners in Lunacy were in fact referring to the West Riding Asylum.

⁷⁸¹ NA, MH50/14, *Commissioners in Lunacy Minute Book*, vol.14, July 1866-Dec 1867, p.240.

⁷⁸² *Twenty-third Annual Report of the Commissioners in Lunacy*, PP 1868-1869 xxvii, p.38.

suicidal tendency...contained in the certificates'. Consequently they did not think it 'necessary to given any special directions concerning them'.⁷⁸³

Failing to provide written instructions was identified by the Commission as a contributory factor in some suicides. Although the verdict returned in a case at Suffolk Asylum declared that, 'the deceased had hung himself, being at the time of unsound mind', the Commission argued that the evidence proved 'there had been great neglect and mismanagement in the case'. When admitted to Suffolk, the patient was suffering from acute melancholia 'of a suicidal nature with great depression'. He subsequently made three attempts 'to hang himself in the asylum', yet no special directions were issued by the medical officer. Furthermore, 'no proper precautions for his safety during the night were adopted'. Due to this failure in communication he 'was locked in an ordinary single room...at 10 o'clock at night, and was supplied with the usual bedding'. He was then left unattended until 6 o'clock the next morning, when 'he was found quite dead, suspended to the shutters'.⁷⁸⁴ In this particular case the asylum was negligent on two counts. Firstly, the patient was inappropriately housed in a single room and secondly, he was not visited by a night attendant. Each of these failures can be attributed to the attendant's lack of knowledge about the patient's behaviour, but blame must rest with the medical officer who did not issue any written instructions.

Attendants were also exempt from blame when a male patient at Nottingham Asylum 'hanged himself in a dormitory'. The 'particulars were at the time communicated to

⁷⁸³ *Twenty-first Annual Report of the Commissioner in Lunacy*, PP 1867 xviii, p.264.

⁷⁸⁴ *Twenty-fourth Annual Report of the Commissioners in Lunacy*, PP 1870 xxxiv, p.23.

our [Commissions] board' and an assessment of the circumstances was then made. The patient was known to have been, at one time, 'very suicidal', but due to his epilepsy he 'had become more imbecile in mind'. It was thought that his suicidal propensity had receded, so the attendants, 'in whose charge he was at the time of the suicide, were not informed that the propensity had ever existed'. This judgement was criticised by the Commission, who were of the opinion that even in this case it remained 'of the highest importance that the attendants in charge should on the admission of a patient be supplied with written information to be retained by them, as to his peculiarities and propensities'.⁷⁸⁵

When patients were admitted to Dorset Asylum 'only verbal information of their suicidal propensities was given to the attendants'. The Commission considered this representative of a lax and inadequate approach to the precautions needed 'for securing the safety of suicidal patients'. The suicide of a male patient in 1870 provided evidence to validate this conclusion. The patient was 'strongly suicidal with intense melancholy', and succeeded in suspending himself 'by the neck from a gas burner in a bath-room'. After the event a 'printed form was issued, and it was ordered that this form, containing a full statement of the habits and propensities should be given to the attendant in charge'.⁷⁸⁶ Improved communication and the sharing of information supported the attendant in his efforts to manage difficult behaviour and guard against suicide. Aware of the advantages this could bring, the Commission

⁷⁸⁵ NRO, SO/HO/1/6/1, Nottingham Lunatic Asylum Annual Reports (1872), p.15.

⁷⁸⁶ *Twenty-fifth Annual Report of the Commissioners in Lunacy*, PP 1871 xxiv, p.29.

used its annual reports as a vehicle to promote the benefits of written instruction and make clear to asylum authorities that their use was consistent with good practice.⁷⁸⁷

During annual visits the Commission also observed deficiencies in the way suicidal patients were housed and made suggestions on how these may be overcome. Concerns were often raised about the use of single rooms. At Kent Asylum a female patient, Mary Bothing, committed suicide by hanging when in a single sleeping room. The Commission believed that a single room was inappropriate, given the patient's dangerous and suicidal tendency. In order to understand the decision a letter was 'directed to Dr Huxley enquiring as to her dangerous propensities, and the objection, if any, that existed to placing her in an associated dormitory'.⁷⁸⁸ When an incorrect decision appeared to have been made, the Commission obtained further information so they could establish the medical superintendent's reasoning. This enabled them to make an informed judgment and determine if criticism was in fact due.

The accommodation for suicidal patients at Worcestershire Asylum received notable attention from the Commission in the 1870s and 1880s. Their concern emanated from a desire to ensure that constant watching, particularly at night, was not impeded by deficiencies in the layout of the building. In 1877 the Commission made it clear that they did not 'see any satisfactory mode of accommodating them [suicidal] in the present building'. Unless the medical superintendent was able to suggest 'some other way of overcoming the difficulty', the Commission recommended 'a separate

⁷⁸⁷ Following the suicide of Anne Pearson at Colney Hatch, by cutting her throat, the Commission suggested the use of written instructions. They advised that the instructions 'should in each case specify the particular features of the patient's suicidal propensity. NA, MH50/14, Commissioners in Lunacy Minute Book, vol.14, p.309.

⁷⁸⁸ NA, MH50/6, *Commissioners in Lunacy Minute Book*, vol.6, 1853, p.270.

ward of inexpensive character being built for each sex'.⁷⁸⁹ Four years later the Commissioners in Lunacy again raised questions related to this matter. It was reported that 'Night nurses are three on each side; one in each division is in charge of about 50 Patients, who are epileptic or suicidal'. This level of supervision was classified as grossly inadequate, but according to the Commission it 'might be improved at no great cost by the removal of certain partition walls and the substitution of girders'.⁷⁹⁰

Visitation of county asylums enabled the Commissioners in Lunacy to observe the everyday practice of institutions and publish recommendations in their annual reports. This process allowed the Commission to voice its concerns and draw attention to those areas of institutional care that were lagging behind the basic standards expected. Annual reports were also a valuable means of communication through which the Commission could reinforce the importance of suicide prevention. However, the Commission's role was not just about prevention. When completed suicides occurred it had to embark on a process of investigation and determine whether any blame was attributable to the asylum staff.

The Process of Investigation

In every case of suicide we have required full particulars as to the place, time of day or night, and other circumstances; by what instrument or means the act was committed, and by whom, and after what period was it discovered.⁷⁹¹

⁷⁸⁹ WCRO, BA9665/1-3, Worcestershire County Asylum Annual Reports (1877), p.11.

