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UNIVERSITY OF SOUTHAMPTON

“Fit Objects for an Asylum”

The Hampshire County Lunatic Asylum and its Patients, 1852-1899.

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ABSTRACT

FACULTY OF SOCIAL SCIENCES

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This research uses the records of the Hampshire County Asylum (HCA) between its opening in 1852 and the end of the nineteenth century to offer a different perspective on asylum history. Though it discusses the asylum in legal, medical and social welfare contexts it focuses on the experience of individuals and their families and the part played by the HCA in their lives. The perspective and methodology of the research reflect the recognition of the importance of individual experience in the construction of historical exposition.

In the course of the research a database of patients' personal information was constructed from asylum records. The resulting analysis of individual experience of admission to the HCA suggests that, for many patients, admission was short-term and temporary, caused by a combination of symptoms and events that erupted into crisis. For others the HCA provided a level of care that could not be sustained at home and for some an asylum admission was only part of a wider and continuing strategy of care which enabled troubled families to continue to function.

The thesis concludes that, although the county asylum was a potent symbol of many aspects of Victorian society, it should be seen, not as defining those who encountered it, but as a part, sometimes essential but often small, of their personal and family narratives.

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Abbreviations

HCA	Hampshire County Asylum
HRO	Hampshire Record Office
PRO	Public Record Office
PP	Parliamentary Papers
QS	Quarter Sessions
GPI	General Paralysis of the Insane

Footnotes

The extensive references to individual patients at the HRO would lead to very cumbersome footnotes. Therefore, all the bibliographical references to individuals mentioned in the text are included in the fourth appendix, except where there are direct quotations from patients' records.

“yet the patients sent here have been, almost without exception, fit objects for an asylum and it would have been difficult to have managed them in their own homes”

Report of the Medical Superintendent of the Hampshire County Lunatic Asylum to Quarter Sessions at Epiphany 1870.

Chapter 1

Introduction

During the nineteenth century the physical and social landscape of almost every county in England and Wales was altered by the construction of a variety of institutions designed to address the problems presented and experienced by its poor and indigent members. Workhouses, prisons, and hospitals appeared to embody the spirit of the age and by the middle of the century almost every county was busy adding a publicly funded lunatic asylum to its collection of institutions. The spirit in which they were constructed was summed up in the “Results and Observations” on the 1851 census.

One of the most unerring tests of the civilisation of a State is to be found in its Public Institutions. A stranger arriving in a country where the most conspicuous objects consist of edifices for religious worship, schools and colleges for the education of the young, almshouses and asylums for the aged or the helpless, workhouses for the poor, hospitals for the sick, barracks for the soldiery and prisons for the custody of offenders, would be at no loss in coming to the conclusion that he was in the midst of a highly civilised and enlightened community.¹

Though lunatic asylums were not specifically mentioned in this list, the records of the Hampshire County Asylum (HCA) indicate that publicly funded lunatic asylums were also seen in this light: by the legislators who made them compulsory, by the commissioners who inspected them, by the Justices of the Peace who planned and built them, by the medical staff who claimed them as their territory and by the chaplains who ministered to their staff and inhabitants. Whether the patients, their families and the communities in which they were located felt the same way is part of the framework within in which the research questions of this thesis are addressed.

¹ Results and Observations, 1851 Census Vol. 1, (London: HMSO, 1854), p.cxv.

This list of different groups of people who were involved with asylums serves to highlight the difficulty of finding a perspective from which to study the phenomenon of asylum acceptance, development and growth during the latter part of the nineteenth century. And not only is it difficult to identify a contemporary viewpoint but it is important to recognise and acknowledge the influence of present day concerns on historical interpretation. Micale and Porter, writing of revisions and counter revisions in the history of psychiatry, expressed the view that,

in no branch of the history of science or medicine has there been less interpretive consensus. In few professions inside or outside the sciences, has it been more difficult to demarcate the scholarly, historical enterprise from urgent present-day debates.²

For example, it is evident that, currently, any historical discussion of the subject is informed by public perceptions of the move towards 'care in the community'. The issue is frequently reported in a personal and sensational way that draws attention to the danger to the public rather than to problems of the individual sufferer. In this respect public attitudes do not seem so very different from those of the nineteenth century though the focus of government policy has shifted dramatically.

Andrew Scull pointed out that the reformers in every generation quoted the faults of the previous generation in order to prove the need for the changes they were promoting,

Those who led the crusade to establish state-supported mental hospitals...saw themselves as rescuing the mad from maltreatment, neglect and inhumanity and ushering in a golden age of kindness, scientifically guided treatment and cure. In this respect their self-portrait is indistinguishable from their present-day successors."³

² M. Micale and R. Porter (Eds.) *Discovering the History of Psychiatry*, (New York and Oxford: Oxford University Press, 1990), p4.

³ Andrew Scull, *Social Order/Mental Disorder*, (Berkeley: University of California Press, 1989), p303.

This chapter discusses how several generations of historians have in turn, accepted asylums at their own assessment as part of a process of social reform, placed them in the more sinister position of being the agents of social control of a paternalistic and hypocritical society or, more recently, located them in a network of personal, local and national tensions. Whatever the current perspective, however, the idea of the therapeutic asylum, fuelled by curative rhetoric and given form by increasingly prescriptive legislation, flourished in an age of institutional solutions to social and medical problems.

1.1 Historiographical background

Historians' ideas about the nature of madness have influenced the way they have presented society's responses in a historical context. A turning point in the perception of madness, encapsulated by Foucault in his image of Pinel striking off the chains of the inhabitants of the Bicêtre, has been loosely recognised by historians in several traditions.⁴ Though some argued for an earlier and more gradual transition in attitudes and practices and others pointed to a continuation of old ideas well into the nineteenth century and well after the general political acceptance of Moral Therapy, they agreed that, at some point during the eighteenth century, the madman ceased to be seen as a wild beast. He or she was no longer considered impervious to heat or cold, pain, or hunger but was portrayed as a human being, who was temporarily disturbed in one aspect of the self, but who could be rehabilitated, with treatment appropriate to his or her humanity.⁵ Madness was no longer thought of in terms of sin and possession and "this paved the way for emergent secular and social mappings of madness."⁶

This Enlightenment theme, of a move from superstition, religion and ignorance to rationality, humanism and science-based knowledge, underpinned not only the practice of medicine and psychiatry but also the growing literature about their history.

⁴ M Foucault, *Madness and Civilisation*, tr. R Howard, (London: Routledge, 1995), p242.

⁵ The mad person was usually characterised as male in the 18th century and men often outnumbered women in asylums.

⁶ R Porter, *Mind Forg'd Manacles*, (London: Penguin, 1990), p108.

Physicians, psychiatrists and nursing staff assimilated the assessment early asylum staff offered of themselves, as part of a humane process of social reform. The asylum's role as the preferred locus of care and custody and the site of treatment and research therefore went mostly unchallenged for more than a century, and psychiatry and models of psychiatric care were developed principally within an asylum setting. In the late twentieth century, in spite of the move towards community care and the diversification of mental health provision among different groups of professionals, mental health workers continued to define themselves in relation and reaction to these institutions.⁷

Historians also were content to accept asylums at their own valuation, placing them first within a context of benevolence and social reform and later within a context of scientific and medical process. One aspect of this approach has been to see the treatment of insanity primarily in terms of legislative change, acknowledging social and economic factors as influences but not as fundamental. In this area the work of Kathleen Jones has been influential since the 1950s, setting the scene for subsequent revisionism while managing to survive alongside it.⁸ In her account the development of the asylum was humane, necessary and, once the machinery of the Poor Law was in place, inevitable.

One cannot ignore the poverty and social distress of many of the patients who came to the asylums; the cruelty and neglect of some of the large private madhouses; and the sheer inefficiency and penny-pinching of many of the people - madhouse proprietors and local justices - who were responsible for lunatics before the national Lunacy Commission began its work. A powerful central body could insist on adequate financing and raise standards. There is no other way in which this could have been achieved.⁹

⁷ Peter Nolan, *A History of Mental Health Nursing*, (London: Stanley Thornes, 1993), p4.

⁸ Kathleen Jones, *Lunacy, Law and Conscience*, (London: Routledge and Kegan Paul, 1955), *A History of the Mental Health Services*, (London: Routledge and Kegan Paul, 1972), *Asylums and After*, (London: Athlone, 1993).

⁹ Jones, 1993, pp92-111.

The instrumental view of medicine that related to this is most clearly seen in the work of Hunter and MacAlpine. They defined insanity as a category of illness, which in the nineteenth century had not been effectively identified. Writing in the early 1970s, they saw psychiatry and mental illness as part of the history of science and ideas, for the most part within a medical and humanitarian context. While they regretted the size of the Colney Hatch asylum and its subsequent spectacular enlargement, they accepted the inevitability and benign character of the nineteenth-century asylum as the locus of care for a series of conditions which they examined using current diagnostic criteria. This commitment to a medical view of insanity and psychiatry defined by current rather than contemporary knowledge meant that their historical view concentrated on the idea of medical progress in which social factors had a supplementary role.¹⁰

Joan Busfield has offered a compelling explanation of this type of history, placing most medical and psychiatric practice within a liberal-scientific framework that has influenced its historians as well as its practitioners.¹¹ According to this description the turning point occurred when science superseded superstition and became the foundation of a process of reform. Since science and progress were seen as synonymous, psychiatry was thus seen as both linear and progressive and any problems or failings were attributed to faults within the system and not to flaws in the framework. It was assumed that a combination of science and professionalism would ensure altruism and objectivity, resulting in a system that would be both beneficial and progressive. Within this framework, psychiatrists were cast as experts, with the knowledge and right to define the terms of mental illness and its treatment. This has been described elsewhere as,

liberal, evolutionist and sympathetic to modern diagnostic categories as the criterion of reality against which earlier discoveries are to be tested and found wanting.¹²

¹⁰ R Hunter and I MacAlpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum- Friern Hospital 1973: A medical and social history*. (London: William Dawson and Sons, 1974), pp200-253.

¹¹ Joan Busfield, *Managing Madness: changing ideas and practice*, (London: Hutchinson, 1986) pp15-21.

¹² P Sedgwick, "Michel Foucault: the anti-history of Psychiatry," *Psychological Medicine*, 11 (1981), 235-248, (p237).

The antidote to this approach developed out of the work of Michel Foucault and particularly out of *Madness and Civilisation*. His exploration of the dialogue between reason and unreason and his re-interpretation of social reform as the new and sinister face of oppression, which succeeded in completely silencing madness, provided a framework for debate which underpinned a fundamental reshaping of the historical territory in the last quarter of the twentieth century.

Foucault's work can be placed, most coherently, close to the rather diverse group of "anti-psychiatrists" whose work, though coming from very different political directions and working outside the historical sphere, questioned the construction of some types of mental condition as pathological, preferring to look at the social construction of deviance and reactions to it and postulating psychiatry as a form of social control.

The work of Thomas Szasz asserted that, by using the labels of illness, a moral judgement was obscured by the suggestion of a scientific and objective assessment, thus relieving the individual of responsibility and reducing his or her autonomy and liberty.¹³ He preferred to characterise mental illness as a metaphor for "problems in living". R.D. Laing's work stressed the need to understand the behaviour of the individual in context and rejected the values that judged people insane as well as the institutions such as the family that constrained them.¹⁴

For this group the social nature of human interaction was vital in understanding human thought and action and was only understandable in relation to the social environment. The pathological approach found the problem in the individual and the solution in science while this approach looked away from the individual to society for the source of the problem. In this situation it was possible for the individual to take responsibility for recovery without suffering the loss of agency that was experienced once he or she was defined as a patient.

In this vein the work of the sociologist, Erving Goffman stressed the dehumanising effects of institutional living to the extent that, in his view, the institution itself became

¹³ Edward Shorter, *A History of Psychiatry*, (New York: John Wiley, 1997), p274.

¹⁴ Shorter, p276.

responsible for some of the symptoms it claimed to cure, a view forcefully and influentially expressed in Ken Kesey's novel *One Flew Over the Cuckoo's Nest*.¹⁵

Criticisms of Foucault's work from a historical point of view centred on the lack of empirical verification for his assertions about the treatment of the mad and these were not unfounded. Roy Porter commented on the fact that the discussion of "The Great Confinement" was not relevant to events in England and doubted whether, in any case, it could be interpreted as an effective means of preventing anarchy and policing the poor.¹⁶ Peter Sedgwick called Foucault "a self-proclaimed dealer in fictions, seemingly unconcerned with accuracy and evidence."¹⁷ He went further and took issue with Foucault's concept of a dialogue between reason and unreason, suggesting that invasive and mechanical interventions to re-condition the insane have always been in use and that, therefore, there had never been a historical period in which the voice of the madman could have been accommodated. Furthermore, he said that it would be impossible for this supposed dialogue to take place,

other than through a concrete and historical critique of social practice and through the parallel evolution of political programmes designed to maximise the acceptance of the mentally ill in work and social intercourse.¹⁸

Whilst the empirical criticisms of Foucault's work may be justified and the so-called "anti-psychiatrists" have been wrong-footed in many areas by the recent advances in the control of symptoms by the pharmaceutical industry,¹⁹ the combination of their views had a profound influence on the interpretation of psychiatric history. In the end Foucault's lack of detail seemed irrelevant because his most important contribution was to explore the symbolism of insanity and to offer up madness as a social and cultural construction relative to the perceptions of the age. Thus he rejected the modernist assumption that historical objects were given or natural and presented all history as culturally relative. In this interpretation the understanding of the

¹⁵ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (London: Penguin, 1991). Ken Kesey, *One Flew Over the Cuckoo's Nest*, (London: Picador, 1973),

¹⁶ Porter, *Mind Forgy'd Manacles*, pp7-9.

¹⁷ Sedgwick, p238.

¹⁸ Sedgwick, p246.

¹⁹ Shorter, pp246-262.

importance of madness was linked fundamentally to the spirit of any age and to the relationship between knowledge and power. Changing institutions and practices were peripheral to that.

For historians, while the conception of psychiatry in the context of the history of science and medicine continued to be important, work after Foucault recognised the relevance of social context and led to interpretations that stressed particular social cultural and economic influences in a fundamental way. Klaus Doerner's book, *Madmen and the Bourgeoisie* took as its theme the relationship between the insane and the community that eventually chose psychiatrists as its intermediaries. He explored the social, cultural and political conditions of a bourgeois society that defined madness and unreason as a means of structuring its own normality and attempted to 'cure' the insane by instilling its own bourgeois morality.²⁰

These theoretical developments were also at the heart of contemporary interpretations of the place of the county asylum in the landscape of social history. Andrew Scull offered this justification for a social approach:

regardless of whether it is correct in some ultimate ontological sense to describe insanity as an illness, once it has been identified as such, people's responses to it are mediated by and through that socially constructed meaning: so we can legitimately ask how it was that, that particular social meaning was arrived at and what its consequences are...we can choose to focus not on whether certain persons are mentally sick or not, but on how their life is reorganised because they are called mentally sick.²¹

This was a justification for his own analysis of the deeper social forces that he perceived to be working on the shifting interpretations and responses associated with insanity. Scull linked a fundamental change in the structure of society with the epistemological rupture in the understanding and treatment of insanity. This, he said, resulted in the "domestication of madness" which moved the emphasis from the

²⁰ Klaus Doerner, *Madmen and the Bourgeoisie*, (Oxford: Blackwell, 1981), pp57-63.

²¹ A. Scull, *Social Order/ Mental Disorder*, (Berkeley: University of California Press, 1989), p123.

external discipline of the body to the internal restraint of the self in the form of Moral Therapy.²² Contemporaries were quick to associate what they perceived as an actual increase in the amount of insanity with the evils of civilisation, represented by the increase of industrialisation and urbanisation, but Scull pointed out that the asylum movement was well under way before Britain became a highly industrialised country and he presented a more subtle exposition.

In his analysis, the rise of the market economy, which underpinned relations between employer and employee, resulted in a redefining of their relationship so that it began with the performance of a task and ended with the payment of wages. The employer felt no responsibility for the unpaid worker and yet alternate sources of sustenance which were available in a more flexible and seasonal system were no longer there, so the worker's dependence on the employer was greater than ever. At the same time Scull detailed the rise of the bourgeoisie and the philosophy of self-help which, arguably, were enshrined in the Poor Law Amendment Act of 1834, and which made each able-bodied individual responsible for his or her own poverty. Poor relief was seen as sustaining rather than relieving poverty and from 1834 the terms on which it was to be offered were to be different. Need was to be tested and the help that was offered was to be supervised in the institutional setting of the workhouse.