⁷⁹⁰ Ibid., Twenty-eighth Annual Report (1881), p.11.

⁷⁹¹ *Fifth Annual Report of the Commissioners in Lunacy*, PP 1850 xxiii, p.13.

The investigation into a completed suicide commenced with a process of information gathering. It was the responsibility of the asylum authorities to provide the Commission with a notice of death and the 'full particulars' of the incident. If an inquest had been held then details were submitted together with the jury's verdict. A notice of death was required when any patient died, but in the case of a suicide the Commission was keen to ascertain whether the act had been facilitated by negligence - hence the requirement of 'full particulars'. Suicide was an unnatural cause of death, so it was not sufficient to register solely for the purpose of statistical records. Questions surrounded the death and it was the Commission's duty, along with the institution, to look at the evidence and try to establish the answers.

Although the Commission requested and received 'full particulars', they did not record all of the given details in their minute book reports. Each entry gave a brief summary that included the patient's name, the name of the institution and the method by which they committed suicide. This was usually followed by an acknowledgement that the notice of death, 'full particulars' and inquest verdict had been duly submitted. If an institution failed to provide the necessary documentation, then consideration of the suicide was postponed until the Commission could make a judgment based on all of the evidence made available to them. The West Riding Asylum issued a notice of death to the Commission following the suicide of Martha Jowell in December 1848. However, consideration was delayed until 'receipt of particulars [was] written for'.⁷⁹² The same reaction was given when Worcestershire

⁷⁹² NA, MH50/3, *Commissioners in Lunacy Minute Book*, vol.3, March 1848-June 1849, p.257.

Asylum supplied only a notice of death for Maria Evans. When further information was requested it was noted that the 'particulars [were] promised' in due course.⁷⁹³

There were instances when even the 'full particulars' did not provide sufficient evidence for the Commission to reach a solid conclusion. When the information provided by the institution was lacking detail or questions arose regarding the actions of the attendant a further investigation was sanctioned. The statement furnished by Suffolk Asylum after the suicide of Eliza Smith in 1848 was 'considered unsatisfactory'. A letter was thus 'written to the Clerk of the asylum requiring further detailed information'.⁷⁹⁴ Specific details were also requested from Hanwell Asylum about the circumstances leading to the suicide of Theodore Edwards in November 1861. 'Notice of the suicide...with the copy of the verdict' had been 'laid before the Board'. These initial details raised further questions, so:

a letter to the visitors was ordered to enquire whether there was any defect in the arrangements of the asylum, which in their opinion rendered it possible for the patient to obtain the knife by which his purpose was affected.⁷⁹⁵

Evidently the Commission felt that the opportunity to commit suicide may have been facilitated by the asylum's failure to adequately safeguard the patient. In addition to their request, the Commission noted that 'it would appear as if such an occurrence would be prevented were the knives counted after every meal'.⁷⁹⁶

⁷⁹³ NA, MH50/6, *Commissioners in Lunacy Minute Book*, vol.6, March 1852-March 1854, p.361.

⁷⁹⁴ NA, MH50/2, *Commissioners in Lunacy Minute Book*, vol.2, December 1846-March 1848, p.449.

⁷⁹⁵ NA, MH50/11, *Commissioners in Lunacy Minute Book*, vol.11, July 1860-July 1862, p.327.

⁷⁹⁶ Ibid.

At Prestwich Asylum there was only one recorded suicide in 1870, for which the particulars were submitted to the Commissioners in Lunacy as required. Upon receiving the particulars the Commission called for further information. They subsequently 'made special enquiry and fully investigated all the circumstances' surrounding the suicide. This left them satisfied that 'no blame is fairly attributed to the attendants in charge'.⁷⁹⁷ It appears that the role of the attendant was the primary focus of most further investigations. If the initial evidence suggested negligence on the part of the attendant then, for future patient safety, it was vital that the truth of the matter was established. The attendant had to be held accountable for his mistake and prevented from repeating it.

As punishment, the attendant was either severely reprimanded or dismissed from his post. Although the Commission was not directly involved in making this decision, they were keen to ensure that the asylum took affirmative action. They directed a letter to the visitors at the West York Asylum 'enquiring whether any and what steps had been taken to punish Mary Hebden...for her gross negligence', which enabled a female patient to hang herself.⁷⁹⁸ When William Gittus committed suicide by 'cutting his throat with a razor', Cambridgeshire Asylum submitted a notice of death and particulars which stated that the attendant had been dismissed. This course of action was taken because the razor had been 'left within his reach by the attendant'.⁷⁹⁹ Despite negligence being cited in the case of a male suicide at Staffordshire County Asylum in 1866, the attendant was allowed to remain in his post. The patient

⁷⁹⁷ LRO, QAM 5/19, Reports of the County Lunatic Asylums (1870), p.56.

⁷⁹⁸ NA, MH50/7, *Commissioners in Lunacy Minute Book*, vol.7, March 1854-August 1855, p.187.

⁷⁹⁹ NA, MH50/11, *Commissioners in Lunacy Minute Book*, vol.11, July 1860-July 1862, p.277.

succeeded in 'placing the sheet of his bed round his neck, and suspending himself from the bars of the window'. The incident was investigated by the committee of visitors, who concluded that the 'Night watch had fallen asleep' when on duty. 'They took in to account his previous good character, efficient conduct of duties before this and the successful prevention of a previous attempt by the patient'. The attendant was subsequently cautioned, subject to a small fine and had his 'wages stopped during the period of suspension'.⁸⁰⁰

The asylum authorities also had to be accountable for contributing to any failure on the part of their staff. When attendant negligence or inadequate arrangements within the asylum had been a contributory factor, the Commission questioned if attendants had been fully informed of the patient's suicidal tendency. The Commission sought clarification of this particular point when they investigated the suicide of Ann Darcey at Chester Asylum. 'On reading the notice of death...and particulars from the medical superintendent...a letter was ordered to enquire...what directions had been given to the attendants in reference to the suicidal tendency of the patient'.⁸⁰¹ Presumably the Commission's intention was to ensure that the institution was not trying to hide vital facts and escape criticism. As a regulatory body, entrusted with authority, it was important for the Commission to investigate cases of bad practice and make institutions accountable for their failings.