However, the extent to which this was true probably lay more in the intention than in the reality. More support for the changes of the 1834 legislation came from agricultural than from industrial areas but most relief was allocated outside the workhouse for many years after 1834. It could be argued that although agricultural areas such as Hampshire had already faced major changes in working practices, they retained the links between master and man, which elsewhere were severed by the drama of industrialisation and the expansion of urban areas. The poor of Hampshire's small towns and villages were more likely to be known as individuals to those who administered poor relief and delivered medical care. Nevertheless, life in rural areas was not unchanging.

Agricultural labourers were finding even less security than in the past as machinery was increasingly used in agriculture and workers were paid a daily or weekly rate.

²² Scull, *Social Order/ Mental Disorder*, pp 54-79.

Hampshire may not have had large manufacturing cities but its coastal towns were growing in association with the navy, (Portsmouth) with commercial and passenger shipping (Southampton) and with the seaside holiday (Bournemouth) and they attracted people from the villages around.²³

According to Andrew Scull, the increasing lack of economic flexibility available to poor families resulted in a closing of boundaries of tolerance around difficult behaviour at a time when the development of large and central bureaucratic structures for the administration of the state's business made a national asylum system possible. Furthermore, his more controversial proposition was that within the small but growing body of people interested in the aspect of deviance or illness known as lunacy there was a strong lobby of madhouse proprietors, themselves entrepreneurs in a capitalist structure, whom he described as developing an increasingly elaborate account of the therapeutic and scientific advantages of the asylum. Scull's argument was that this was also taken up by medical superintendents of county asylums who contributed significantly to the expansion of the asylum system by enabling families to give up responsibility for their difficult members at an earlier stage than previously.

This analysis has remained very influential though other work has stressed the complexity of the development of the New Poor Law and its relationship with lunacy legislation as well as the limited influence of medical superintendents over the actual admission process.²⁴ One of the aims of this research was to assess the extent to which this analysis applied in individual situations.

1.2 Empirical Studies

The contributions of writers such as Foucault, Scull and Doerner produced a theoretical framework which was largely economic and political but which rested only

²³ The area served by the HCA remained fairly consistent during the whole period as Portsmouth built its own asylum in the 1870s and Southampton usually made other arrangements for its lunatics. Only the Christchurch union, which included Bournemouth, sent increasing numbers of patients as the population of the area increased rapidly in the late nineteenth century.

²⁴ Peter Bartlett, *The Poor Law of Lunacy*, (London: Leicester University Press, 1999).

lightly on empirical evidence. However, a series of detailed studies of asylum records began to develop a multi-faceted account of the confinement of the insane. These questioned some of the major assumptions of earlier writers by taking the analysis to a local level and concentrating on particular social circumstances and characteristics of asylum populations and the communities from which they came.

Scull's thesis suggested, on a broad level, that the growth in the number of asylum inmates was fuelled by the willingness of families to use the asylum as a resource, the implication being that it was the difficult and peripheral members of family and community who were most likely to be removed when they became too much of a burden,

its primary value to the community was as a handy place to which to consign the disturbing, the vaguely menacing, the unwanted and the useless, those potentially or actually troublesome people who posed threats to the social order and business of daily living which were not readily subject to control by the legal system.²⁵

However, he did not address the issue of how certification came about in individual cases nor look in any detail at the characteristics of those admitted to asylums.

John Walton and subsequent researchers used demographic analysis of asylum records as a way of exploring these wider themes. Walton's research suggested that in the middle decades of the century, at least, "the county asylum provided relief for desperate families rather than an easy option for the uncaring or irresponsible," and that it was therefore "difficult to show that the asylum was dominated by a subculture of the disorderly poor."²⁶

Whilst he agreed with Scull that families found their own reasons for using asylums he disagreed about what those reasons were. The implication here was that the arguments for the need and use of the asylums by ordinary families whose care options were

²⁵ A Scull, *The Most Solitary of Afflictions*, (New Haven and London: Yale University Press, 1993), p352.

²⁶ John Walton, "Casting Out and Bringing Back in Victorian England: Pauper Lunatics 1840-1870", in *The Anatomy of Madness*, Vol. 2, ed. by W. Bynum, R. Porter and M. Shepherd. (London: Tavistock 1985), pp138 –141.

limited were at least as strong as the arguments for a state driven asylum-building programme, whether it were for philanthropic or oppressive reasons. Subsequent research also indicated that middle life and the associated stage of the life cycle produced more candidates for asylum admission than old age or a socially isolated life style.²⁷ Data from private asylums confirmed this for the middle classes, where the decision-making was located much more obviously within the family.²⁸

As a result of further research in specific asylums a pattern emerged, which both supported and contradicted some of Scull's work. The silting up of asylums with the old, sick and incurable, which the Victorians had noted and despaired of, and which Scull had confirmed, became depressingly clear but was contrasted with high turnover and rapid re-admission rates among the rest of the asylum population, which had not previously been emphasised in research. So the pattern of asylum admissions and discharges was not as straightforward as first thought.

Anne Digby's work on 'The Retreat' showed how difficult the interpretation of this sort of data was. She noted that,

if we look at the asylum population this gives credibility to the contemporary view of asylums as filled up with chronic patients, whereas if we look at the outcomes of admission, a more optimistic perspective on the success of therapy is possible.²⁹

Furthermore, these patterns of movement became even more interesting when associated with calculations of length of stay since it became evident that many of those admitted were resident for less than one year. My earlier work on the HCA showed that in the early years of the 1870s and the 1890s over fifty percent of all those

²⁷Richard Adair, Joseph Melling and William Forsythe, " Migration, Family Structure and Pauper Lunacy in Victorian England: Admissions to the Devon County Pauper Lunatic Asylum 1845-1900", *Continuity and Change*, 12 (1997), p 393.

²⁸ Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1917*, (Cambridge: Cambridge University Press, 1985). Charlotte MacKenzie, *Psychiatry for the Rich*, (London and New York, Routledge, 1992).

²⁹Digby, *Madness, Morality and Medicine*: p219.

admitted were resident for less than twelve months.³⁰ These results were similar to Digby's, although in the Retreat the average length of stay was longer and the private management of the Retreat and its religious basis meant that factors such as cost to the relatives were more likely to be involved in decisions about admissions and discharges.

Digby's study was important to the formulation of this research in both its methodology and its conclusions. The Retreat differed from the HCA in its size and the social composition of its population, especially once non-Quakers, who were not subsidised, were admitted. Though the circumstances of both admission and discharge were therefore affected by financial and social situations that were different from those that affected the admissions and discharges at a county asylum, many of Digby's observations were relevant. She noted the steadily increasing proportion of women patients, the predominance of single over married patients and the admission of most patients in young adulthood and early middle age. This suggested that influences outside the asylum and within the family were similar regardless of certain economic and social factors. The methodological implications of this study are discussed in chapter two.

The demographic analysis moved further along with the linking of asylum records to civil records, such as the census, in order to begin an analysis of the social and economic circumstances of patients and the role of family and friends in the admission and discharge of asylum inmates.³¹ David Wright's call to historians to recognise that the history of insanity should be seen as separate from the history of confinement addressed the growing recognition of the complexity of the relationship between the understanding of insanity and the fact of asylum residence. In my research analysis of the records of patients who were admitted on several occasions proved a useful way of looking at this aspect of the subject.³²

³⁰ S. M. Burt, *A Permanent Expense and a Constant Sorrow: Admissions to the Hampshire County Lunatic Asylum 1852-1894*. Unpublished MA dissertation, University of Southampton, 1997.

³¹ David Wright, "Getting out of the asylum: Understanding the Confinement of the Insane in the Nineteenth Century." *Social History of Medicine*, 10 (1997), pp137-155.

³² Wright, "Getting out of the Asylum," p137.

The picture that emerged from recent research, therefore, was of asylums at the intersection of national policy and local exigencies.³³ County asylums were part of a complex and growing administrative network, made possible, as Scull suggested earlier, by the methods of a growing national bureaucracy, a stable tax revenue and the ability to generate sufficient capital building funds by use of local taxation.³⁴ Peter Bartlett suggested that, at the local level, there were tensions in the supervision of asylums, between on the one hand, the guardians and paid officials of the Poor Law, who had responsibility for the patient in the community and for financing their upkeep, and on the other hand the visiting committee, who supervised the construction and administration of the county asylum. The latter, he suggested, were members of society who represented, especially early on and in rural areas, an earlier more paternalistic view of the Poor Law and local administration in general. These were the Justices of the Peace who supervised the asylum as a visiting committee and in turn reported to other Justices sitting in Quarter Sessions.³⁵

The importance of local context and conditions and the resulting tensions were also the theme of recent empirical work such as that carried out on the data extracted from the records of the Devon County Lunatic Asylum at Exminster.³⁶ Whilst acknowledging a debt to Scull for the theoretical framework, this work concentrated on teasing out the social structure and patterns of family life associated with the journey to the asylum and, less frequently, home again, which it saw as having been influenced,

³³ Bartlett, *The Poor Law of Lunacy*.

³⁴ Scull, *The Most Solitary of Afflictions*, p43.

³⁵ Bartlett, *The Poor Law of Lunacy*, p116.

³⁶ Wm. Forsythe, Joseph Melling and Richard Adair, "The New Poor Law and the County Pauper Lunatic Asylum: the Devon experience 1834-1884, *Social History of Medicine* (1996), 336-355. Adair, Melling and Forsythe, "Migration, Family Structure and Pauper Lunacy in Victorian England: Admissions to the Devon County Pauper Lunatic Asylum 1845-1900", *Continuity and Change*, 12 (1997), 337-401. Adair, Forsythe and Melling, "'A danger to the Public?' Disposing of the pauper lunatic in Victorian and Edwardian England: the experience of the Exminster Asylum 1845-1914." *Medical History* 42 (1998), 1-25.

not merely by the broad market, class and ideological dynamics...but also by a complex interplay between local kinship and community ties and the evolving institutions of the Poor Law, which demarcated the boundaries of social regulation in people's lives.³⁷

Thus Melling, Adair, and Forsythe dealt with the different social variables supplied by the admission registers, and considered the impact of gender, of occupation and of marital status. They looked at the industrialisation and urbanisation thesis originally tested by Walton in terms of migration patterns and family structure, and examined the economic and political tensions implicit in the close working relationship of the county asylum and the Poor Law unions suggested by Bartlett. Most importantly they were able to emphasise the fact that the asylum was not the only option available to families and lay officials, even if it has turned out to be the most visible and easily investigated.³⁸ Their research portrays the complex interactions of individuals at the heart of a process characterised by complex ideological relationships.

The recent historiography of the subject may be said, therefore, to have moved through three phases. A period of Whiggish reformism where asylums were seen as progressive examples of enlightened and humane provision for the insane poor, carried out by the great and the good, was followed by a period of Foucauldian criticism, which encompassed more sinister accounts of social and psychological control. Finally came a more diverse and pragmatic model, which focussed on community, family and individual interaction with asylums, which were seen in the context of care as well as of control. In this it reflects the general shifts in the philosophy of history discussed in the next chapter

Institutions have been described as the means of removing and controlling deviant and abnormal individuals, who disrupted an increasingly conformist working-class society, which was in turn moulded by social aspirations and standards filtering down from the middle-class to the working-class. The historian F.M.L. Thompson has questioned the one-way nature of such a process and described a culture of

³⁷ Richard Adair, Joseph Melling and William Forsythe, "Migration, Family Structure and Pauper Lunacy in Victorian England, p 394.

³⁸ Adair, Forsythe and Melling, "A danger to the Public? See also *Outside the Walls of the Asylum*, ed. by P. Bartlett and D Wright, (London: Athlone, 1999).

respectability, which developed from within, thereby questioning the reduction of a huge class of people to the status of inactive bodies on whom social and cultural forces could work at will.³⁹ In other words, while the 'ruling class' put in place institutions, both literal and metaphorical, to mould the society they saw as desirable, the working-class was willing and able, both to conform to the mores of the institutions on offer and also to take them, change them, and use them for its own purposes.

Though the county asylum was for those in receipt of poor relief, this could be received in a variety of ways even in the mid to late nineteenth century, without the family necessarily having to give up its autonomy. This begs the question about how such decisions were taken, who took them and how the family might have been affected. As Mark Finnane said,

There is little place for the notion of an innocent family...so often it is the history of familial relations which is essential to appreciating the decision to commit.⁴⁰

It would be disingenuous to suggest that the asylum was used only in response to medical need and that social circumstances and family conditions were not influential in determining the making of the decision and its timing, and this research shows many differing responses to the HCA and to the individuals who were admitted. It is also important not to lose sight of the very real distress experienced by many or most patients and their families. Reception orders and medical certificates bear witness to the extreme circumstances of many cases prior to admission.

The importance of the individual and his or her family in the historical context of the asylum is stressed as a way of enriching theoretical and contextual approaches. The groups which comprise the family, the community and the state helped to shape society's norms and to dictate acceptable behaviour to its members, both publicly and,

³⁹ F.M.L. Thompson, *The Rise of Respectable Society: A Social History of Britain, 1830-1900*, (London: Fontana, 1988). "Social Control in Victorian Britain", *Economic History Review*, 2nd Series XXIV (1981), 189-207.

⁴⁰ Mark Finnane, "Asylums, Families and the State," *History Workshop Journal*, (1984), 134-147, (p137).

to a lesser extent, in private. However, the nature of the records, reinforced by much of the analysis, means that those in authority in the community and the asylum; doctors, Poor Law officials, Justices and asylum officers, have always appeared as prime movers in the process of asylum admission. Yet most individuals admitted were removed from their families to the wards of the asylum, not by sudden command from outside but as part of a process which involved their relatives, friends and neighbours. We can, in effect only understand the asylum and the experience of its patients by locating it and them within the community.

Using the records of the HCA this research considers the circumstances in which some Hampshire people became 'fit objects for an asylum' and the ways in which their families were affected by and responded to, the process. The underlying theme is that of choice. The HCA could be seen as one possible course of action among several but the reason for the choice depended on who was making it. The research therefore looked at three aspects of the community's relationship with the HCA. The nature of the asylum as an institution and its self-image and the image presented to the community was one aspect. The second aspect was the nature of the asylum population. Certain social and demographic characteristics might indicate that asylum treatment was not so much a personal choice as an aspect of the social regulation of one section of society by another. Thirdly the research explored the nature of personal choice by looking at patients and their families in the community and the way in which they and their households responded to the presence of mental handicap or mental illness.

These aspects are examined in the three main strands of the research. First it considers what it was about the asylum itself that might make it a positive rather than a negative or neutral choice. In other words might it have been seen as offering a solution to a problem rather than just being a place to move the problem to? The asylum's self image as a medical establishment rather than a branch of the Poor Law network is an important factor in this discussion. Secondly, by looking at the extent to which the asylum community reflected the wider community of the county, it opens up the question of the degree of agency of families in these matters. Thirdly, it examines the involvement of family and friends and of Poor Law officers in the admission and discharge processes.

In addition, it was necessary to develop a research method, which would enable records created for institutional purposes to be used in order to try to reach beyond the institution and into the lives of patients and their families. Could the many volumes of patients' records be used to explore both the experience and prospects of a whole asylum population as well as the lived experience of individuals and groups within that population? And would it be possible to link HCA records to other records of the period to enhance the analysis? The methodology is discussed in chapter two.

The Hampshire County Lunatic Asylum was unspectacular in the “grand scheme” of earlier psychiatric history. It could not boast a famous medical superintendent, a great discovery or a titillating scandal. Nevertheless, between 1852 and 1900, over seven thousand residents of Hampshire were admitted as certified “lunatics, idiots or persons of unsound mind” and understanding their journey and that of their families will be the purpose of the following chapters.

Chapter 2

Methodology and Sources

Chapter one located my research questions within the historiography of insanity, psychiatry and confinement and concluded that the next step should be to approach the asylum through its users: the patients and their families. This chapter addresses the epistemological and methodological issues inherent in trying to answer questions relating to individual and family experiences of asylum admissions. Having considered the theoretical basis of the methodology I discuss the nature of the sources, the design of the project and the presentation of the research.