At the end of the investigation process, as well as determining accountability, the Commission often made specific recommendations designed to prevent a

⁸⁰⁰ *Twenty-second Annual Report of the Commissioners in Lunacy*, PP 1867-1868 xxxi, p.75.

⁸⁰¹ NA, HM50/12, *Commissioners in Lunacy Minute Book*, vol.12, July 1862-July 1864, pp.328-329.

reoccurrence of events. James Davey, a patient at Somerset Asylum, cut his 'throat with a knife secreted at Dinner'. The Commission responded by directing a letter to the 'Visitors suggesting [the] expediency of having knives collected and counted after meals'.⁸⁰² The positioning of gas brackets also caused concern following suicides at several asylums. As discussed in chapter four, a small number of medical superintendents questioned the use of gas brackets since they frequently facilitated acts of suicide. The Commission came to share this concern and made suggestions about how and where gas brackets should be better fitted. In a letter sent to Prestwich Asylum they suggested:

having all the Gas fittings in rooms and offices, to which patients have access when not under observation by attendants, so lightly put up in future as not to bear the weight of a heavy body suspended from them.⁸⁰³

At Buckinghamshire Asylum the Commission proposed a more drastic solution when it asked that an enquiry be made to the medical superintendent 'as to the removal of gas-brackets'. This followed the suicide of Hester Turrill in July 1875, who was given access to the 'bedroom floor alone' and proceeded to make use of the gas bracket to effect her suicide.⁸⁰⁴ The medical superintendent of Kent Asylum also received criticism for his decision to place Mary Ann Reeves in 'a single room where a gas bracket existed'. The Commission expressed their regret that a suicidal patient had been placed in this position since it was known that the gas bracket had in 'so many

⁸⁰² NA, MH50/5, *Commissioners in Lunacy Minute Book*, vol.5, April 1851-April 1852, p.18.

⁸⁰³ NA, MH50/8, *Commissioners in Lunacy Minute Book*, vol.8, September 1855- February 1857, p.273.

⁸⁰⁴ NA, MH50/19, *Commissioners in Lunacy Minute Book*, vol.19, February 1875-March 1877, p.65.

cases suggested the idea and furnished the means of self-destruction.’⁸⁰⁵ The use of a single room in the case of Mary Leworthy at Bristol Asylum also came under scrutiny by the Commission. On the night of her admission, Mary was placed in a single room where she was later found ‘hanging from the bar of a shutter’. The Commission declared that ‘a full enquiry will be made by them into the circumstances under which the bar of the shutter was left in so insecure a state’. In addition they made it clear that ‘a patient with so strong a disposition to suicide should either have been placed in an associated dormitory’, or if in a single room then a ‘special attendant should for a time have been placed to sit up with her’.⁸⁰⁶ In their response to the cases at Kent and Bristol the Commission used the outcome of their investigation to remind each institution of its obligation to ensure the safety of suicidal patients.

Written communication was clearly the norm when the Commissioners in Lunacy corresponded with an asylum. However, events at Lancaster Asylum in the 1860s forced the Commission to be more proactive. The Commission received notification of a suicide by drowning in the reservoir in 1867. Since this was the ‘third fatal event of this description’ the Commission ‘thought it right to inspect the spot’. By visiting the site they would be better able to determine ‘whether any efficient protection could be erected’. Having viewed the reservoir for themselves, the Commission declared that ‘the present wire fence is evidently quite inadequate, and could easily be climbed by any active person. We fear that it would not be possible to erect a really safe fence’. Instead the Commission suggested that:

⁸⁰⁵ NA, MH50/17, *Commissioners in Lunacy Minute Book*, vol.17, March 1871-December 1872, p.276.

⁸⁰⁶ NA, MH50/19, *Commissioners in Lunacy Minute Book*, vol.19, February 1875-March 1877, p.230.

Could it be effected it seems to us that the best plan would be to enlarge the reservoir on the Moor, and to reduce the other to such a size as would admit of its being covered over.⁸⁰⁷

Having made its own suggestion the Commission hoped that ‘the matter will receive the consideration of the Visitors’. Unfortunately in their next report, of 1868, the Commission found that ‘nothing has yet been found practicable we regret to say towards rendering the reservoir more secure’.⁸⁰⁸ This incident, and others cited, demonstrates the Commission’s dual approach to their investigations. The Commission did not just criticise institutions and then denounce their error by shaming them. Instead, they highlighted notable mistakes and balanced this with constructive suggestions. This combination offered a non-dictatorial approach that was likely to foster co-operation from asylum authorities and encourage them to adopt the Commission’s recommendations.

The Commission and private asylums

This study is primarily concerned with suicidal lunatics in public asylums, but the Commissioners in Lunacy focused their efforts on both private and public provision for the insane. The 1845 Lunatics Act required the Commissioners to visit all licensed houses as part of their role as a central regulatory body. Consequently, their annual reports and minute books deliver commentaries on the standards observed in both types of institution. Completed suicides in private asylums were recorded fairly frequently in the Commissioners’ minute books. This occurrence prompts a brief

⁸⁰⁷ LRO, QAM5/16, Reports of the County Lunatic Asylums (1867), p.12.

⁸⁰⁸ Ibid., p.13.

discussion of the Commission's attitude and response to suicide prevention in private asylums for the purpose of comparison. From this it can be determined whether any notable differences in practice existed due to the distinct institutional environment, and whether the Commission approached its process of investigation and recommendations differently as a result.

Private asylums received either fee-paying wealthy patients or paupers paid for by the local authorities. Licensed houses for upper and middle class lunatics were generally much smaller in size than county asylums. According to Scull, private patients could therefore expect a higher level of medical attention and were likely to have at least weekly contact with the resident physician.⁸⁰⁹ The ratio of attendants to patients was also generally higher than in pauper establishments or public institutions. However, this did not make the attendant's duties any less demanding. Parry-Jones states that in addition to general patient observation, attendants were engaged in activities such as 'accompanying patients in their exercise and recreation...attending to their personal needs...and the application of mechanical restraint'.⁸¹⁰ The same was expected of attendants in pauper asylums, but their task was made harder by overcrowding.⁸¹¹

Treatment and patient management techniques tended to mirror those practised in public asylums. Moral treatment was adopted in most licensed houses by the 1860s.