2.1 Writing History

Three related questions of epistemology and methodology challenge all historians. They concern the identification of events from the past, characterised as history, the most appropriate way of studying them and the best way of communicating them. The following summary is fairly brief but the question of how these three issues affect the account to be presented here could encompass the whole canon of recent historiographical theory. The developments in the historiography of madness outlined in the first chapter are related to the move, during the twentieth century, from emphasis on specific political events, shaped by important people, to a focus on the wider social and cultural influences within society. This change in emphasis encouraged the idea of “history from below” and at the same time the growth of the wider field of social history has made respectable the historical study of areas such as health, the family, and sexuality, in which individuals are permitted to have as important a place in history as great events or social forces.

With new areas of scholarship have come new ideas about the best approaches. The impact of the “Annales” school, in particular has been to stress the importance of process and relationships as much as events and people. It draws attention to the long

term and to historical specificity, in conjunction with the more theoretical and generalised approach of some of the social sciences. Most recently the epistemology and methodology underpinning these questions have been affected by the reflexivity imposed on history by the assimilation of postmodern theory.

If postmodernism can be summarised briefly, it is characterised by diversity, subjectivity and relativism and a move towards seeing historical events as independent or contingent upon other events rather than as part of an overarching narrative of progress. Its main effect has been to challenge convictions about the objectivity of knowledge by questioning whether it is ever possible to have an external viewpoint on reality. Nancy F. Partner was probably overstating the case when she referred to, “language-model epistemology... smuggled out of linguistics and philosophy departments and lobbed like grenades into unsuspecting history departments”, but the association of post structuralist language theory with postmodernism, when applied to history, has a potentially destabilising effect.¹ By suggesting that rather than being liberated by our ability to use language, we are instead constrained within a web of language, one aspect of postmodernism is to question the existence of external referents and postulate that language can only ever be self-referential. Therefore every act of historical interpretation can never be more than textual analysis and every example of historical writing is only a form of discourse to be analysed on its own terms and not with reference to anything that is real.

The implication for historians is that any claim for truth or objectivity is pointless and the main culprits and casualties are the “facts” which can no longer be used as the yardstick of reality. In the postmodern analysis the facts are not independent. They have been mediated at three levels, through the texts themselves, which have been cast as reconstructions of events, through the partial and fragmentary survival of those texts, and by the interpretation of the historian.² So the facts are not, actually, objective material and it is not so straightforward to be “firmly bound by the authority of our sources”, thus avoiding the trap of “present-centredness”.³ In fact, present-

¹ Partner, Nancy, F., “Making up Lost Time: Writing on the writing of History”, in *History and Theory*, ed. by Brian Fay, Philip Pomper and Richard T. Vann, (Oxford and Malden, Mass, 1998), 69-89 (p73).

² Susan Stanford Friedman, “Making History: reflections on feminism, narrative and desire.” In *The Postmodern History Reader* ed. by Keith Jenkins, (London and New York: Routledge, 1997), 231-236, (p233).

³ G. Elton, “Return to Essentials” in *The Postmodern History Reader*, p179.

centredness is celebrated by postmodernism, to the extent that Foucault wrote of all histories as histories of the present.

A postmodern approach to historical research therefore imposes different duties on the historian. Though historians have long practised criticism of their sources, taking careful note of the reasons for and circumstances of, their production and dissemination, the postmodern interpretation stresses that the facts themselves are texts requiring a critical reading. By defining all viewpoints as relative, subjective and of equal importance attention is moved away from the 'upper case', where specific events are linked with social forces, famous men or the inexorable course of progress, towards the 'lower case'.⁴ This is potentially liberating as it could allow the marginalised to have a voice, thus rescuing them from the anonymity of the mass of ordinary people, who are then perceived as active rather than as passive or reactive. Nevertheless, the problem of history and the narrative thread remains. Even if all events are seen as independent or contingent the act of selection by the historian imposes a narrative or sequence and the 'lower case' history may in the end represent a change of emphasis rather than a fundamental change in the process.

Foucault provides the link between this brief summary of historical epistemology and this research. His concern for the construction of 'general history' as opposed to 'total history' was to,

determine what forms of relation may legitimately be made between the various forms of social categorisation, but to do this without recourse to any master schema, any ultimate theory of causation.⁵

Firstly he was concerned with the status of history as discourse, secondly with the entanglement of history with questions of power and thirdly he asked questions about the relationship of the past with the present.⁶ All these questions are relevant to research in this area. Power of one group over another is central to many

⁴ Keith Jenkins, ed., *The Postmodern History Reader*, pp2-3.

⁵ Jeffery Weeks, "Foucault for Historians," *History Workshop Journal* 14 (1982), 106-119, (p110).

⁶ Andrew Thacker, "Foucault and the Writing of History," in *The Impact of Michel Foucault on the Social Sciences and Humanities*, ed. by Mora Lloyd and Andrew Thacker, (London: Macmillan, 1997), 29-44, (p30).

historiographical discussions of asylum history. Current understanding of insanity is crucial to our interpretation of the past, as the number of recent publications related to historical aspects of 'care in the community' demonstrates. His argument, that history was a series of random and unrelated contingencies arranged and rearranged by historians to achieve the continuity they sought, challenged the methodology of most historical work. He argued that historians should acknowledge the discontinuity of history and use it as a working concept and not see it as an external condition that must be reduced to an artificial narrative coherence.⁷

In *Madness and Civilisation*, Foucault did not claim that the phenomenon of madness had never existed but attempted to understand the discursive practices which made it meaningful for one generation and changed it for the next.⁸ This meant acquiring large amounts of data and giving attention to failed as well as successful discourses. The possibility of searching for meaning and perspective rather than truth meant that all texts could be acknowledged as meaningful and not just those that told the story the historian wanted to tell. Foucault has been criticised for his cavalier use of historical evidence and, in *Madness and Civilisation*, for his apparent generalising of the experience of France to the whole of Europe. However, his discernment of the history of madness as part of the history of rationality has been influential and the legacy of the evaluation of madness as culturally and historically specific has been generally assimilated.

From the point of view of writing history the problem with a postmodern approach is that though human affairs may indeed consist of random events, it is certainly true that human beings themselves impose narrative coherence upon their lives without waiting for historians to tell them about it. For most people history is made distinct from fiction by a curiosity about what actually happened in the past and an expectation of scrupulous standards of investigation and proof. They expect it to be possible for the historian to investigate what actually happened at the same time as offering a personal insight or interpretation. If individual memory sustains a consciousness of living in a stream of time that connects the event itself with the contemporary world as Appleby, Hunt and Jacob recently suggested, then it ought to

⁷ Thacker, p31.

⁸ Weeks, p112.

be possible to accept their definition of historical objectivity as, “an interactive relationship between an enquiring subject and an external object”.⁹ This advocated the concept of ‘practical realism’, which acknowledged that “Linguistic conventions arise because human beings possessed of imagination and understanding use language in response to things outside their minds”.¹⁰ It accepted that different viewpoints existed, but construed this as perspective rather than interpretation, and suggested that the validity of reconstruction depended on the accuracy and completeness of the observations, and not on the perspective. If each generation needed to see the past in terms meaningful to it then, “Successive generations of scholars do not so much revise historical knowledge as they reinvest it with contemporary interest”.¹¹

This argument celebrates much of the diversity offered by postmodernism while accepting that, as well as offering interpretation, historians generate a body of knowledge that can be used and developed. “If history did not involve a relationship with an object outside the self, it would have no capacity to extend the range of human understanding.”¹² This enables both the writer and reader to search for both knowledge and meaning without succumbing to the fatal malady of ultra-relativism that could otherwise render much scholarly activity meaningless.

If all historical enquiry and writing therefore consists of three interwoven and reflexive strands, the selection of events or themes for study, the events themselves and the contemporary framework within which they are both selected and interpreted, then it is important to set this research in context. It was formulated at a time when the nineteenth-century county asylums were being emptied of their patients and converted to residential accommodation for a very different class of people from the original pauper occupants. Contemporary concerns were not with the problems of institutionalisation but with the perceived failings of the alternatives. Stories such as that of Ben Silcock, the young man with schizophrenia, who climbed into the lions’ enclosure at London Zoo, encapsulated the themes of contemporary debate into the

⁹ Joyce Appleby, Lynn Hunt and Margaret Jacob, *Telling the Truth about History*, (New York and London: Norton, 1995), p 258 –259.

¹⁰ Appleby, Hunt and Jacob, p 247

¹¹ Appleby, Hunt and Jacob, p265.

¹² Appleby, Hunt and Jacob, p265.

details of one case and exemplified the modern preoccupation with the individual story.¹³

It seemed important, therefore, to find an approach that acknowledged the importance of individual lives and decisions in the interface with the institutions of the age. Foucault's insights tempered with the 'practical realism' of Appleby et al provided a theoretical basis while in practical terms the microhistorical approach advocated by Giovanni Levi seemed to be a way of working which avoided reducing the historian's voice to purely rhetorical activity.¹⁴ While micro history has sometimes been perceived as a collection of techniques rather than a historical perspective, Levi saw it as directed towards

the search for a more realistic description of human behaviour, ...which recognises [man's] relative freedom beyond, though not outside, the constraints of prescriptive and oppressive normative systems. Thus all social action is seen to be the result of constant negotiation, manipulation, choices and decisions in the face of a normative reality, which though pervasive, nevertheless offers many possibilities for personal interpretations and freedoms.¹⁵

This, then, was a way of "acknowledging the limits of knowledge and reason whilst at the same time constructing a historiography capable of organising and explaining the world of the past."¹⁶

By allowing for generalisations from large sets of data in concert with microscopic analysis of individuals, the method addressed several issues apart from the problem of describing vast social structures, without losing sight of the individual's social space. It encompassed social contradictions such as the conflicting values of two normative institutions such as the family and the state and also allowed for the fact that each

¹³ Kathleen Jones, *Asylums and After*, p243, discusses the Silcock case and its implications for the treatment of the mentally ill in a non-institutional setting.

¹⁴ Giovanni Levi, "On Microhistory" in *New Perspectives on Historical Writing*, ed. by Peter Burke, (Cambridge: Polity Press, 1991), pp93-113.

¹⁵ Levi, p94

¹⁶ Levi, p95

individual person experienced a different set of relationships that determined reactions and choices. At the most detailed level it could even include autobiography.

Microhistory has its own limitations. As Brad S. Gregory pointed out,

Historical understanding may be more complete and more nuanced at close range, but it is confined in other ways that derive from the methods employed, the sources available and the restricted scale of the enterprise.¹⁷

Human lives and relationships are complex, multi-faceted and constantly changing. Oral sources, which have become so important in the study of everyday life, are not available for this period. The records available, which for the most part are demographic and bureaucratic, rarely reach into those aspects of people's lives that are most personal. For example, though it might appear through census records that one person lived close to many potentially helpful members of his or her immediate family, we cannot usually know whether they were on speaking terms. However, asylum records may have more chance than many other types of record in providing at least a glimpse into a more personal world because of the interest of their creators in defining the relationship between the normal, the abnormal and the acceptable in personal behaviour.

I have not set out to prove that the larger processes described by people such as Scull, did not exist or have an effect, but to make a contribution towards understanding at a personal and individual level, the interaction between an asylum - the HCA - and the world outside. This research into the HCA and its patients uses a large set of data organised in a database in order to examine a number of problems related to the growth of asylum populations, the operation of admission and discharge policies and the course and outcome of asylum careers. It then makes use of the database to distinguish smaller groups of people for more detailed analysis and finally moves to the level of the individual. It looks outside narratives of progress or social control and towards an understanding of individuals with free will who nevertheless were

¹⁷ Brad S. Gregory, "Is Small Beautiful?" *History and Theory* 38 (1999), 100-111, (p106).

constrained by social norms. We need to understand them on their own terms as well as for what they can contribute to our own perspective on the care of people who are considered to be mentally ill.

2.2 Design of the study

This research was designed to make the fullest possible use of the nineteenth-century records of the HCA in order to explore the three strands discussed in chapter one, the image of the asylum, the nature of its population of patients and the experience of individuals.

The first stage was the construction of a database of all details from the admission registers from 1852 to 1899. This was used to describe the asylum population and compare it to the population of Hampshire. It was also possible to select individual patients who could form the basis of a sample for more specific analysis. The personal information contained in reception orders and casebooks, in administrative records, and in some cases, in census, Poor Law and parish records, was the source material for the exploration of individual experience and family responses. I was occasionally fortunate to encounter family historians who were tracing an ancestor in the records of the HCA and who were willing to share the results of their enquiries with me. The genealogical method began to seem very attractive but the enormous amount of time needed for such research made it impractical to pursue this line of enquiry in more than a very few cases. However, I feel that it is certainly in this direction that micro-history will develop, as computers, the Internet and the sheer enthusiasm of family historians begin to open up previously neglected material.¹⁸

¹⁸ In the context of this research the definition of a family historian is someone researching the history of his or her own family. In many cases this goes far beyond the realm of genealogy and demonstrates a genuine wish to understand the people and the times in which they lived.

2.3 The Database

The database of admission details was compiled using Microsoft™ *Access* and charts and tables were constructed in Microsoft™ *Excel*. The aim was not to create a sophisticated statistical analysis of this data but to establish a means by which aspects of the asylum population could be described and to highlight areas of interest suitable for further study. Chapter four looks at this material in detail.

The database includes almost all the information in the admission registers from December 13th 1852 until December 31st 1899.¹⁹ As far as possible this was entered in the form in which it appeared in the registers, though some modifications were necessary for convenience in manipulating and extracting data. For this reason there are more fields in the database than there are columns in the original documents. Altogether there are thirty fields and 8704 individual entries.²⁰

My earlier study selected three cohorts of two years each, taken from the admissions registers of the HCA at twenty-year intervals. It looked at their social and demographic characteristics as well as the outcome of their admissions in terms of length of stay and the nature of its ending.²¹ However, these early samples only accounted for about twelve percent of total admissions in the nineteenth-century period and concentrated on key periods in the asylum's history. These were, its opening, the point at which it became critically overcrowded in the 1870s and the period immediately after the 1890 Lunacy Act, when Kathleen Jones considers that "legalism" had triumphed at the expense of medical considerations. The HCA was then beginning to deteriorate structurally as a result of its age and overcrowding.

The principles on which this study is based are similar to those described by Anne Digby in her study of 'The Retreat'. In this she aspired to,

¹⁹ Some private admissions were kept in separate registers and have been omitted and the names of some doctors and magistrates were omitted from early entries.

²⁰ The HCA database was built upon an earlier version constructed in 1997, containing about a thousand records.

²¹ S.M. Burt, *A Permanent Expense and a Constant Sorrow: Admissions to the Hampshire County Lunatic Asylum 1852-1899*. Unpublished MA Dissertation. University of Southampton, 1997.

a gain in precision in researching some key issues; an improved ability to conduct a dynamic rather than a static view of an institution; and new insights not easily acquired by more traditional methods of analysis.²²

Digby was interested in the extent to which the population of the Retreat continued to reflect its public image, particularly in view of its changing policies towards payment and religious affiliation. I have tried to understand the dynamic between individual families and the movement of their members in and out of the asylum. This is, in effect, an attempt to see both the wood and the trees. Like Digby, I have used the numbers descriptively rather than statistically. Advances in computing since Digby's study in the 1980s meant that I could handle all the data on a personal computer and readily use flexible sorting and queries making it unnecessary to code the material before analysis, though some coding was helpful. The time required for data inputting was considerable but unavoidable if I wished to be able to follow up complete case histories and small groups of patients.

The patients' records include all the admission and discharge records of every incidence of admission to the asylum. As each Act of Parliament was passed, many clauses were devoted to record keeping to the extent of laying down the form of words to be used at every stage of the process. The layout of these registers remained consistent throughout the period so it is tempting to see the admissions registers as a uniform source and in some respects they are. Their consistency and tabular form lend themselves to database storage and the flexibility of structure of modern database software makes it possible to transfer the information unchanged. However, some changes were necessary to facilitate indexing for the research and it is important to remember that the database is not the equivalent of the admissions register but a translation of it and therefore a source in its own right.

The registers contain both social and medical information. Socially, they give straightforward information such as name, age, sex, marital status and address. They also record the dates of admission and discharge and the date, if any, of the most

²² Digby, Anne, "Quantitative and Qualitative Perspectives on the Asylum," in *Problems and Methods in the History of Medicine*, ed. by, Roy Porter and Andrew Wear, (London: Croom Helm, 1987), 153-172, (p153).

recent previous admission. Occupations are also recorded, but not in every case, especially for women. Other information relates to the patient's physical health and mental condition. They record physical health with varying degrees of detail across the period. There is also a column to record the type of mental disorder and its probable cause. The columns designed to record the progress of the condition before admission contain information about epilepsy and idiocy and the length of time the condition has been present as well as the person's age at the first attack. Finally the outcome is recorded as one of four categories: 'Recovered', 'Relieved', 'Not improved' and 'Died'.

The registers are therefore a reliable source of some demographic data and furthermore they give dates of previous admissions, as well as of discharge and of the classification of the discharge. In terms of medical information and personal details there is considerably less information and it is necessary to look into the case notes to amplify that. They also contain the names of all the doctors and magistrates involved in the admission process.²³ The discharge records are also complete and they duplicate much of the information contained in the admissions registers. The death certificate and post mortem reports are often found here though they are sometimes also to be found in the casebooks.

However, the structured appearance of the registers and their transposition into a database can mask the fact that the categories reflect asylum officers' perception of a person's condition rather than its objective reality. The tables which the Victorians themselves created from such columns as 'probable cause' were confidently presented annually in asylum reports but only very detailed analysis could suggest the extent to which meanings varied over time or from person to person. Neither do we know, in each case, how the meaning written down was influenced by the current orthodoxy of the asylum, the medical profession or even the wider world. It is therefore important to avoid drawing over-precise interpretations from imprecise information and the interpretation of this area remains very subjective.

In the same way, columns such as 'outcome', which used only the four categories of 'Recovered', 'Relieved', 'Not Improved' and 'Died', can appear straightforward but the boundaries between categories apart from death were subject to renegotiation, both

²³ Not all are recorded in the database, however, as the 1997 version did not contain this information.

generally and on a case by case basis. Similarly the main categories used to describe mental condition, 'mania', 'melancholia', 'dementia' and 'idiocy', were used throughout the period, and there is little way of knowing what they might have meant except on a case by case analysis. Therefore they are simple enough to appear to lend themselves readily to quantification while in reality they were sufficiently broad as to refer to types of behaviour only in the most general terms. Nevertheless, bearing all this in mind, they are useful in helping to outline the type of situation that may have existed in a person's home.

In the early years of the twentieth century asylums were changing; progress in the understanding of some neurological conditions such as general paralysis, the growing interest in the influences of heredity, the desire for clearer distinctions between mental deficiency and mental illness and the impact of the psychological effects of modern warfare all played a part. In Hampshire, the practical difficulties of staffing the male wards, caused first by the Boer War (1899-1902) and then by the First World War, and the organisational changes resulting from the construction of a second asylum for Hampshire, signalled the end of half a century of continuity for the HCA. It would have been interesting to have followed the HCA and its patients into this period but it would have added several thousand names to the database and presented difficulties of access to material which is subject to the rules of one hundred year closure. A comparison of the last decade of the nineteenth century at the HCA, with the first two decades of the twentieth would make an interesting future project.

2.4 Use of personal records

The admission registers and statistical records of the HCA provide ample sources for the quantitative analysis of the asylum population but the major questions and themes outlined in the first chapter relate to the interaction among patients, their families and the asylum and its personnel. Roy Porter described past medical events as "complex social rituals, involving family and community as well as sufferers and physicians," and hoped that "A people's history of suffering might restore to the history of medicine,

its human face.”²⁴ In other words he sought a history of medicine from below since in the medical hierarchy, the patient, no matter what his or her social status, is usually at the bottom, as accounts of the illness of George III show only too well.²⁵

Studies of the modern experience of the mental hospital have relied heavily, if not entirely, on oral reports and interviews.²⁶ Although this approach presents difficulties of its own, both ethical and empirical, it gives the voice of the individual sufferer a chance to be heard.²⁷ For this period, 1850 to 1900, the most usual source is documentary, which makes the voice of the pauper lunatic and his or her family much more difficult to hear. It is not impossible to find written descriptions of sickness or madness and articulate sufferers have put down their feelings on paper.²⁸ However, the mostly inarticulate sufferers who found their way into the great county asylums had little chance of expressing themselves in the same way, particularly while they were still resident.

Few historians, however, can call up sources to order and the records of the HCA provide a great deal of information about the patients in the asylum and are almost complete for the period studied. Notable exceptions are the medical journals and the majority of the correspondence on any subject. However, taken together with other existing asylum records, they have the potential to reveal something of the circumstances of the lives of asylum inmates before and during their incarceration. In fact the nineteenth-century records of the HCA provide a rich source of material for both quantitative study and case studies of individuals.

Within the patients' records the information was recorded in three types of document, much of it was duplicated, and the social was mixed quite unselfconsciously with the medical. Furthermore, some of the information recorded might be called ‘concrete’

²⁴ Roy Porter, “The Patient’s View: Doing Medical History from below” *Theory and Society* 14, (1985), 175-198, (pp175 and 194.)

²⁵ Hunter, R., and I. MacAlpine, *George III and the Mad Business*, (London: Allen Lane, The Penguin Press, 1969), pp53-70.

²⁶ See for example, Diana Gittins, *Madness in its place: Narratives of Severalls Hospital 1913-1997*, (London: Routledge, 1998).

²⁷Rebecca Fido and Maggie Potts, “ ‘It’s not true what was written down’ Experiences of Life in a Mental Handicap Institution”, *Oral History* (Autumn 1989), pp 31-34. Jan Walmsley, “Life History Interviews with People with Learning Disabilities”, *Oral History* (Spring 1995), pp71-77.

²⁸ Roy Porter, *A Social History of Madness*, (London: Weidenfeld and Nicolson, 1987), discusses what it is like to be ‘mad’ through the writings of a number of articulate and literate sufferers.

while much was very subjective and some was recorded in such a way as to make it appear objective, when it was, in fact the opposite.

2.4.1 Reception Orders

The document that accompanied the patient into the asylum was the reception order, signed by a magistrate or by a relieving officer and local clergyman. The second page of the order consisted of the medical certificate, signed by a local physician or by a Poor Law medical officer. The reception order, more than any other document, can offer useful insights into the role of the family. It identified the person authorising the removal to an asylum and gave information about the patient's previous place of residence. The occupation of the signing relative was often given and the inclusion of both the abode and the responsible Poor Law union is a useful way of linking information in these records with other records such as those of the Census or the workhouse. The importance of the reception order for this research, however, is in the section that asked for the facts of insanity as communicated to the medical officer. As the period progressed more and more of this information was transferred into the casebooks but it was often summarised rather than copied and in the process the verbatim reports, sometimes recorded, were obscured.

This constitutes almost the only information we have which can be considered to be directly from the family or friend of the inmate and as such is very valuable.²⁹ It is, however, important not to lose sight of the possibility of a hidden agenda on the part of the family. They might for example wish to conceal evidence of domestic trouble, particularly if violence or sexual abuse was involved. They were unlikely, for obvious reasons, to wish to ascribe insanity to heredity. David Wright has pointed out the usefulness of the statement in assessing the relationship between lay and medical testimony, juxtaposed as this section is with the comments of the medical officer,³⁰

²⁹ Because of the similarity, at first glance, to the information in the casebooks these documents may not appear valuable and they were very nearly lost early in 2000, for this reason. Fortunately they have now been catalogued at the Hampshire Record Office. An example is included in Appendix 2.

³⁰ David Wright, "Getting out of the asylum: Understanding the Confinement of the Insane in the Nineteenth Century", *Social History of Medicine* 10, (1997), 137-155, (p148).

2.4.2 Casebooks

The casebooks duplicated some of the information in the admissions registers and reception orders but statements were not always accurately or completely transferred. The case continuation notes varied in frequency and quality, particularly after about a year. They rarely detailed any treatment offered although prescription drugs were usually noted. As Jonathan Andrews has said, case notes were not designed to give the historian complete access to the patient's interaction with the asylum, but as a legal requirement and as clinical aids for those managing the patient on a daily basis. Moreover, they were not designed simply for internal readers but as a protection against possible accusations of ill treatment or wrongful confinement. The notes, as completed during the patient's residence in the HCA, therefore tended to convey more about the asylum's preoccupations than about the patients and their histories.³¹ However, they also often contained information obtained from family members and sometimes charted the involvement of 'friends' in the discharge process.³²

2.5 Administrative records

Individual patients sometimes feature in the administrative records of the asylum and the reports of the Commissioners in Lunacy.

2.5.1 Asylum Reports

The public face of the asylum was displayed in its annual reports. As a report from a committee of Justices of the Peace to the larger body of Justices sitting in Quarter Session, these had a two-fold purpose. They gave an idea of what appeared important to managers and managing staff, conveying the reassuring continuation of the status quo and providing an appropriately courteous vehicle for any strong opinions that needed public airing. Typical of such concerns were the constant problems of overcrowding and the misunderstanding of lay officials and Poor Law medical officers about what constituted a suitable case for asylum treatment. Indirectly they offer

³¹ Jonathon Andrews, "Case Notes, Case Histories, and the Patient's Experience of Insanity at Garnavel Royal Asylum, Glasgow in the Nineteenth Century," *Social History of Medicine* 11 (2), 1998, 255-281, (p266).

³² The term 'friends' was used to describe anyone closely associated with the patient especially in the admission and discharge procedure. It most often refers to family members.

insight into family perceptions of what constituted a fit case for asylum treatment. Though the Poor Law medical officers signed the medical certificates, they were usually responding to a request from the family or workhouse officer responsible and as such a lay opinion about the definition of insanity was being processed through them.

In the early years the second medical superintendent, Dr John Manley, also occasionally used these reports to educate readers in the difficulties of defining and treating insanity. But, increasingly during the tenure of the third superintendent, Dr Thomas Worthington, these reports dealt with the fabric of the building, the problems of drainage and disease, the cost of administration and the maintenance of good order among staff and inmates. These were endless and, in a sense, comfortable issues, with which lay administrators could get to grips and which the Justices and later the county council could understand. Individual cases were occasionally mentioned, although usually only when there had been an unusual incident or death, and they were sometimes described in more detail here than elsewhere. In those cases there is usually enough information to trace the individual in the patients' records, though they would have remained anonymous to contemporaries. By ensuring the good order of the establishment the asylum was conforming to the 'normal' standards of the world outside, thus neutralising some of the strangeness of the asylum and establishing a place for it within the structured social world of the Victorians. The recipients of the reports, who included all the Justices, were able to engage with the asylum in a way which prevented their having to confront, except in the occasional unavoidable case, the problem of insanity or its consequences.

As a source the reports also provide names of the local men involved in the asylum's administration, and detailed tables of statistics and financial accounts. For a historian the accounts are a way of understanding the economic life of the asylum as well as helping to paint a picture of daily life by demonstrating the relative importance of different items. The statistical tables were presented with a minimum of analysis, and subjective data, such as diagnostic categories or causes of mental condition, were presented on equal terms with purely numerical data.

2.5.2 Minute Books

The members of the Visiting Committee had to be involved with the asylum at a deeper level than other Justices and their minute books show the process of management on a weekly basis. The issues considered worthy of inclusion in the minutes were increasingly associated with finance, building, public health and the public image of the asylum. Although the committee had to confirm all patient discharges there are few examples of their going ahead with a discharge against the advice of the medical superintendent. The minute books are almost the only source of information about staff at the asylum, who tend to be the forgotten element in asylum studies.³³ Decisions about appointments and dismissals as well as discipline and rewards were taken at these meetings, though appointments for senior posts appear to have taken place in London. The earlier journals contain more personal information about individuals than the later ones and more than the asylum reports but it is important to remember that even in these relatively private records a major concern was to present the establishment in the best possible light.

2.5.3 Reports of the Commissioners in Lunacy

The Commissioners in Lunacy visited annually and without warning. They stayed for two days, looked in every corner, supposedly gave patients the chance of speaking to them and sampled the food. Their reports were reproduced in an appendix to the annual reports to the Lord Chancellor and these reports often contain other references to events at the HCA. Their reports were brief, appear to have been compiled on the spot, usually being written directly into the Visitors' minute book and they dealt with the humdrum details of asylum administration.³⁴ The patients, apparently rarely complained of ill treatment, only of wrongful confinement and the commissioners always referred them to the visiting committee. The food was sometimes criticised and the day to day running of the wards was sometimes altered as a result of the reports but usually the emphasis was on the material rather than the mental welfare of the patients.

³³ There are almost no records associated solely with staff during this period apart from a couple of rulebooks and sporadic references in minute books and asylum reports.

³⁴ Annual reports of the Commissioners in Lunacy to the Lord Chancellor 1845 –1900.

However, strong recommendations about the general structure and administration of the asylum were sometimes made and the Commissioners were tenacious in not letting their pet issues drop. For many years, for example, they recommended the construction of pathology laboratories at Knowle, without success. These politely worded tussles are an illustration of the strong local influences in the management of the HCA. The strategy of the asylum managers appeared to be to capitulate on issues which were easily resolved while holding out when the suggestions were too expensive or not in their personal list of priorities. The commissioners eventually had their way over the construction of a new water supply in the late 1880s, but only after several years of fatalities from typhoid.³⁵

2.6 Case studies

Altogether over three hundred documents relating to one hundred and fifty individual cases were transcribed and examined. It should be noted here that these individuals were not selected because they were representative of the wider population of the HCA described in the database analysis. Because of my strong interest in the lives and circumstances of the individuals for whom the HCA became a part of life, I selected documents for the possibilities they represented for study over a period of time, or for the detail offered, or because of the possibility of using the extended research carried out either by myself or my genealogical contacts. Thirty-one individuals were selected through the database because each had been admitted to the asylum on five or more occasions. Others were the ancestors of the family historians contacted through the Hampshire Record Office (HRO) and the Hampshire Genealogical Society. Others, such as those defined as 'idiotic' or senile were chosen because their age or condition related to some of the findings of the database. The most serendipitous selections were those case notes containing unusual or additional material. In this group it was necessary to acknowledge that the additional material might mean that particularly unusual cases were being considered, which might have little to say about the experience of most people admitted to the HCA. However, such cases were very few and the main benefit to the research was that the unusual events surrounding the

³⁵ Annual reports of the Hampshire County Lunatic Asylum 1889 and 1890.

admission of individuals such as the Alfred and Lissette Stockwell, and Henry Orchard tended to lead to the inclusion of detailed notes about home circumstances and events which were really very similar to those of other patients admitted. These were, it seems, ordinary people who were involved in, or witnesses to, extraordinary events. Furthermore the more family details that were included on admission the more likely it was that it would be possible to trace individuals after their discharge or their families during their residence at Knowle.

The resulting sample contained a larger proportion of women than men among the individuals selected and particularly as a proportion of the total number of incidences of admission in the sample. It also contained a larger proportion of children than the whole asylum population (9.9% as opposed to just under 2% of all HCA admissions), and a slightly smaller proportion of the elderly (7.8% as opposed to 10.4% of HCA admissions).

Chapters five and six use this material to consider how the more subjective categories on the patients' documents can help us to understand the circumstances under which individuals were admitted to the HCA. Census material has been used to follow some of the patients and the families outside the asylum. Personal correspondence gives fleeting insights into the lives and attitudes of those who were most concerned with individuals admitted to Knowle. Chapter seven looks at the responses of households and families. The thesis thus travels from the general to the specific, from the construction and analysis of a population through the HCA database to the analysis of individual lives.

Chapter 3

The HCA in Perspective

Mid-nineteenth-century legislation made it compulsory for counties to build and maintain pauper lunatic asylums but it was not compulsory to send all cases of lunacy for asylum treatment. A decision had to be made and a number of options ranging from inaction to certification continued to be available. The background to the establishment of the HCA and the context in which it operated are important in social, geographical and ideological terms. Socially it needs to be seen in the context of the rural and agricultural society of nineteenth-century Hampshire. Geographically its location, in the south-east corner of one of the most southerly counties, presented difficulties to be overcome by individuals and Poor Law unions wishing to send patients there. It also places it outside the urban and industrial framework of some earlier studies and makes it different from the more isolated situation of the south-west peninsula. Ideologically the HCA needs to be seen in terms of both the Poor Law, which had such an impact on the rural workforce and the ideals and aspirations of the rapidly changing medical environment at the time.