In practice this meant the:

⁸⁰⁹ Scull, *The Most Solitary of Afflictions*, p.294.

⁸¹⁰ Parry-Jones, *The Trade in Lunacy*, pp.154-155.

⁸¹¹ *Ibid.*, p.249. Parry-Jones argues that such conditions made the maintenance of security and classification far more difficult to achieve than in private asylums for wealthier patients.

classification of patients according to clinical state, and their separate management; the provision of indoor and outdoor amusements; the provision of facilities for exercise and for employment, primarily for the working classes; attention to religious activities and the accommodation of patient in light, well-ventilated and cheerful surrounding.⁸¹²

However, this practice was not fully realised in all licensed houses, particularly those which were considered less respectable. Classification only went as far as the separation of patients according to social class, gender, and the noisy from the quiet. The employment of private patients also proved difficult because many were not familiar with manual labour. Such patients were allowed to find occupation in leisure activities which proved less strenuous. Adherence to non-restraint was also subject to partial acceptance and its use varied between institutions. Parry-Jones argues that in licensed houses catering for wealthy lunatics, restraint could be dispensed with far more easily because it could be replaced by increased observation. This was made possible by the higher attendant to patient ratio and the proprietor's ability to increase his charges.⁸¹³ The use of restraint in suicidal cases met with a similar reaction to that expressed by the medical superintendents in public asylums. The majority of proprietors believed that restraint could not be fully dispensed with in the case of suicidal patients, particularly if the attendants were not wholly reliable. When patients were destructive or violent then it was considered justifiable to employ restraint as a remedial tool.

⁸¹² Ibid., p.181.

⁸¹³ Ibid., pp.185-186.

In chapter four it was demonstrated that the introduction of moral treatment and non-restraint in public asylums changed the role of the attendant. When these techniques were adopted in licensed houses similar changes were required. It was essential that attendants conducted their duties with increased vigilance and a greater tolerance of demanding or disturbed behaviour. The introduction of non-restraint led to a closer inspection of the attendant's role and as a result, according to Parry-Jones, the 'importance of the attendant's work became more generally acknowledged'.⁸¹⁴ In keeping with the philosophy of moral treatment and non-restraint, attendants were expected to show greater humanity and vigilance. The replacement of restraint with observation and care created demands that were sometimes difficult to sustain. However, the necessary qualities were developed over time as experience bred greater understanding of the attendant's new role.

To effect change in public asylums the Commissioners used the publication of annual reports and recommended improvements, but for private asylums their moral authority was given additional leverage. Hervey acknowledges that the Commission's ability to effect change in private asylums was helped significantly by the board's control over licensing.⁸¹⁵ Although the threat of revocation was made at the Infirmary Asylum at Norwich in 1854, the Commission's procedure of investigation remained the same in private and public asylums. The licensed house was required to send a notice of death and 'full particulars' of the suicide, after which the Commission would decide if a further enquiry was needed. The suicide of

⁸¹⁴ Ibid., p.185.

⁸¹⁵ Hervey, 'A slavish bowing down: the Lunacy Commission and the psychiatric profession 1845-60', in Porter, Bynum and Shepherd (eds.) *The Anatomy of Madness*, vol.2, p.114.

Alexander Bruce at Sussex House, London, in 1848 prompted such action. The Commission was keen to understand precisely how the patient gained access to a razor. It was requested that the 'keeper', Joseph Crane, attend a special board meeting so that he could be 'examined more especially with reference to the circumstances under which Mr. Bruce for possession of the razor'. The following account is 'the substance of his statement':

The Razor belonged to another keeper...by whom it was lent to witness. Patient was permitted by witness to shave himself, and Razor was put into a case with another, and ultimately secreted by witness as usual behind some papers and a shelf in a large dark closet in witness' bedroom. No one but himself and the other keeper knew where Razors were placed. If the doors of bath rooms were open Patient could see witness go to the closet. Witness, however, distinctly remembers having closed Patients room door after him.⁸¹⁶

The razor was placed back in the closet at approximately 9 o'clock in the morning but the patient did not cut his throat until '10 minutes before 4 in the afternoon'. The patient had removed the 'case of Razors from closet mentioned' and secreted one in his pocket. The 'keeper' could not account for the 'Patients getting possession of Razors'. It was also recorded that the inmate 'was not suspected of a suicidal propensity', although he had previously been violent towards 'the other keeper'. The question of attendant negligence is certainly worthy of investigation in this case, but sole blame cannot be placed on Joseph Crane when the circumstances are properly considered. It was stated that the patient was not classified as suicidal, therefore the

⁸¹⁶ NA, MH50/3, *Commissioners in Lunacy Minute Book*, vol.3, March 1848-June 1849, p.257.

attendant had no reason to believe that he was endangering the patient's life by allowing him to shave. Furthermore, it seems that the asylum did not, as a designated rule, require potentially dangerous implements to be locked away to prevent such incidents occurring. In view of the evidence the Commission did not attribute blame to the attendant, but instead issued a letter to 'Dr Winslow recommending that Razors when not in use, should be, kept under lock and key'⁸¹⁷; a practice already adhered to in public asylums.

The dangers of patients shaving themselves also dominated the Commission's investigation into the suicide of George Macheson at Moorcroft House, Middlesex, in 1863:

On reading the notice of death, with particulars connected with this suicide from Dr. Stilwell and the coroners depositions, a letter was ordered stating that the attendant...should be severely reprimanded for leaving the room when the patient was shaving.⁸¹⁸

The Commission expressed its concern that a 'patient of so manifestly a suicidal tendency ought not to have been allowed to shave himself'.⁸¹⁹ Unlike the previous case at Sussex House, in this instance the patient's suicidal disposition was known. The attendant's actions appear reprehensible given his knowledge of the patient's condition. The Commission's decision to suggest only a severe reprimand could be construed as lenient given the attendant's negligence. From the evidence available

⁸¹⁷ Ibid., p.259.

⁸¹⁸ Na, MH50/12, *Commissioners in Lunacy Minute Book*, vol.12, July 1862-July 1864, p.166.

⁸¹⁹ Ibid.

in annual reports and minute books, it is apparent that the dismissal of attendants, in both private and public asylums, was rare.

At the Clapham Retreat a further enquiry was made into the circumstances surrounding the suicide of Mr Walter Yonge. The patient died on the 15 March 1849 by strangulation and in 'consequence of Mr. Bush's letter in answer to one from the Secretary', Mr. Campbell and Mr. Gaskell visited the institution and 'made enquiry into the circumstances'.⁸²⁰ The Commissioners were informed that:

Mr. Yonge had...manifested a strong disposition to commit suicide from the time of his admission and that during the last two weeks of his life, he was placed in constant restraint night and day, and that he ultimately effected his purpose by breaking out of his confinement and strangling himself with some portion of the article of dress used to prevent him from committing suicide.⁸²¹

The results of their investigation did not prompt the Commissioners 'to impute any want of care or attention on the part of Mr. Bush or the attendant'. However, in their opinion 'the mode adopted in Mr Yonge's case to prevent him from committing suicide was injudicious and improper'.⁸²² It can be presumed that the Commission's final comment was a reminder that non-restraint was considered preferable or where restraint was necessary it should have been mild and for only a short period of time. Although the asylum staff escaped blame, the evidence provided does suggest that

⁸²⁰ NA, MH50/3, *Commissioners in Lunacy Minute Book*, vol.3, March 1848-June 1849, p.374.

⁸²¹ Ibid.

⁸²² Ibid.

the patient was not constantly watched when restrained and was therefore afforded the opportunity to escape from his confines. This example provides evidence in support of Parry-Jones' claim that greater vigilance was not expected of attendants until the mid-nineteenth century, and was then developed by experience.⁸²³

In 1854, events at the Infirmary Asylum in Norwich led the Commission to take severe action against the institution. The suicide of a patient, referred to only as 'Fransham', prompted the Commission to launch a special enquiry. The board read the correspondence received from the Visitors and the superintendent, and also 'considered the Special Report by Mr Campbell and Mr Turner'. In light of this material they 'ordered that the case be referred to Mr Law with a view to Criminal Proceedings against Robert Scotter, the attendant'. Full details of the suicide are not given in this entry, but it can be presumed that gross negligence warranted the Commission's harsh course of action. The enforcement of criminal proceedings was certainly rare, given the cost and time implications involved with this action. In addition, a statement was also to be sent to the Lord Chancellor 'recommending revocation of the License of the Infirmary Asylum'.⁸²⁴ Hervey acknowledges that the Commission's ability to effect change in private asylums was helped significantly by the board's control over licensing.⁸²⁵

Hervey concluded that one of the Commission's major achievements was bringing private asylums under control. It certainly targeted the issue of suicide prevention and management with the same vigour as in public asylums. Regardless of whether

⁸²³ Parry-Jones, *The Trade in Lunacy*, p.187.

⁸²⁴ NA, MH50/6, *Commissioners in Lunacy Minute Book*, vol.6, March 1852-March 1854, p.403.

⁸²⁵ Hervey, 'A Slavish Bowing Down', p.114.

an institution was private or public, the Commission's agenda remained the same. Its prime intention was to raise the basic standards of care and ensure that cases of negligence were identified and asylum staff were duly made accountable. The only difference existed with the Commission's ability to recommend the revocation of a private asylum's license. However, this additional leverage was rarely used. The only notable difference in the institutional environment of the private asylum was the staff of attendants who cared for the patients. The introduction of moral treatment and non-restraint required attendants in both private and public asylums to modify their conduct, but in private asylums this may have been felt more acutely. As Parry-Jones suggests, attendants in private asylums were more familiar with duties that were 'primarily custodial'.⁸²⁶ The transition towards greater humanity, vigilance and care was likely to take longer as attendants moved away from their often traditional approach and familiarised themselves with their less custodial role.

* * * * *

The work of the Lunacy Commission has been subject to relatively limited attention from historians of the nineteenth-century asylum. Those who have studied its role as an inspectorate, like Mellett, Bartlett and Hervey, have tried to establish whether the Commission took a pragmatic or systematic approach to its work. Their efforts to raise the standards of care for suicidal patients and monitor adherence to prevention techniques was predominately pragmatic in nature. The Commission used their annual visitations to observe suicide management and prevention techniques first-hand. However, the bulk of their criticisms, investigations and recommended

⁸²⁶ Parry-Jones, *The Trade in Lunacy*, p.154.

improvements came as a reactive response to the circumstances of individual suicides. As Bartlett argues, this did not mean their responses proved ineffectual, but where improvement did follow, it was the result of gradual change that was encouraged by persuasion and suggestion rather than the 'hard selling of broad ideology'.⁸²⁷

The Commission lacked any formal, statutory power and pursued a conciliatory approach that inhibited its ability to institute dramatic change. Innovation was not the Commission's strength; instead it focused on reinforcing and promoting known methods of suicide management and prevention. It paid particular attention to the adoption of a designated night watch and the issuing of written instructions. The Commission achieved relative success in both of these areas. However, limited numbers and a lack of authority prevented the Commission achieving anything more significant. It was only able to effect marginal improvements in the basic standard of care and suicide prevention. This was largely due to the distant presence it retained as a central body. Institutions only had to anticipate a yearly inspection rather than continuous scrutiny. Whilst for the Commission itself, a limited presence hindered its ability to actively enforce compliance with the recommendations they made. The Commission's enquiries did require a certain level of transparency and they succeeded in applying some pressure on asylum authorities. Unfortunately, where bad practice or negligence was uncovered the repercussions for asylum staff were not particularly harsh. As is shown by the case examples discussed, dismissals were relatively few in number and prosecutions even rarer. Overall, the Commission did

⁸²⁷ Bartlett, *The Poor Law of Lunacy*, p.208.

not establish itself as an innovative policy-making body, but instead used its position of relative authority to act as a mild deterrent and remind institutions of their obligation to protect patients and prevent suicide.

CONCLUSION

The nineteenth-century public asylum was intended to provide therapeutic intervention and safe custody for persons afflicted with insanity. This broadly defined policy was applicable to all patients within the asylum's homogeneous population. However, the balance with which therapy and control were enforced varied between patient categories. Suicidal patients were only one group among several that the asylum had to manage, but they were one of the more important groups. A suicidal propensity was characterised by dangerous and difficult behaviour that necessitated a protective approach to patient management. Suicidal lunatics experienced mood changes, sudden shifts in behaviour, restlessness, and poor sleep habits which made their conduct unpredictable, dangerous and hard to manage. These forms of behaviour demanded a pragmatic response that substituted the leading principles of therapy and curative treatment with prevention and protection. The latter emerged as the accepted and dominant concerns in the treatment and management of suicidal patients. Danger, risk and unpredictability are synonymous with suicide and are an obstacle for persons charged with managing and preventing self-destruction. It was necessary for prevention techniques to adapt and respond to variances in the institutional environment, available resources, and the individual manifestations shown by each patient.