3.1 Hampshire

Hampshire was the eighth largest county in England and Wales during this period and was almost entirely agricultural.¹ Kelly's Directory of 1855 noted that there was a good yield of grain, in spite of average soil; there were sheep grazing on the chalk downs; the local hogs produced good quality bacon. There were no important manufactures though it remarked that the dockyards in Southampton and Portsmouth, "bring in a good deal of employment".² At the end of the period not much had changed. The Victoria County History, published in 1912, recorded that

¹ Official documents and reports at this time refer also to Southamptonshire or the County of Southampton.

² *Post Office Directory of Hampshire*, (London: Kelly and Co, 1855).

of works employing any considerable number of hands there are only the factories at Portsmouth and Gosport in connexion with the Royal Navy, and the docks and shipping trade of Southampton. With these exceptions Hampshire is almost entirely an agricultural county.³

Between 1851 and 1900 the populations of Southampton and Portsmouth had almost trebled and Bournemouth had been transformed from a group of seaside villages to a thriving town. The population of the Christchurch district, which included Bournemouth, increased eightfold in this period.⁴ The Isle of Wight had become a county in its own right. However, various complicated financial and contractual arrangements with the coastal boroughs meant that most of the patients at the HCA continued to be drawn from the villages and market towns of the rural communities located everywhere from the fishing areas near the Sussex border to the New Forest in the west and the chalk downs in the north. The fact that the HCA was located in the extreme south-east of the county meant that many visiting relatives of those admitted saw more of their native county than they ever had before.

The railway guides, which opened up Hampshire for the traveller, found human contributions to the county landscape, in the form of industry, churches and great houses, of more interest than the natural face of the countryside, but north Hampshire's "low wooded hills, green meadows and open chalk downs" were considered preferable to "that flat and dreary coast district" around Emsworth and to the "mean dirty towns" of Portsmouth and Portsea.⁵

Scattered about this gentle countryside, agricultural labourers and their families continued to live and work much as they had done for centuries though the framework within which they were employed was changing. Before 1834 the system of relief under the Old Poor Law was informally built into the year's employment pattern. Workers could be employed when they were needed and, within some

³ William Page, ed. *Victoria County History of Hampshire* Vol. 5, (London: Constable, 1912), p409.

⁴ Results and Observations on the Census of England and Wales, 1901, (London: HMSO, 1902).

⁵ *Murray's Handbook for Travellers in Surrey, Hampshire and the Isle of Wight*. (London: John Murray, 1858), pp143, 141 and 216.

geographical limits, where they were needed. When work was short, poor relief could be sought without great stigma, until a new season brought new work. The New Poor Law, with its emphasis on the relieving officer and the workhouse made short-term relief more difficult to claim, especially for the able bodied, and “created conditions of dependence in which precarious employment at low wages had to be accepted”.⁶ From a heyday in 1851, when two million people in Britain were employed on the land, agriculture, especially in the southern counties, was moving into and through a period of depression.⁷

Riding through Hampshire in the 1820s William Cobbett had warned that the downtrodden state of the agricultural worker would eventually lead to direct political action.⁸ The Swing Riots of 1830-31 seemed to prove his point. However, half a century later it seemed that little had changed. In the 1860s and 1870s Dr Joseph Stevens, medical officer at St Mary Bourne, was doing his best to alleviate the effects of rural poverty while disapproving of the direct political action some of his patients had chosen to take.⁹

Government reports into rural diets and accommodation showed deficiencies in both. In the parliamentary report of 1858 John Simon wrote that “privation still exists as a cause of premature death [and] diseases from insufficient nourishment form a very considerable part”.¹⁰ In 1869 Wyndham Portal of the Hampshire Chamber of Commerce and also a member of the visiting committee of the HCA wrote,

⁶ K.D.M. Snell, *Annals of the Labouring Poor: Social Change and Agrarian England, 1660-1900*, (Cambridge: Cambridge University Press, 1985), p119-124.

⁷ W.A. Armstrong, “The Countryside” in *The Cambridge Social History of Britain 1750-1950*, ed. by F.M.L. Thompson, Vol. 1, Regions and Communities, (Cambridge: Cambridge University Press, 1990), 87-153, (p113).

⁸ William Cobbett, *Rural Rides*, (London: Penguin Classics, 1985), p266-7.

⁹ Joseph Stevens, *The farm labourer, at home and in the field*, (London: Wyman and Sons, 1874), p5.

¹⁰ Papers relative to the sanitary state of the people of England and Wales. PP XXIII p 267, quoted in John D.G. Isherwood, *Pigsties and Privies*, unpublished MA thesis, University of Oxford, 1997, p20.

The want of accommodation for the poor has been their biggest drawback.... Dampness, cleanliness, want of means for storing and preserving food or clothing, insufficient sewerage and 'necessary accommodation', entire ignorance on sanitary subjects – these are all immediate causes of loss and hardship.¹¹

Such reports inevitably focus attention on the most problematic cases and there were many families in Hampshire's towns and villages who lived in better conditions than these. Stevens, in fact, thought that the Hampshire labourer's diet was adequate, if monotonous,¹² and many Hampshire landowners made it their business to improve the quality of accommodation for their workers for both sanitary and moral reasons.¹³ However, this was the group of people from whom the greater proportion of the HCA's patients was drawn. In such conditions the family group had to be strong and co-operative to survive.

3.2 The rural family

In general terms the rural families of Hampshire in this period formed nuclear households though they were different from the nuclear households we recognise today. Size and composition might change more rapidly and more often. There would usually have been more children than in a modern household and they would have remained in residence for a shorter period of time. Older children would have been leaving home to seek work when the youngest members of the family were still in infancy. The family's prosperity rested upon the number of members of the household, their ages, their ability to work and their state of health. If the balance of those factors became unfavourable at any time they might suddenly find themselves unable to support each other.

¹¹ G.E. Brickell, *The North-West Hants Agricultural Labourer, 1867-75* quoted in Isherwood, p26.

¹² Isherwood, p21.

¹³ Page, p510.

However, the fact that households did not usually contain extended family groups does not mean that the unit always stood alone.¹⁴ Anderson may have considered that, in industrialising areas of Lancashire in the mid-nineteenth century, kin rather than neighbours offered aid with “short-run overtones of a calculative kind”, but Elizabeth Roberts, who researched the same area in a later time period, concluded that neighbours were as likely to provide a source of support as relatives.¹⁵ In the small rural communities of Hampshire, some of which had only tens or hundreds of inhabitants, and where many people were interrelated, it seems likely that few families or individuals would have been completely unable to call upon the assistance of relatives or neighbours. Both groups appear as family supporters in the records of the HCA. Nevertheless, as everyone was in the same situation, help might necessarily be offered on a contingent, short term or reciprocal basis. Under the Old Poor Law occasional poor relief could also be part of the support system but under the new arrangements, after 1834, this was likely to be experienced in this casual way by fewer families.

In economic terms the working class family, of which the rural family of this period was a subset, was always precariously balanced just ahead of the point of collapse. The idea of a family wage began to dominate middle-class ideology in this period but the reality for working class families was that several wages were needed to sustain any but the smallest family group.¹⁶ Snell has suggested that a son or daughter in service would have found it harder in this period than earlier to save a little towards his or her own marriage. Low wages and insecurity had the perverse effect of encouraging earlier marriage because the only way of young people finding somewhere of their own to live was to be married.¹⁷ Hampshire women still worked in the fields in the late nineteenth century, though less often than in the past, but increasingly, in both urban and rural areas the importance of women's economic contribution lay in managing the house and children as well as the household budget.¹⁸

¹⁴ Barry Reay, *Microhistories: demography, society and culture in rural England, 1800-1930*, (Cambridge: Cambridge University Press, 1996), pp156-175.

¹⁵ Michael Anderson, *Family Structure in Nineteenth-Century Lancashire*, (Cambridge: Cambridge University Press, 1971), p171. Roberts, Elizabeth, *A woman's place*, (Oxford, Blackwell, 1984), pp183-187.

¹⁶ Diana Gittins, *The Family in Question*, (London: Macmillan, 1985), pp27-28.

¹⁷ Snell, pp246-248.

¹⁸ Snell, p357. Roberts, p125.

These, then, were the communities and families from which many of the patients of the HCA were drawn. The myth of rural stability and tranquillity masked hard lives and constant struggle. If any crucial member of the family became a candidate for asylum admission the situation at home would have been an important factor but the image and status of the HCA itself may also have influenced the decision.

3.3 The Hampshire County Asylum

As far as the asylum itself was concerned the official line was that this was a medical establishment dedicated to “soothe, alleviate and cure the sufferings and mental diseases of those unfortunate individuals who crave our warmest sympathies and also promote their early recovery.”¹⁹ The medical superintendents and managers of the HCA continued to stress this throughout the period. But treatment in an asylum lay at the end of a series of formal procedures which were carried through by the officers of the Poor Law and the final authorisation of admission, by a Justice of the Peace, was a legal process and not a medical one.

The formal relationship between all these aspects is best summed up in the combination of signatures required on each reception order. The doctor's signature was compulsory and the relieving officer also signed the form. The legal process was completed by the additional signature of a Justice of the Peace or, less frequently, a local clergyman. Between them they represented the humane medical institution, the community, which was morally and financially responsible for the upkeep of the patient, and the authority of the law and its execution within the locality. The formal consent of the patient and his or her family was not required but their input is represented on the documents of admission by their statements about the patients' health and behaviour.

County asylums therefore can be seen as part of a nationally supervised network of asylums covering much of the United Kingdom, and also as local institutions responding to local needs and local people. They could be seen as branches of an

¹⁹ Visitor's annual report to Quarter Sessions 1856.

increasingly repressive and stigmatising poor law or as medical institutions with a humane ideology and good intentions, which were parts of the development of the idea of hospitals as the main site of medical intervention. The tensions implicit in these relationships make it necessary to consider how the HCA was accommodated within this framework. It had to meet the demands of its administrators and the needs of its patients and their families while living up to the ideals of the reformers who framed the legislation and whose representatives supervised its implementation.

Pre-eighteenth century asylums were religious or charitable foundations while the private madhouse as an entrepreneurial endeavour is located in the eighteenth century, at the end of which the public profile of mad-houses and mad-doctoring was raised by the widely discussed madness of George III and his treatment by the Willises. One reaction to the 'trade in lunacy', which was initially most concerned with those who could afford to pay and only later catered for pauper lunatics, was the development of legislation to protect the financial interests of the confined, as well as a system of licensing and an embryonic inspectorate to address abuses of power.²⁰ The increasing tendency for Poor Law unions to contract with private madhouses for the care of their pauper lunatics ensured that this group eventually came under the gaze of the inspectors from the Lunacy Commission. After the Act of 1774 made it a legal requirement that private asylums should be licensed by Justices sitting in Quarter Sessions the order books of the Hampshire Quarter Sessions record a growing number of licences being sought for the care of Hampshire's pauper lunatics, as well as a growth in the capacity of some individual establishments.²¹

In Hampshire, from 1811 onwards, discussion of the possibility of establishing a county asylum in accordance with the County Asylums Act of 1808²² cropped up from time to time and after a costing and consultative exercise in 1814 the first serious attempt to get the project under way started in 1815. That year's discussions and the eventual rejection of the scheme the following year, after the presentation of a petition signed by local ratepayers, reflect the difficulties of reconciling state policy with local interests.²³

²⁰ Kathleen Jones, *Asylums and After*, (London: Athlone, 1993), p60-77.

²¹ Act for Regulating Private Madhouses, 1774, 14Geo III c 9.

²² 48Geo III c 96.

²³ Minutes of a Committee to consider the building of a lunatic asylum 1811-1816. Quarter Sessions Order Books, 1810 – 1816. Hampshire Chronicle, January 2nd and 16th 1815 and January 17th 1816.

Those who voted for the asylum included Lords Cavan and Carnavon, William Sturges-Bourne, MP and George Rose MP all of whom would have been in a position to follow the passage of lunacy legislation through parliament as well as having an understanding of it in the wider context of the Poor Law and the vagrancy laws. William Sturges-Bourne gave his name to the Act of Parliament of 1819 that prefigured the Poor Law legislation of 1834 by providing for a fixed committee of local ratepayers to administer poor relief, as well as for paid assistance for the voluntary overseer. He later served briefly in the cabinet in 1827 as Home Secretary²⁴ Those who voted against were local knights and gentlemen who may have been swayed by local financial considerations as well as popular fears about wrongful confinement. The petition referred not only to the financial burden in addition to that of the new prison but to the fear that “persons are forcibly dragged from their relatives and connections to what...could only be considered in the light of a gaol.”²⁵ However, this does not seem to have been a line of argument which was pursued beyond this debate and the asylum sector expanded over the following thirty years although Hampshire Justices had missed that opportunity to take the supervision of the insane into their own hands.

Not only did Hampshire’s asylums then grow in number but also in size. In 1774 Daniel Hinchin was granted a licence for his madhouse in Basingstoke, and by 1840 there were at least six licensed premises in the county with places for up to 300 pauper lunatics. Grove Place at Nursling, near Southampton, was a family business continuously from 1813 to 1855, reaching a peak of 100 patients by 1850. Its increasing financial difficulties as more and more County patients were transferred to Knowle, leaving only those from the Borough of Southampton, as well as the continuing critical reports of the Commissioners in Lunacy, finally guaranteed that the Justices would not renew the licence. However, none of the local establishments could

²⁴ Norman McCord, *British History 1815-1906* (Oxford: Oxford University Press, 1991), p74. Chris Cook, *Companion to Britain in the Nineteenth Century*, (London and New York: Longman, 1999), p33.

²⁵ Hampshire Chronicle January 17th 1815.

compete with Fisherton House in Salisbury, Wiltshire, which was used by Hampshire Poor Law unions even after the building at Knowle was completed.²⁶

John Twynam, at Lainston, had an expanding establishment during the same period and by 1843 was licensed for 80 paupers and 12 private patients.²⁷ His outburst against the critical report of the Metropolitan Commissioners who inspected his premises in 1844 is therefore hardly surprising in view of the threat it posed to his business. He suggested that it was couched in such critical terms in order to promote the acceptance of the 1845 lunacy legislation,

[M]ine has been a practical life, spent among these unfortunate cases, and in the daily habit of watching and alleviating their afflictions; while my Lord Ashley's had been only a brief acquaintance with the Lunacy Commission and a set speech or two addressed to the feelings of the members of the House of Commons, for the purpose of inducing them to urge the Magistrates of large Counties to adopt his favourite plan of creating large County establishments, whether their finances will admit of it or not.²⁸

This outburst was probably motivated by self-interest but Twynam was making an important point. The publicly-funded asylum was an expensive option. It cost three times as much to keep a pauper in any kind of asylum as in a workhouse and the local Poor Law unions would have to bear the cost. The building of county asylums also represented a large capital outlay which had to be supported by local ratepayers. Institutional solutions were popular, it seemed, and there appeared to be a place in an institution in Hampshire for any lunatic who needed it but the institutions already existing emphasised containment and punishment rather than cure and lunatics were to be found in workhouses, bridewells, prisons and private asylums. In 1846 this number was estimated at 300 though more than half as many again were lodged in other places.

²⁶ Fisherton House had the capacity to cope with violent and criminal lunatics especially before Broadmoor was opened in 1863. It also took private patients and those who could not be admitted to County Asylums because their borough did not have a contract to send them. In Hampshire this applied at various times to Southampton, Portsmouth, Winchester and Andover.

²⁷ HRO Q1/30-41 Quarter Sessions Order Books 1814-1847.

²⁸ John Twynam M.D. *A statement of the condition of lunatic paupers in the County of Hants*. 1844.

In 1816, having paid for a new gaol in Winchester, the ratepayers were not prepared to find a possible £20,000 to build an asylum. In 1845, when legislation meant that they no longer had a choice, they sanctioned the borrowing of £50,000 to build at Knowle and the controversy was transferred to the selection of a location. It was to be seven years before the completed asylum opened its doors. There were delays related to the mechanics of purchase of land and construction of buildings as well as to some public debate. A site at Catisfield was rejected, ostensibly because of problems with a river but possibly as a result of pressure from some locals. A petition from Catisfield businessmen called for its reinstatement as more convenient for all concerned and rejected “any selfish remonstrance coming from parties who seem to have terrified themselves with phantoms of their own affrighted imaginations”.²⁹ This and the earlier comment are isolated statements but they demonstrate a shift of interest among those with power, from the rights of the individual patient to the safety of the community, which is sometimes reflected in decisions to certify individuals during this period. It seems likely that some local people found it hard to reconcile a belief in the need for an asylum with the possibility of finding one on their doorstep. Eventually the more distant site at Knowle was selected and the tradesmen of Wickham rather than Catisfield and Titchfield benefited from its proximity.

Obviously local people were not complacent about the perceived risks of having a large psychiatric institution nearby but in the end the response appears to have been pragmatic. It was compulsory to build by now, of course. By 1845 the idea of institutional responses to a variety of situations including poverty, was much better established than it had been in the early days of lunacy legislation, and the benefits of the contracts for provisions which would be required at such a large establishment were presumably not lost on local traders. Asylum accounts show a healthy trade between the asylum and local dealers. At the same time it should be noted that a substantial period was allowed to pass between the setting up of a committee to look into the matter, in 1844, just before the compulsory legislation, and the moment when building work could begin in 1850. This may reflect the difficulty of reconciling humanitarian ideals with practicalities of finance and construction.

²⁹ PRO. M83/96

Whatever the underlying factors, the committee formed in 1846 took its job very seriously and wished to set up the Hampshire asylum, as far as possible, according to best practice. The site at Knowle, in the countryside but near a town, had all the recommended characteristics. It was on a hill, had a good water supply, and had a farm and enough land and forest to become virtually self-sufficient. The location would be uplifting though the architecture would not be ostentatious and it would be both healthy and a good economic proposition. The description in the report of 1849 could have been an advertisement for a very desirable residence, situated as it was on,

a table land of about forty acres, raised about one hundred feet above the stream, which forms a boundary of the estate towards the west, allowing a southern aspect and a magnificent view to the coast, the Solent and the Isle of Wight.³⁰

At four hundred beds the asylum at Knowle was far bigger than the two hundred and fifty considered appropriate for the application of moral therapy, which rested on the relationship between medical officer and patient, but acknowledging this would have meant building several asylums so, from the beginning, practical and therapeutic considerations found themselves in a precarious balance.

3.4 The County Asylum and the Poor Law

Evidence of an ‘unsound mind’ was a necessary but not a sufficient qualification for admission to a County Asylum. The other qualification was poverty. At various times in the nineteenth century the HCA admitted fee-paying patients but they constituted no more than a handful at any one time and their presence was subject to the changing opinions of legislators and the exigencies of space. When the asylum population was nearing capacity they were given notice to leave. Though their fees were higher than

³⁰ Report of the Committee for building a lunatic asylum, Midsummer 1849. The inhabitants of the new Knowle village, currently under construction in and around the 19th century asylum, have reason to be grateful for their consideration.

those of pauper patients the small numbers in the HCA meant that they never made a significant contribution to the asylum's income.³¹

Most patients at Knowle, therefore, were supported by poor relief and the formal part of the journey to the Asylum began with a visit from the relieving officer. County asylums were not included in Poor Law legislation and the local officers and national commissioners of the Poor Law had no official say in the appointment of asylum staff or the management of the institution. However, though the county asylum was not technically a Poor Law institution it was necessarily in a relationship with the both the institutions and the administrative personnel and apparatus of the Poor Law. Lunacy legislation was designed to deal with a sizeable minority of individuals who had previously been the responsibility of Poor Law officials and institutions. Those now eligible for admission to asylums remained the responsibility of the guardians and many others were retained in workhouses or supported at home by means of outdoor relief payments. It is these aspects which led Peter Bartlett to argue that county asylums had more in common with Poor Law institutions than with private asylums or charitable hospitals.³² In administrative terms this may have been the case but the asylums did not see themselves in this light and aspired to be considered as hospitals.

Though there is a strong Poor Law connection, one of the difficulties of defining a place for the county asylum within the local operation of the Poor Law is that its medical services were, in themselves, a problematic part of the system. Historians have contrasted the considerable variety of medical services available under the auspices of the Old Poor Law with the more uniform but less flexible system in place after the 1834 Poor Law Amendment Act.³³ Ruth Hodgkinson has noted the absence of any recommendations, in the 1834 Act or in any subsequent legislation, for the institution of a medical service subject to the same sort of national conditions as the

³¹ In any case, they tended to represent a class of people who were socially only just above the pauper admitted. The private patients whose property and rights the law defended were more likely to be boarded out or placed in a private asylum where they were more at risk of a permanent loss of liberty. Bartlett identifies two strands of law, dealing separately with private and pauper patients. Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England*, (London: Leicester University Press, 1999), and p9.

³² Bartlett, *The Poor Law of Lunacy*, p2

³³ Anne Digby, *Making a Medical Living*, (Cambridge: Cambridge University Press, 1994), p224. Hilary Marland, *Medicine and Society in Wakefield and Huddersfield, 1780-1870*, (Cambridge: Cambridge University Press, 1987), p372.

administration of the Poor Law.³⁴ Medical treatment therefore continued to be allocated on an ad hoc basis, with the relieving officer acting as intermediary between the patient and the medical officer.³⁵ Local guardians had considerable discretion in all aspects of medical relief, from the definition of 'medical destitution' to the sanctioning of medical 'extras'.³⁶ Anne Digby described Poor Law doctors as gatekeepers using their judgement "within the grey area between medical treatment and economic need".³⁷ In spite of representations from Poor Law medical officers, who frequently felt undermined by the relieving officer's intervention, the response of the legislators was to try to improve on the details rather than to effect a fundamental change to the arrangements.³⁸

This local discretion meant that the sick and poor could expect varying degrees of treatment depending on the attitudes of the local guardians as put into practice by the relieving officer. Hodgkinson argued that, until the 1870s, the involvement of the relieving officer meant that the principle of less eligibility was applied to some recipients of medical relief and that treatment was sometimes withheld when families would not co-operate. And even after that,

Though the sick came to be regarded as the special and unfortunate class of poor, and though increased leniency was shown towards them, they were by no means treated with exceptional kindness and often experienced great difficulty getting medical aid.³⁹

In many cases it was illness that pushed a family over the edge into destitution and the acceptance of poor relief, even for medical reasons, made them not just poor, but also paupers, who forfeited any civil rights they might have. Londoners found some separation of medical help and less eligibility after the Metropolitan Poor Act of 1867

³⁴ Ruth G. Hodgkinson, *The Origins of the National Health Service*, (London: Wellcome Historical Library, 1967), p3.

³⁵ Hodgkinson, p19.

³⁶ Hodgkinson, p275.

³⁷ Anne Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford: Oxford University Press, 1999), p250.

³⁸ Digby, *The Evolution of British General Practice*, p63.

³⁹ Digby, *The Evolution of British General Practice*, p269-274.

but not until after the Medical Relief (Disqualifications Removal) Act of 1885 could the granting of such assistance be allowed without resulting in disenfranchisement.⁴⁰

With regard to lunatics, relieving officers and medical officers had a similar responsibility as they had for the sick, and initially the same procedures had to be followed. The relieving officer made the decision about whether to call the doctor who would then suggest an appropriate course of action. This could involve treatment at home or in a workhouse infirmary, or it could necessitate removal to an asylum. The HCA records suggest that they frequently tried both of the former courses of action before deciding on the latter. Once an asylum admission was declared necessary the appropriate paperwork was presented to a local magistrate and with his signature the admission could take place.⁴¹

However, by concentrating on the formal processes of admission to the asylum there is a danger of ignoring the part played by patients' families. Research into the local operation of the Poor Law has highlighted the ways in which individuals and their families, far from being passive recipients of whatever was offered, were willing to use the system when necessary and were prepared to reject poor relief when offered on terms they disliked. Lynn Hollen Lees emphasised that, "welfare aid under the Poor Laws came as a result of application and negotiation in which the destitute took an active part."⁴² This was true even of medical relief, where there were examples of families refusing to send children to the workhouse even though their own medical treatment was conditional upon it.⁴³ In cases of mental illness the same freedom to send for help or not was available to families. The difference was that once the relieving officer and the doctor had decided that admission to the asylum was necessary the family was not in a position to refuse. It would have been essential for families to consider the possibility of such an admission before they requested official help and they might even have seen that as the desired outcome.

⁴⁰ David Englander, *Poverty and Poor Law Reform in 19th Century Britain, 1834-1914*, (London, Longman, 1998), p25.

⁴¹ The admission could also be authorised by the joint signatures of the relieving officer and the local clergyman but this happened less frequently as the century progressed.

⁴² Lynn Hollen Lees, *The Solidarities of Strangers: The English Poor Laws and the People, 1700-1948*, (Cambridge: Cambridge University Press, 1998), p39.

⁴³ Hodgkinson, p289.

So to what extent did the image the asylum projected, both deliberately and accidentally, influence the decision to use its services? One important consideration is the extent to which individuals assigned different status to asylums and workhouses. However closely the local asylum and the officers of the Poor Law were involved with each other at the admission stage the legislation that encouraged and later compelled the construction of county asylums was separate from Poor Law legislation and the institution to which patients were sent was not a Poor Law institution. Once someone was admitted as a patient the responsible union had only to pay for his or her upkeep and check on their well being from time to time. Though lunacy legislation, like the New Poor Law grew out of the vagrancy laws of the eighteenth century Kathleen Jones looked back to the seventeenth century Poor Law and the establishment of St Peter's workhouse in Bristol for the principles with which it was underpinned. These were firstly, that the care of the insane should be a public responsibility, secondly that they should be accommodated separately and finally, that they should be offered treatment and not punishment.⁴⁴

Peter Bartlett's discussion of lunacy law in relation to the Poor Law developed this idea of the influence of pre-1834 poor relief ideals and practices. He concluded that the permissive legislation of the first third of the nineteenth century was developed within the framework of the old Poor Law, which was still administered in a paternalistic way by Justices of the Peace, within local communities. It was this group of people who were charged with the construction and management of the new county asylums and their responsibility was restated in the mid-century Lunatics and County Asylums Acts which came into force after the New Poor Law had centralised its regulations nationally and formalised its officials and procedures locally.⁴⁵

Much blurring of boundaries between the Poor Law and the law of lunacy was caused by the involvement of the workhouse as a receptacle for lunatics, either as an interim or an alternative measure. Some workhouses had infirmaries to which individuals might be sent, in the hope that their condition was temporary. Or having been deemed incapable of looking after themselves they could be cared for as long as they were not

⁴⁴ Jones, *Asylums and After*, p 11.

⁴⁵ Bartlett, *The Poor Law of Lunacy*, p 92.

dangerous to themselves or others. Using these criteria many individuals suffering senile dementia or with a mental handicap found themselves in workhouse wards.

This overlapping of institutions resulted in an overlapping of territories, which was at the root of many of the tensions between the county asylum and the operation of the Poor Law. Their ambiguous and occasionally strained relationship is epitomised in the mutual rights of inspection. Poor Law officials could visit the local asylum to inspect the conditions under which their people were being held and the Commissioners in Lunacy could inspect facilities for lunatics held in workhouse wards. The local Justices of the Peace who managed the HCA could and did inspect returns of lunatics and idiots supported outside the asylum and expressed opinions as to whether the arrangements for their care were suitable. In June 1856 the visitors of the HCA required the medical superintendent to write to the guardians of the Hartley Wintney union for,

a more detailed account of the state of health and care taken of a lunatic named Ann Slyfield residing with her parents at Eversley who is reported to require constant attendance to prevent her from injuring herself during her fits of epilepsy, which are frequent and severe.⁴⁶

The response was presumably satisfactory, as Ann was not mentioned again. Later in the same year enquiries were made about “two idiot girls [who] though harmless were not properly looked after by their parents.”⁴⁷ The asylum officers had the power to investigate and to criticise but not to decide upon a course of action. As the family was still living in the community the responsibility fell upon the guardians, who decided to take the whole family into the workhouse.⁴⁸

The debate about the suitability of workhouses continued throughout the period and by the end of the century the proportion of lunatics supported by unions in smaller workhouses had decreased.⁴⁹ The larger boroughs tried to avoid the expense of building an asylum of their own by adding specialist wards to already large

⁴⁶ Minutes of the Visting Committee of the HCA, June 28th 1856. p 214.

⁴⁷ Minutes of the Visiting Committee of the HCA October 23rd 1856. p 234.

⁴⁸ Minutes of the Visiting Committee of the HCA November 22nd 1856. p 244.

⁴⁹ See the example of the Alton Union in Chapter 6/7.

workhouses. These boroughs had not been party to the construction of the HCA and thus had no automatic right to send patients there except at a higher rate of weekly maintenance, under a negotiated contract. The spaces available for their patients were contingent on the capacity of the asylum and the boroughs were sometimes faced with having to find alternative accommodation at short notice.

Southampton and to a lesser extent, Winchester and Andover dealt with the problem by continuing to place pauper patients in private asylums. In the 1850s Southampton's workhouse wards were subject to the most critical inspections by the Commissioners in Lunacy who wrote that, "This workhouse in respect to locality, construction, and arrangements is most unfit, in every respect, for the residence of insane persons, and is generally discreditable to the authorities of Southampton."⁵⁰ At the same time they reported that lunatics in the Portsea Island workhouse were occupying four rooms, sleeping on straw beds and had little or no furniture, and no pictures on the walls. Apart from using spoons for broth they were expected to eat with their fingers and they exercised in the same area where soiled beds and bedding were put out to dry.⁵¹

The Portsea Island union had previously housed lunatics in the workhouse and infirmary until they became too difficult to handle, when they were moved to a private asylum at Hilsea. The death of the proprietor, after being bitten by one of these patients caused them to reconsider their policy.⁵² During the 1860s Portsea Island union planned its own asylum and the Commissioners in Lunacy insisted that no facilities such as kitchens should be held in common with the workhouse, as this would interfere "with the separate and independent character required by the statute."⁵³ In the meantime the workhouse lunatic ward continued to be used but even so, Portsmouth's lunatics also found themselves placed in private asylums as far away as London. Eventually a borough asylum opened at Milton in 1876, still very close to the workhouse.

Southampton union built a better workhouse in 1867, with a designated ward and staff for lunatics. This continued to operate into the twentieth century but, along with the

⁵⁰ Appendix to Supplement of the 12th Report of the Commissioners in Lunacy 1857-58, p59.

⁵¹ Appendix to Supplement of the 12th Report of the Commissioners in Lunacy 1857-58, p57

⁵² Report of the Commissioners in Lunacy to the Lord Chancellor, 1844, p42 and p148.

⁵³ 11th Annual Report of the Commissioners in Lunacy, 1857, p7

boroughs of Andover and Winchester, Southampton did not resolve its placement problems until after the First World War, when Hampshire's second asylum was opened at Park Prewett, near Basingstoke. After it became a separate authority in 1888 the Isle of Wight also planned and built its own asylum, which opened in 1896.

In theory, therefore, the legislation laid down that workhouses and asylums were for different types of person and operated under different principles. Both poor law and lunacy law suggested that there should be different sub-categories of workhouse and asylum to deal with different types of pauper and lunatic. In the workhouse the able-bodied male could thus be treated differently from those pauperised by age and infirmity. In one type of asylum the maniac, whose condition though frightening, might be recoverable, could be offered treatment, while in others the senile patient could be cared for, or an 'idiot' child could be educated.

In practice, both asylums and workhouses were most likely to be large mixed establishments subject to some internal classification. The Commissioners in Lunacy, while compelled to rely on the administrative machinery of the Poor Law, were committed to the separate nature of the asylum network and strove to maintain a separate identity in what was a complex relationship. However, while Poor Law Commissioners and Lunacy Commissioners might have been reasonably clear about where their lines of responsibility were drawn, locally the situation was not so clear and this was made more complicated still by the fact that some Justices of the Peace who served on the committee of visitors of the HCA were also guardians of the poor for their respective Poor Law unions.

Thus, the two institutions of the union workhouse and the county asylum appeared superficially to have much in common though county asylums were not in any formal way a part of the Poor Law system. A complicated system of rights and responsibilities assigned to officials from both areas, who reported to different supervisory bodies, resulted in a curious overlapping of territories that regularly required careful negotiation. The lunacy commissioners continued to inspect the conditions under which lunatics were maintained in workhouse. The management committee at the HCA scrutinised pauper lunatic returns and queried the problem cases that appeared still to be at home. Some Poor Law guardians and medical officers periodically

asserted their right to inspect those patients in the asylum who were a charge on the union, ostensibly to ensure their well-being but often to make sure that the union was getting value for money. This was a supposedly co-operative process but it could easily lead to tension if one set of rights was exercised at the expense of another. Though the two institutions appeared similar the principles informing the direction of each were rather different and this made it difficult for officials from each sector to inspect the other's patients and premises as they were working from different theoretical starting points.