An examination of self-destruction, lunacy and the asylum has allowed suicide and suicidal behaviour to be located within the context of nineteenth-century institutionalisation and the emerging psychiatric profession. To a large extent this has been illuminated by an examination of patient case-notes, which give some insight

into the 'human aspects' of asylum care. They have provided an important window into the perspective of patients and relatives, and the attitudes and approaches of the medical superintendents who compiled case records. Case-notes and asylum documents reveal the anxiety and apprehension that was shared by asylum staff, patients and relatives. The patient's medical history and case entries shed light on the attitudes of lay and medical agencies towards asylum admission, treatment and the risk of suicide. These documents have made it possible to determine who was involved in the process of admission and the behaviour that triggered committal. They reveal how lay and medical persons interpreted mental illness and suicidal behaviour, and how the parties interacted during admission and discharge. Case-notes also reveal details about the treatment and management techniques applied to suicidal patients and how successful they were in preventing suicide and aiding recovery. This has allowed changes in patient management to be mapped over the course of the nineteenth century as techniques responded to the changing nature of the asylum.

The handling of suicidal lunatics was determined by practical concerns that arose from the dangers associated with suicide, and the changing landscape of lunacy provision. Alienists recognised they could play a professional role in developing knowledge about suicide and insanity, and a practical role in the effective management of suicidal behaviour. In addition, they realised that the confines of the asylum offered a protective environment in which treatment of the patient's mental affliction and management of their suicidal behaviour could be pursued in tandem. The asylum's response to suicide and the prevention strategies adopted were neither

conceived nor conducted in isolation from broader changes in lunacy provision. The management of suicidal behaviour operated within a transitional environment that was affected by changes in treatment practices, attitudes towards the insane, the evolution of the psychiatric profession and the growth of public asylums. These developments each had a significant bearing on the practice of suicide management and prevention. At different times throughout the nineteenth century these changes forced the handling of suicidal lunatics to be re-evaluated and adapted where necessary.

Nineteenth-century responses to suicide were influenced by cultural, medical and social perceptions of self-destruction and disruptive behaviour. Dangerous, disturbed and 'abnormal' behaviour prompted differing interpretations and reactions from lay and medical circles. Secular interpretations of self-destruction were strengthened by the emerging psychiatric profession's medical model of suicide. Alienists put forward rational arguments that encouraged society to consider the range of emotional, social and medical causes that prompted individuals to commit suicide. Religious condemnation was largely eroded and replaced by medical explanations that focused on the relationship between suicide and mental disturbance. Alienists' interest in suicide was connected to the professionalisation of psychiatry and the development of psychiatric knowledge. They consciously extended the boundaries of their expertise and asserted psychiatry's right to preside over the care of the insane and suicidal. Developments in psychiatric understanding allowed alienists to argue convincingly, based on empirical knowledge, that suicidal ideation was frequently induced by emotional upheaval or insanity. Practical experience enabled alienists to

develop an exclusive body of knowledge and formulate an informed approach to the identification, management and prevention of suicide.

By the early nineteenth century, family and friends were more inclined to construe suicidal behaviour as a bi-product of insanity rather than to be religious or supernatural in origin. This quashed some of the fear previously experienced by relatives when disturbed and dangerous behaviour manifested itself. Psychiatry's medical paradigm gave reassurance that the condition was rooted in an emotional or physical cause which could be treated and effectively managed; preferably in the asylum. Alienists offered families an alternative, more suitable, place of treatment in the form of the asylum. Suicide had been drawn into the medical arena and defined in 'psychiatric' terms, so it was only fitting that provision was provided within a medical setting.

The asylum was portrayed as a curative institution in which suicidal behaviour would be effectively, and safely, managed by experienced attendants. Families trying to cope with disturbed and dangerous individuals were receptive to the promise of recovery and prevention against suicide. Those who had struggled to contain suicidal behaviour of the most determined form were given the opportunity for respite. Alienists' bid to take medical ownership of suicide raised public confidence in the 'profession's' ability to treat and manage suicidal lunatics more successfully than domestic and workhouse provision. Over time, however, the differences between rhetoric and reality became apparent. The idealised and optimistic pronouncements of alienists and medical superintendents were undermined by the limitations of

asylum staff who were few in number, untrained, and poorly paid. Attendants were recruited to undertake a complex task that combined protection for dangerous and vulnerable patients with a therapeutic role. Their work was extremely demanding, but training was limited and skills were usually developed by practical experience. Poor levels of staffing increased the burden placed on attendants and contributed to the demise of the idealised curative institution that alienists initially conceived and actively promoted.

Standards of suicide prevention and patient management were inspected and monitored after 1845 by the Commissioners in Lunacy. The Commission shared alienists' concerns about prevention and the importance of patient surveillance. They recognised the asylum's obligation to care for and protect suicidal patients. The Commission relied on a pragmatic and persuasive approach that generated piecemeal change in response to its observations and criticisms. A lack of authority impeded its ability to institute dramatic or innovative policies and transform the conduct of suicide prevention. Their efforts did lead to an improvement in areas such as night-watches and written instruction, which only reinforced known and accepted practices rather than introducing new techniques. The Commission's power to investigate completed suicides was relatively limited in scope. Their investigations prompted some transparency from asylum authorities, but the penalties for negligence and bad practice were often too moderate. Although the Commission's work was hampered by logistical and practical issues, asylum inspection remained important. Basic standards of care and suicide prevention would be reinforced if asylum authorities knew they were accountable to an external body. Despite its

evident limitations the Commission existed as a mild deterrent and continual reminder that the asylum was expected to protect patients against the threat of suicide.