Peter Bartlett characterised this tension as deriving from the clash between the paternalistic ideals of the Old Poor Law, upheld by the Justices of the Peace, who were charged with building and managing the county asylum, and the paid officials of the New Poor Law, whose job it was to make sure that no one received any relief to which they were not entitled.⁵⁴ While supporting the importance of the local/national tension in policy towards asylum admissions, research on the Devon County Asylum at Exminster, also examined how the attitudes and actions of individual Poor Law union officials in different unions could influence local policy on asylum admissions. It stressed the central role of Poor Law officials as mediators between the community and the asylum in deciding the terms on which people were admitted.⁵⁵ Bartlett also saw this as principally a local issue on which the Commissioners in Lunacy and the national context had very little influence until contributions towards the maintenance of paupers in asylums began to come from central funds from 1874. Thus, it appears as a local and legal tension related to the treatment of the poor rather than a contrast between more general medical and economic responses to insanity. Nevertheless, local responses were also both medical and economic. Hilary Marland has described how, in spite of the guardians of the Wakefield and Huddersfield union's attempts to place lunatics in the workhouse rather than the county asylum, it was not unusual for a large part of the annual medical relief bill in Wakefield to be spent on the maintenance of pauper lunatics in the Yorkshire asylums.⁵⁶ Anne Digby characterised the Poor Law medical relief arrangements after 1834 as 'driven by a cost-cutting economy and

⁵⁴ Bartlett, *The Poor Law of Lunacy*, p 2.

⁵⁵ William Forsythe, Joseph Melling and Richard Adair, "The New Poor Law and the County Pauper Lunatic Asylum: the Devon experience 1834-1884, *Social History of Medicine* (1996).

⁵⁶ Marland, p 84.

informed by a deterrent social philosophy [which] loaded the dice against the development of an adequate system of medical care".⁵⁷

Whether or not the distinctions between treatment under the Poor Law or under lunacy laws were apparent to the people who found themselves engaged with them, it seems likely that an asylum may have appeared more attractive than a workhouse in that conditions for its residents were more comfortable.⁵⁸ The asylum characterised itself as a medical establishment, even when outcomes were dubiously related to medical endeavour as defined by an increasingly scientific view of medicine. The element of pauperisation may therefore have been obscured by the idea of medical treatment, which was part of the asylum's self image. The next section considers the extent to which that self-image corresponded with the public image and with the reality.

3.5 A Medical Institution?

The importance of the doctor's signature on the reception order, which was a prerequisite for every asylum admission, signified that from the point of view of all concerned, including the state, this was the negotiation of a medical situation. The legislators were laying emphasis on the idea of insanity as a disease: an image that was reinforced in many ways as the century progressed. Similarly, the insistence on the appointment of a medically qualified superintendent stresses the legislators' belief in the asylum as a medical institution. This can be seen as part of a trend to focus on hospitals, and particularly specialist hospitals, as the main sites of medical intervention in acute cases.⁵⁹

The HCA was always presented in this light, especially in its annual reports. The visiting committee regularly extolled the virtues of early admission and healthy employment.

⁵⁷ Digby, *Making a Medical Living*, p244.

⁵⁸ Bartlett, *The Poor Law of Lunacy*, p135

⁵⁹ Lindsay Gramshaw, "The Rise of the Modern Hospital in Britain", in *Medicine in Society*, ed. by Andrew Wear, (Cambridge: Cambridge University Press, 1992), p 205.

The visitors beg to call the attention of the various Boards of Guardians and the Medical Gentlemen employed by the Unions, to the necessity of removing Paupers under their charge as early as possible to the Asylum, after the symptoms of insanity have shown themselves; for the sooner a patient afflicted with insanity is placed under the proper treatment, the greater are the possibilities of a speedy and perfect recovery.⁶⁰

This suggests that they subscribed to a view of medicine and, by association, psychiatry, which was essentially a clinical and interventionist process resulting in cure. This understanding of medicine privileged the treatment of the temporarily acutely ill person, whose recovery might reasonably be expected to contribute to the HCA's cure statistics, above the care of the chronically sick or incurable, who simply contributed to the image of the asylum as a depressing but convenient disposal place.

In 1856 Dr Manley explained his methods of treating different types of case. Maniacs benefited from blood-letting and melancholics from the administration of opiates and useful employment; the demented could sometimes work if supervised and the idiotic should be kept clean and encouraged to learn to do as much for themselves as possible. All attempts to cure or even alleviate epilepsy had failed and general paralysis cases presented no hope of cure but must simply be looked after. All cases of insanity appeared to be related to the internal organs of digestion, and much treatment was directed towards restoring all bodily functions to a 'normal' condition.⁶¹ The casebooks of the HCA give no indication that this approach changed during the period studied though this is an area in which further research is necessary.

There is a strong argument, therefore, that as the psychiatric profession was unable to understand or actively intervene in mental illness to effect a reliable cure, the asylum could not, in any real sense be considered a medical institution. It has also been argued that the medical image applied a gloss of scientific and medical respectability onto an institution which was designed to achieve a social purpose, that of segregating difficult

⁶⁰ Visitors' Annual Report, 1855, p2

⁶¹ Visitors' Annual Report 1856, p16.

or potentially dangerous members of society.⁶² However, the lack of success of the HCA in achieving either a scientific medical way of functioning or in achieving the large number of cures by which hospitals tried to measure their success, was less important than its belief in the medical validity of its activities and its contribution to the safe-keeping and care of its patients.

It has been suggested that during the nineteenth century a re-interpretation of the mind and its relationship with the body affected the understanding of the nature and treatment of illness and the relationship of the sick person with the rest of society.⁶³ Such a reinterpretation would mean that between the end of the eighteenth century and the beginning of the twentieth century the 'natural' relationship of the individual's illness with his own body, described by the patient in terms of symptoms, was replaced by the assessment of a pathological set of signs observed by the expert, by which an individual's relationship to the 'normal' population could be judged.⁶⁴ These criteria could apply not just to the physically sick individual's state of health but to his or her ways of thinking and behaviour.

In the latter part of the century the widespread acceptance of germ theory and the subsequent successes in the field of surgery ensured that medicine's identification with science was continually stressed. The laboratory, the post-mortem and the identification and treatment of disease took precedence and from now on the disease would be treated rather than the individual. Though the personal consultation was part of the process, this was now an opportunity for the doctor to make a diagnosis through the observations resulting from a physical examination rather than for him to listen to the patient's experience or opinion. As individual medical consultation became more common at all levels of society, it became less valuable as a personal interaction.⁶⁵

Within this conceptual framework, doctors practising orthodox medicine eclipsed other practitioners and by the end of the century formed a bounded, self-regulating professional body which nevertheless encompassed a full range of ability, experience

⁶² Scull, A., *The Most Solitary of Afflictions*, (London and New Haven: Yale University Press, 1993), p246.

⁶³ Lawrence, Christopher, *Medicine in the Making of Modern Britain*, (London and New York, Routledge, 1994), p45.

⁶⁴ Gramshaw, p 204.

⁶⁵ Lawrence, p 72.

and social status. Hospitals and their teaching consultants moved to the top of a hierarchy of medical resources to form an influential medical elite which was to play a major role in defining what was normal in Victorian society.⁶⁶ For example, many of the arguments that affected and restricted the activities of women in the public sphere were based on definitions offered by medical and scientific men.⁶⁷

In many ways it can be seen that the county asylums, growing rapidly in size and number after the middle of the century, were involved in this process of professionalisation and scientific authentication. At the beginning of the nineteenth century, madhouses and asylums were as likely to be managed by lay men or women as they were to have a medical manager. Medical consultation in asylums and workhouses was concerned only with bodily ailments. Moral Therapy, as pioneered at 'The Retreat', had entirely lay antecedents and no resident medical officer was appointed there before 1838.⁶⁸ After the legislation in the middle of the century all county asylums were administered by medically qualified male practitioners.

Andrew Scull suggested that asylum doctors claimed territorial rights in the new asylums by asserting a medical knowledge of the causes of madness and expertise in its cure, which were not fully justified. They then continued to use medical themes and arguments to establish themselves as experts in a serious and difficult field. By defining madness as a disease of the brain, masking the true working of the mind, they could claim insanity as a valid field of interest for medicine without offending any religious or moral sensibilities. At the same time they could monopolise the idea of Moral Therapy as part of a medical rationale, by combining it with interventions only available to them as members of the newly self-aware medical profession.⁶⁹

By the 1830s medical control of asylums was generally confirmed and from 1846 the Lunacy Commissioners evinced general hostility to non-medically run asylums. Scull considered that asylum doctors reinforced their position by the creation of professional organisations such as the Medico-Psychological Association, and the publication of specialist journals that expressed the debates of the day in a complex

⁶⁶ Lawrence, p3.

⁶⁷ Rowald, Katharina, ed., *Gender and Science: Late nineteenth-century debates on the female mind and body*. (Bristol: Thoemmes Press, 1996), p. xvi.

⁶⁸ Anne Digby, *Madness, Morals and Medicine*, p107.

⁶⁹ Scull, A., *Social Order/ Mental Disorder*, (Berkeley: University of California Press, 1989), pp153-161.

and technical way, which removed them from the public domain. During the later nineteenth century advances in neuro-physiology were used to tie the mental to the physical and from the 1860s mental problems were increasingly formulated in the language of degeneration.

At the same time as the pathological theories continued to have little effect on therapy, asylums grew in size as well as in number and an increasingly cumbersome and static career structure for asylum doctors resulted in the stagnation of the therapeutic asylum. Moral Therapy then meant little more than the efficient management of large numbers.⁷⁰ His conclusion therefore was that, having used medical discourse to set up their empire, alienists continued to use the language of medicine to mask the true role of asylums in controlling social deviance.

[B]y sustaining the illusion that asylums were medical institutions, they placed a humanitarian and scientific gloss on ... legitimising the removal of awkward and troublesome people whose confinement would have been awkward to justify on other grounds.⁷¹

He contended that the unintended result of this was that these doctors had, in effect, cut themselves off from other parts of the medical world. Evidence from the HCA suggests that the medical staff were indeed somewhat isolated from their colleagues in other branches of the profession. To a certain extent the geographical location of the institution reinforced this. Before the beginning of the twentieth century there was very little opportunity for practice in their field outside the confines of the asylum and since the positions here were salaried and subject to the scrutiny of lay employers in the form of the management committee of Justices of the Peace, they also tended to be low in status in comparison with doctors in private practice. It also seems likely that the social position of the medical superintendent in the local community might be rather delicately balanced because of the nature of his work and the necessity to live on site. His junior staff found themselves as trapped within the asylum as the patients themselves, almost as stigmatised and restricted, within a rigid career structure which

⁷⁰ Scull, *The Most Solitary of Afflictions*, pp232-244.

⁷¹ Andrew Scull, p 246.

increasingly became dependent on 'dead men's shoes'. Junior doctors at the HCA, as at other asylums, were accommodated within the building and their behaviour was subject to almost as much scrutiny as that of the patients. Sensitive to accusations of neglect and cruelty, doctors and attendants could be dismissed for any signs of misconduct, personal or professional.

Furthermore the returns of the Commissioners in Lunacy show that those who were fortunate enough to become medical superintendent of a large county asylum tended to remain in office for some time supervising a frequently changing staff of junior doctors, who used the asylum as a way of gaining a useful testimonial as a stepping stone to other jobs. This was certainly the case in Hampshire. After a shaky start, when the first-appointed superintendent was in post for only a few months before taking extended sick leave prior to resigning, Doctor John Manley was appointed in 1854. He was a young man and remained in this post until his retirement in 1885 at the age of fifty-six. He was succeeded by Doctor Thomas Worthington who held the appointment for twenty-five years and Doctor Worthington's successor was a member of the asylum staff who had been appointed as third assistant medical officer in 1890 and worked his way up to the position of superintendent. In the meantime a succession of young doctors joined the asylum staff for a brief period before moving on to other things. In the course of the forty-eight years of this study twenty-eight assistant medical officers were appointed. Most stayed for about one year and left for a variety of reasons. Of those whose intentions are known, three went into private practice, one joined the Army Medical Corps and one took up an appointment in the colonies. Two left after accusations of immoral conduct. Those who stayed for more than a few years were rewarded with promotion within the asylum service, either to more senior medical posts or, in two cases, as superintendents of other asylums.⁷²

Although there were certainly problems with the asylum service as a career in that doctors who were employed at the HCA were isolated from medical colleagues in other specialities, it is important not to see the medical staff purely as victims of the system. The rapid turnover of staff might indicate that not all doctors joined in the hope of rising to the position of medical superintendent of a large asylum. Then, as

⁷² Appointments of medical staff are recorded in the minutes of the visiting committee, the annual reports of the committee and the medical superintendent and the reports of the Commissioners in Lunacy.

now, there must have been some that sought experience, some who found their vocation to be mistaken and others that just needed a job. There was never a shortage of qualified applicants for any medical position that became available. And, of course, some were able to use it as a path to other things.

For those who remained, though the rewards might not have been as great as in private practice they were at least certain and clearly defined. In 1874 a senior medical officer at the HCA could expect to earn £110 a year, rising by increments to £150 and with board and lodging supplied. The medical superintendent's salary at that time was raised to £700 in recognition of his twenty years service. Retirement after long service at any level would usually be rewarded with a pension. Furthermore it seems clear from the surviving records that those officers who served longer than a few months were both dedicated to their work and interested in their patients. The two medical superintendents of this period found the work arduous and frustrating and sometimes deleterious to their health but both appear to have considered it a vocation to which they gave all their energies. Doctor Manley, in particular, benefited from the conscientious assistance of his wife from her arrival as a bride in 1854 until her early death in 1881.

A well developed and constantly reiterated rhetoric of cure masked the fact that the work done in asylums was more closely associated with care of the type of patient often to be found in the workhouse infirmary. Progress in the field of surgery helped general medicine to establish its credentials in the developing specialist and teaching hospitals, concentrating on acute cases in normally healthy people. There was pressure on asylums too, in the latter part of the century, to adopt a more scientific approach. The Lunacy Commissioners pushed for more post-mortems to be conducted and for pathology laboratories to be built, especially from the 1890s. The tone of their reports suggests that Hampshire was lagging behind other counties in this respect.

The medical records are properly kept but none of the fine pathological investigation now so usual in asylums is undertaken here, largely, if not altogether because there are neither the accommodation nor the appliances for such research.⁷³

Year after year, they came back to this point. Post-mortems should be carried out in all cases where they were not expressly forbidden and the asylum should provide pathology laboratories for the use of the medical staff. Medical science tried to establish new and certain connections between the organic condition of the body and the existence of mental illness, but life at the HCA continued as usual suggesting that the commitment to the scientific medical image may have indeed been superficial. The long service of those at the top of the hierarchy may also have been problematic in this respect as mid-century attitudes persisted into the later part of the century. It was not unusual for members of the visiting committee to serve for twenty years or more. They often found it difficult to accept or initiate change especially when it involved financial outlay, as the saga of the drains in the 1880s and 1890s demonstrated.⁷⁴

Emphasis on the detail shows the complications and contradictions inherent in the interpretation of the county asylum as a medical institution. The management committee and senior officers subscribed to the idea that the asylum would be a medical curative institution and yet it was clear that they continued to have responsibility for managing cases of all types. In 1852 they allowed for only enough beds for a proportion of the county's known lunatics,

deducting those they found to be well taken care of by their friends and those who were sufficiently harmless to be retained with safety in the Union Poorhouses.⁷⁵

⁷³ Appendix to the 54th Annual Report of the Commissioners in Lunacy, 1900.

⁷⁴ The drains were thought to be contaminating the water supply. The Lunacy Commissioners called in an expert and the visitors called in one of their own. The two reports were contradictory and the visitors decided to believe their own man, who said the water supply was pure. Several outbreaks of typhoid and dysentery later they capitulated and invested the money necessary to establish a new water supply.

⁷⁵ Visitors' Annual Report, 1854.