Dangerousness and risk have appeared as a constant theme throughout this study, underpinning discussion on patient committal, treatment, discharge, and professional responses to suicide. This stems from the recurrent use of these words in contemporary literature, patient records and asylum documents. Dangerousness and risk virtually define suicide in general terms and the apprehension that surrounds its presence. Medical and lay parties recognised that the handling of suicide had to be formulated around the danger that patients posed to themselves. The asylum's response to suicide focused on counteracting this threat and endeavouring to prevent acts of suicide and to safeguard patient welfare. The dangerousness of suicidal patients needed to be assessed on an individual basis, taking account of previous suicide attempts and the lunatic's mental affliction. The patient's condition was evaluated during the initial stages of identification, then, in more depth, at the point of diagnosis and classification. The outcome of this assessment subsequently influenced the selection of appropriate treatment and management methods.

Dangerousness, and the necessity of determining patient risk, was most prevalent and important during the processes of committal and discharge. It was imperative that the severity of the patient's mental condition and suicidal propensity were established at the point of admission, because the labels 'dangerous' and 'suicidal' framed the institutional context of patient management. Lay accounts are scattered

with details of suicide attempts and the unmanageable behaviour that challenged domestic provision. When families and workhouse authorities made the decision to commit an individual, they were usually motivated by a desire to alleviate pressure on their limited resources and to place the lunatic in a secure environment. The asylum was a last resort, rather than an easy alternative that was frequently and flippantly used by families who could not be bothered to struggle with domestic care.

Patient management concentrated on the balance between cure and custody, but the management of suicide had first and foremost to overcome the patient's lack of self-control. This was achieved by introducing a number of external interventions that were designed to prevent self-destruction. Without self-control, patients could not rely on reasoned judgment, reflection and the instinct of self-preservation to prevent them from attempting suicide. The absence of these internal mechanisms forced patient management to be conducted with a different agenda. Restraint and seclusion were employed as substitutes for self-control because they restricted patient movement and limited access to dangerous implements; this reduced opportunities for suicide. Neither technique was indiscriminately employed to control or punish suicidal patients. The objective was to contain dangerous behaviour in a secure environment that minimised opportunities for self-injury and suicide. The management of suicidal lunatics demanded a reversal of priorities that ensured protection and prevention dominated the handling of patients and kept suicide rates to an absolute minimum.

The ethos of prevention and protection was absorbed into standard practice and adapted versions of general management techniques were then applied to the

suicidal. Broadly accepted techniques, such as patient surveillance and restraint, were modified in accordance with the changing context in which each was practised during the nineteenth century and the dangers associated with suicidal behaviour. The changing nature of public asylums from the mid to late nineteenth century led to an increasing reliance on the structure, organisation and system of the institution. Institutional efficiency and individualised treatment were harder to maintain simultaneously when caring for large numbers of people. Discipline, order, and regimentation became the yardsticks of asylum practice. This was to the detriment and consequent erosion of moral treatment as uniformity proved more achievable with a large patient population than individual 'therapy'. Medical superintendents and asylum staff accepted the asylum's shift towards custodialism, but they remained committed to the premise of suicide prevention. According to Erving Goffman, asylum staff were engaged in 'the constant conflict between humane standards on one hand and institutional efficiency on the other'.⁸²⁸ Attendants were charged with balancing the demands of the 'total institution' and its patients.

The shortcomings of late-nineteenth century asylumdom shifted the balance towards a reliance on the maintenance of order and control, and the steady lessening of any attempts at individualisation. Routine became the cornerstone of institutional confinement, as asylum staff tried to sustain a semblance of order amongst a large and diverse patient population. Custody was an implicit element of institutional confinement, but the changing nature of the asylum ensured that, during the latter decades of the century, it was an explicit characteristic. Suicidal lunatics were not

⁸²⁸ E. Goffman, *Asylums. Essays on the social situation of mental patients and other inmates*, (London: 1961), p.76.

exempt from the asylum's custodial approach. Patient passivity was sought and individuality was largely overlooked as practical problems undermined therapeutic intention. The treatment of patients *en masse* impeded attempts to encourage self-control and modify individual behaviour. The demise of moral treatment lessened the patient focus and enabled the virtues of discipline and order to inform management techniques. A cohesive regimented style of patient management emerged in which the 'medical' and therapeutic needs of suicidal patients were secondary to institutional efficiency and organisation.

The asylum's reversal of priorities impacted on the management of suicidal patients, yet it did not lead to the wholesale abandonment or demise of patient protection and suicide prevention. Although the asylum's custodial features undermined alienists' therapeutic ambitions, the necessity of preserving life ensured that the welfare of suicidal patients remained a concern. Restraint, seclusion, surveillance, and, to a lesser extent, sedation were imposed to counteract dangerous behaviour and impede suicide attempts. Each technique was used for its ability to contain patient activity and restrict access to potential methods of suicide. In this context, management retained an element of control, but only for the purposes of protection and safety. External interventions were introduced as a necessary substitute for the patient's loss of self-control and to assist attendants in their task as 'managers'. The asylum's custodial function filtered in to the management of suicidal patients, but it did not erode the principle of protection and prevention.

Some historians, most notably Foucault and Scull, have argued that the asylum was a centrally administered instrument of social control in which bourgeois values and conformity were promoted. Foucault perceives the asylum as a form of moral imprisonment where patients were controlled by judgement and surveillance. Once contained within the asylum's judicial space, lunatics were subject to psychological control under the guise of moral treatment; they were imprisoned in a moral world.⁸²⁹ Scull considers the separation of the insane to be a segregative control mechanism that distinguished the mentally ill from other deviants in society. Lunatics represented a problem population that consisted of inconvenient and troublesome people who potentially threatened nineteenth-century social order. An institutional response to this form of deviance alleviated bourgeois concerns and placed the insane under the medical control of the asylum.⁸³⁰

The social control models proposed by Foucault and Scull were intended to be applied to the general asylum population. However, for suicidal patients this concept is more difficult to justify. Persons exhibiting a suicidal propensity were deviating from the boundaries of 'normal' behaviour and were separated from society on that basis. Their behaviour posed an immediate threat to themselves rather than to bourgeois standards and the social order. Institutional confinement of suicidal lunatics was, for the most part, predicated on the need to preserve life. The asylum isolated the suicidal from society so that their behaviour could be monitored and controlled with the intention of obstructing suicide. Its function as an apparatus of social control and

⁸²⁹ Foucault, *Madness and Civilization*, pp.247-248.

⁸³⁰ For a detailed discussion of Scull's social control model see, Scull, *The Most Solitary of Afflictions* and A. Scull, 'Madness and Segregative Control: The Rise of the Insane Asylum', *Social Problems*, vol. 24 (1977), 337-351.

conformity was subordinate in the management of people who had to be protected from themselves. An inability to participate in the capitalist system and bourgeois dissatisfaction with the spread of deviance were less influential because committal was driven by the simplistic need to prevent death.

The asylum's suicidal population was brought into sharper focus by Shepherd and Wright's work on self-murder in the non-restraint period.⁸³¹ Their research identifies specific trends and reaches conclusions that have been acknowledged and tested during this study. Shepherd and Wright's work was confined to attempted suicide, but this thesis has considered both attempted and completed suicides. This has enabled a cohesive picture of the asylum's handling of suicidal patients to be formed. Commonalities were found with Shepherd and Wright's analysis of the admission process and the behaviours that triggered committal. Admission records and patient documents from the case studies used in this research reveal that threats and attempted suicide were the main precursors to committal. This supports the evidence put forward by Shepherd and Wright from the Brookwood and Buckinghamshire Asylums. It validates and strengthens the widely proposed argument that dangerous behaviour and suicidal activity were the most important criteria in the decision to commit suicidal lunatics.⁸³²

Shepherd and Wright focus on patient surveillance and sedation as the most commonly prescribed responses to suicide during the non-restraint period. They

⁸³¹ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', pp.175-196.

⁸³² The prevalence of suicidal ideation and attempted suicide as precursors to admission is also identified by Adair, Forsythe and Melling (in their study of the Devon County Asylum), and Walton in his work on the Lancaster Asylum. R. Adair, B. Forsythe and J. Melling, 'A Danger to the Public?', pp.13-15; J. Walton, 'Casting Out and Bringing Back', p.140.

rightly argue that non-restraint stimulated a change in the management of suicidal patients and that surveillance became an absolute necessity, but their discussion of treatment is relatively narrow. The confines of an article may have prevented a detailed examination of other strategies such as manual restraint, moral treatment and seclusion. Although the emphasis Shepherd and Wright place on surveillance and sedation is warranted, they do not make it explicit that patient observation was integral to suicide prevention irrespective of non-restraint. It is noted that in the absence of mechanical restraint 'a close watch was kept on patients at risk' as a strategy against suicide. This implies that surveillance only assumed an important role once restraint was abolished as 'the tried-and-tested means of preventing self-harm'.⁸³³

The asylum's role as an apparatus of social control also permeates Shepherd and Wright's discussion. They refer to the 'regulation and control of violent and dangerous inmates' and the 'control of suicidal admissions'.⁸³⁴ This infers that the management and prevention of suicide retained an inherent element of control, but the nuances of the word 'control' are not sufficiently drawn out. Without clarification, Shepherd and Wright's use of 'control' is a little ambiguous and implies that patient behaviour was regulated for punitive and custodial gain. Control of suicidal lunatics needs to be explained and understood for its preventive action as an external intervention when patients were unable to exert self-control.

⁸³³ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p.191.

⁸³⁴ Ibid.

The risk of suicide pervaded the day-to-day care of patients and the running of the asylum. It impacted on treatment and management, affecting both patient care and the work of asylum attendants. Effective management was dependent on techniques that reduced the risk of suicide to an acceptable level during treatment of the mental illness which it complicated. Suicide prevention was an added task that placed further demands on asylum medical staff and attendants. Despite patient assessment, skilled management and adherence to prevention strategies, it was (and still is) impossible to anticipate and thwart all suicide attempts. Patient determination and ingenuity, coupled with an extensive workload, made it difficult for asylum staff to effectively manage every suicidal lunatic. Alienists, asylum authorities and attendants recognised this reality, but nonetheless made effective use of the resources and skills at their disposal to restrict the number of attempted and completed suicides.

Methods of suicide management and prevention were greatly affected by changes in the institutional environment, particularly overcrowding, but they did not collapse under the strain. Management techniques, and attendants' delivery of them, were conducted with pragmatism and versatility. A reactive, labour intensive style allowed protection and prevention to remain marginally ahead of control and custody. Institutional efficiency and routine dominated the asylum regime of the late nineteenth century, but the dangerousness and risk associated with suicide dictated that the individual needs and safety of the suicidal population were not entirely sacrificed in the pursuit of custodialism and uniformity. Throughout the nineteenth century, asylum managers, medical men and staff remained aware of their obligation to provide safe custody and prevent suicide even in circumstances where patient

populations were swelling and cure rates were rapidly declining. Despite the pessimism permeating asylumdom at the close of the century, suicide prevention remained a recognised and essential practice in the treatment and management of the insane.

APPENDICES

Appendix 1

Table 1: Favoured means used prior to admission (male patients)

Asylum	Admission dates before admission	No. of patients to attempt suicide	Cut throat	Hanging	Strangulation	Drowning	Poison
Birmingham	1851-1860	7	1	2	1	2	1
Leicestershire	1846-1860	12	6	3	2	0	1
Rainhill	1853-1860	3	2	0	0	0	0
Warwickshire	1852-1860	12	5	3	1	1	0
Worcestershire	1859-1860	3	0	0	1	1	0

Sources: BCA MS344/M2/2a, LCRO DE3533/185-189, LRO M614 RAJ/11/1-2, WRO BA10127/14, WCRO CR1664/617 & CR 1664/619. The admission documents for some patients reveal that they attempted suicide prior to admission but the method used is not recorded. This accounts for the shortfall between the overall number of patients recorded in this table and the totals for each method.

Appendix 2

Favoured means used prior to admission (female patients)

Asylum	Admission dates	No. of patients to attempt suicide before admission	Cut throat	Hanging	Strangulation	Drowning	Poison
Birmingham	1851 - 1860	9	2	0	4	2	1
Leicestershire	1846 - 1860	11	4	1	4	1	1
Rainhill	1853 - 1860	11	3	2	1	4	0
Warwickshire	1852 - 1860	22	7	4	4	3	0
Worcestershire	1859 - 1860	5	0	1	0	3	0

Sources: BCA MS344/12/2a, LCRO DE3533/185-189, LRO M614 RAI/8/3 & M614 RAI/11/1-2, WRO BA10127/14, WCRO CR1664/617 & CR1664/619.

The admission documents for some patients reveal that they attempted suicide prior to admission, but the method used is not recorded. This accounts for the shortfall between the total number of patients recorded in this table and the total for each method.

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