They expected to receive only treatable cases and were prepared to accept that the workhouse was a suitable alternative for those whose primary need was a place of safe-keeping and care. Furthermore they expected that in spite of the anticipated increase in the population generally, their four-hundred bed asylum would remain adequate for some time because of the number of cures which could now be effected.

yet your Committee, in the anticipation of a much larger number being permanently cured than has heretofore been the case hoped that accommodation would be amply sufficient for some time.⁷⁶

The data suggests that to a degree, the medical officers in the community and the officials of the Poor Law agreed with them. Around fifty percent of cases admitted fell into the acute categories that were thought to be treatable. But the Poor Law unions also continued to send hopeless and terminal cases in spite of exhortations against this from the medical superintendents. This could be taken to support the idea that dependent and embarrassing people were simply being disposed of. But it could also suggest that for lay people the idea of a medical establishment represented not only cure but the possibility of long-term care, impossible to sustain at home and undesirable in the workhouse. In this nineteenth-century debate lie the perennial problems which all health services face, involving questions about the relative emphasis on the allocation of resources to acute and chronic patients and the relative status of individuals and institutions offering care or cure.

The continual emphasis in annual reports on the importance of the early admission of acute cases in effecting a cure is directly at odds with the general association of the HCA with the incurable and the chronically sick. Nevertheless, if little progress was obvious in a scientific medical context it is interesting to ask whether other medical advances were being made, perhaps in less prominent fields such as nursing, which might be directly related to the “unsatisfactory class of cases” that the medical superintendent was still complaining about in 1891.⁷⁷ It has been suggested that

⁷⁶ Visitors' Annual Report, 1854.

⁷⁷ Medical superintendent's annual report, 1891, p 11.

the middle to late nineteenth century might be considered as the ‘golden age’ of mental nursing when the emphasis was on care because there was no other way of managing patients, and if patients got better it was due to care.⁷⁸

This seems like a rather optimistic view of a body of poorly paid, poorly educated and over-worked people who were trying to make a living in a difficult environment. In the HCA staff turnover was high and there was always a problem in attracting high calibre attendants and nurses. In 1889 the medical superintendent, Thomas Worthington regretted that “the greatest of difficulty exists in obtaining respectable and fairly intelligent young women,” and later he remarked that “there seems to be an idea that a girl who has failed at every thing else will make a capital nurse in an Asylum.”⁷⁹

The problem was compounded by the fact that in mental nursing as in asylum medicine there was a marked separation from the general sector from an early stage. General nursing had a bad reputation before the changes associated with the aftermath of Florence Nightingale’s work in the Crimea in the 1850s. The foundation of her school for nurses at St Thomas’s hospital in 1860 signalled a change in the status of nurses and the management of nursing in hospitals. In 1887 the foundation of the British Nurses Association took a step towards providing nurses with a representative body. However, this did not include mental nurses, who by 1891 also had a training scheme and a nationally recognised examination available to them. The mutual antipathy resulted in a separate Association of Asylum Workers (AWA) and a continuing separation of the two groups, which extended into the twentieth century.⁸⁰

In both sorts of institution, nursing largely consisted of domestic work. Cleanliness and good organisation were at the root of healthy minds and healthy bodies. Both groups were also involved with the personal bodily care of many of their patients but asylum attendants might also be required to supervise their patients’ work. As an important component of Moral Therapy the organisation of patients’ employment might be considered a legitimate part of the attendant’s job.

⁷⁸ Peter Nolan, *A History of Mental Health Nursing* (London: Stanley Thorne, 1993), p 57.

⁷⁹ Medical Superintendent’s Annual Reports, 1889 and 1893.

⁸⁰ Nolan, p69.

The low status of the county asylum in the hierarchy of hospitals seems to have had a depressing effect on the status of both male and female attendants. From the mid-nineteenth century general nursing became more acceptable as a job for a better-educated girl but the asylum nurses were likely to be drawn from the same social group as their patients. Male staff were often former soldiers who were usually recruited for their physique and practical skills and women were often initially employed as kitchen or laundry maids and were gradually promoted to be attendants. Before the 1870s their first step on the road to a professional training might have to be to learn to read and write. An evening class established for female patients at the HCA attracted and encouraged a number of female staff who, at the end of a twelve hour working day, were willing to learn 'reading, writing, spelling and some arithmetic, dictation and geography'.⁸¹

Towards the end of the century, an organic interpretation of mental illness began to predominate and nurses and attendants were required to participate in more medical interventions. The training schemes, which emerged at this stage, included knowledge of physiology and the theory of nursing. Although nurses and attendants in asylums now had a qualification available to them it was not a necessary qualification but an optional extra to be undertaken whilst working. Lectures and classes were held at the HCA from the mid-1890s but in 1899 only thirteen staff entered the examination, of whom eleven passed and received the extra two pounds a year on their salaries.⁸² Progress was slow. Even at the end of the first quarter of the twentieth century only twenty-six percent of male employees in asylums and sixteen percent of females possessed the Medico-Psychological Association certificate.⁸³

Although formal training was not common during most of the period, the general behaviour of attendants towards patients was carefully watched and regulated. Rough or unkind or dishonest behaviour was not tolerated and in spite of the difficulties in obtaining new staff, misdemeanours in this respect were punished by dismissal. Attempts to develop good standards of nursing were made though the general

⁸¹ Visitors' Annual Report, 1866.

⁸² Visitors' Annual Report, 1900.

⁸³ Robert Dingwall, Anne Marie Rafferty and Charles Webster, *An Introduction to the Social History of Nursing* (London, Routledge, 1988), p129.

overcrowding and understaffing made it difficult to rise above the most basic levels. In this situation standards of personal behaviour were valued as much as professional expertise. A female attendant who retired in 1880, after serving for twenty-one years was remembered for the way 'her kindness and ever ready sympathy won upon the hearts of her more or less afflicted and often wayward workers'.⁸⁴ Though Dr Manley linked the willingness of relapsed patients to return to the asylum to its reputation as a hospital which offered the possibility of cure, the superiority of asylum conditions compared with those of the workhouse in this period, may have been as much of an incentive.⁸⁵

The medicalisation of insanity also held advantages for users of the asylum system, who were the friends of the patients and the patients themselves, and they may have been willing to accept a more general definition of a hospital that included care and protection as well as cure. Charlotte MacKenzie's work on the private Ticehurst Asylum revealed that families were the prime movers in the certification and committal process. They may have been assisted in accepting the asylum as an acceptable course of action by assimilating the idea of hospitalisation, which came with the medical identity.

Hospitalisation justified the removal of a disruptive individual, while at the same time promising medical treatment and a possible cure. Hospital treatment thus addressed the powerful sense of guilt and helplessness expressed by so many families when dealing with an insane relative.⁸⁶

The Ticehurst patients studied by MacKenzie were middle-class so the decisions made by their families on their behalf were usually based on factors other than financial hardship, but the idea that the promise of treatment in a hospital might address the guilt that accompanies the decision to send a relative to an asylum is helpful in the case of pauper lunatics too. It was often possible to seek medical relief without entering the

⁸⁴ Visitors' Annual Report, 1881 p10

⁸⁵ Visitors' Annual Report, 1863

⁸⁶ Charlotte MacKenzie, 'Social factors in the Admission, Discharge and Continuing Stay of Patients at Ticehurst Asylum, 1845-1871', in *The Anatomy of Madness*, Vol. 2: *Institutions and Society*. ed. by, W. Bynum, R. Porter, and M. Shepherd, (London: Tavistock, 1985), p 151.

workhouse and as the reputations of some Poor Law infirmaries improved so did the status of the treatment offered there. Patients above the status of paupers were regularly admitted to the separate Poor Law infirmaries appearing in larger towns.⁸⁷ This culminated in 1885 with the Medical Relief (Disqualifications Removal) Act, which allowed for the granting of assistance without disenfranchisement.⁸⁸ Though opinions about its legality varied it also became acceptable and then usual for patients to be admitted to asylums on the understanding that their friends would make a contribution to the cost of their upkeep. By the end of the 1890s the guardians of the Lymington union were pursuing Harry Rickman through the courts for the balance of his wife's maintenance in the HCA.

In order to build up a picture of the medical world in the later nineteenth century one might include the following characteristics; a trend towards scientific methods and models carried out within specialised hospitals, the existence of specialist publications and professional associations, the development of nursing and medical practice as professions and the emergence of a career structure for both doctors and nurses. All of these characteristics were reflected in the HCA, where the public emphasis was on the curability of acute cases and their speedy release back into the community. But somehow they never quite developed successfully within its environment. Its status as a medical institution was always compromised by the characteristics it shared with the workhouse infirmary, which increasingly found itself the repository of those whom age and infirmity had rendered destitute. However, the characterisation of the nineteenth-century lunatic asylum as a medical institution should not be completely discounted. Doctors established a social and professional identity as experts in a difficult field, patients could hope that their stay would be temporary and curative, as for some it was; families could justify their choice as in the best interest of their relative's health. By whatever process some patients reached a stage where they could be discharged as recovered. Some were later re-admitted but many were patients only once and for a short time.

Indeed, for all groups there appears to be no obvious connection between the medical treatment they were offered and the outcome of their stay. In case after case the same

⁸⁷ Derek Fraser, *The Evolution of the British Welfare State*, 2nd edn., (London Macmillan, 1984), p94. Anne Digby, *Making a Medical Living*, p 247.

⁸⁸ Englander, p25.

depressing entries record “no change”, perhaps followed by “the same”, and then either gradual or sudden recovery, but the outcome seems to have crept up on all concerned rather than have been achieved by intervention in a medical scientific way. Case notes record little therapeutic intervention except in cases of physical illness but whether there was any connection between the treatment offered and the recoveries which took place is not a question which can be pursued at this point.

However, scientific intervention in the hope of altering the course of a case is only one aspect of medicine and one that in most respects is particularly identified with the twentieth century. It would be misleading to consider the claims of the medical establishment only in this light. Whilst nineteenth-century asylums could offer little in the way of medical treatment or therapy, it is worth considering whether they could offer a refuge, or genuine asylum. If recovery was usually spontaneous then at least they provided a place and a time for it to happen. Though large and overcrowded, especially in the last quarter of the century, a short residence in the asylum could represent an opportunity to eat well, sleep alone and be relieved of day to day anxieties, thus having an effect on the health of the individual if not resulting in the permanent cure of their mental problems, and both staff and families recognised this. In 1857 the purpose of the HCA was described as “to restore, relieve or protect those who are afflicted with the greatest of all visitations that befall the human race.”⁸⁹ A cure would be desirable but failing that, good care of the patient was also an aim of a well-run asylum until such time as separate institutions for that purpose could be constructed. Whatever the motives of those who set the process of certification in motion the aim of the asylum seems to have been to return individuals to the community as soon as was safe and reasonable.

At first sight the records of the HCA appear to support Scull’s thesis. The institution promoted itself as a medical and curative establishment and tried to play down its role in caring for the chronically sick, or containing the dangerous. The definition of medicine as an essentially interventionist and clinical process was assumed by doctors as part of a general model of medicine to which they and society generally subscribed. To a certain extent they succeeded. Within the local area the HCA established itself as a centre of professional expertise, employing well-qualified doctors and, as the century

⁸⁹ Medical Superintendent’s Annual Report, 1857, p14.

progressed, encouraging them to obtain extra qualifications. Medical officers from Knowle were regularly required to offer expert opinions in court cases. In seeking to establish their territory asylum doctors were doing no more than doctors in other increasingly specialised branches of medicine, or practitioners in other professions. Theories of professional expansion and empire building are in danger of ignoring or underestimating the degree to which people followed a career in the asylum service because they had a genuine interest or sense of vocation. All aspects of any profession have advantages and disadvantages and some doctors employed at the HCA gave and gained more than others. Their individual aspirations and experiences are as important as those of the patients and could form the basis of further research.

The contradiction between the curative rhetoric and the actual situation in asylums points to a conflict between what the HCA wished to offer and what its users really wanted. The predominantly poor circumstances and prognoses of its inmates and its connection with the Poor Law meant that it was more closely associated in people's minds with the Poor Law infirmary than with other more specialist medical facilities that developed during the nineteenth century. Its ability simply to care for its patients and generally keep them safe was often all that families required at the moment the decision was taken. A decision in such circumstances may have been made on a pragmatic and contingent basis but was not incompatible with hopes for a positive outcome, as the following chapters will show.

Chapter 4

The HCA Community

Nineteenth-century theory may have imposed a medical model onto the manifestation and treatment of insanity but chapter three has shown that the connection of much lunacy legislation with poverty and the operation of the Poor Law was inescapable. The use of county asylums by the state and by its citizens as a response to the effects of a newly urbanised and industrialised society on traditional patterns of social support has been a theme of much historical writing.

In this research, I wanted to ask who the patients of the HCA between 1852 and 1899 were. The creation of the HCA database provided a means by which it was possible to examine the relationship of the HCA population with the population of the county as a whole. If the agents of the state were tidying up the streets then one might expect to find many of society's vagrants and misfits. If individual families were policing the behaviour of their members there might be individuals whose alleged moral failings made them outcasts; drunks and the mothers of illegitimate children are two examples. If the structure of traditional social support was shaky then there might be a bias in the figures towards those whose claim on the support of a particular family was tenuous: the single, the aged and the homeless. Within the database, asylum careers are set out from the point of admission to the moment of discharge and it is possible to create a picture of the HCA population as it changed across the period and as it appeared at specific moments.

In such an analysis it might well be possible to identify types of patients and trends in their admissions and discharges but I wanted to go beyond analysis at this level and look at the experience of individuals, not while they were patients in the HCA but at the points in their lives when they were at their most vulnerable, shortly before admission and immediately after their discharge. In this respect the database could act as a gateway, helping to identify individuals whose lives could be followed in the more detailed HCA records and in other sources of social information. This chapter

addresses the first of these themes and the others are discussed in the following chapters.

This chapter considers two issues which are linked but which also deserve a certain amount of separate analysis. They are the nature of the growth of the HCA population and the social characteristics of that population in their relationship with the admission and discharge of individuals. It refers primarily to the large amount of data contained in the HCA database described in chapter two, as well as to the census reports for the relevant years. The number of variables involved makes a degree of artificial separation of topics inevitable though the relationship of gender to asylum admissions is a unifying thread.

Joan Scott counselled caution in dealing with women's experience as particular if by doing so we treat the experience of men as universal,¹ and yet the literature linking women to insanity and confinement is extensive. Of the many pieces of feminist writing devoted to the subject, Elaine Showalter's book *The Female Malady* has been very influential in suggesting that the patriarchal doctors of the nineteenth century, while vague about the causes of insanity generally, produced theories of female insanity which were linked to nature, femininity, and "specifically and confidently ...to the biological crises of the female life cycle."² On the other hand she also discussed how women could have been made mad by the constrictive nature of the lives they were forced to lead.³ This idea of female madness as both social construct and social product was criticised by Joan Busfield, who recognised also that both men and women, when diagnosed as mad, were affected by a gendered approach.⁴

In this research I was conscious that gender was just one of a number of variables involved in analysing the experience of both men and women admitted to the HCA. When considering gender in relation to the HCA it is important to bear in mind that this asylum, in common with other public asylums of the era and in accordance with the legislation, consisted of two symmetrical wings, for men and women, built around

¹ Joan Wallach Scott, *Gender and the Politics of History* (New York: Columbia University Press, 1988) p 25.

² Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980*, (London: Virago, 1987) p55.

³ Showalter, *The Female Malady*, pp61-65.

⁴ Joan Busfield, "Mental illness as Social Product or Social Construct: a contradiction in feminists' arguments?" *Sociology of Health and Illness* 10 (1988) p521-536.

a central administration block, with separate staffs and facilities. Administratively therefore, admissions and discharges were as likely to reflect the pressures on each accommodation wing of the asylum as they were to demonstrate evidence of an overall policy towards men and women. Although this appears to be a single population in which women consistently outnumber men, it can also be seen as two separate populations, each with its own growth dynamic within the asylum and its own criteria for entry. When analysing the database, therefore, I have usually considered male and female numbers separately and made comparisons within as well as between groups.

4.1 Counting admissions

The reports of the Commissioners in Lunacy touch on many subjects relevant to the manifestation and treatment of insanity, particularly as they related to pauper asylums, but their overwhelming concern, once the principles of moral therapy and non-restraint had been explored, was that of the ever-rising numbers of people admitted and the over-crowding resulting from a steadily expanding asylum population. Although they had expected a steady rise at first, as the benefits of early admission were acknowledged, they were at a loss to understand its inexorable progression, resulting in continual building activity across the country and the inevitable sanitary headaches of endemic and epidemic disease. Over the years HCA staff dealt with outbreaks of scarlet fever, measles, influenza and smallpox as well as with the constant stream of patients, who either arrived suffering from tuberculosis or contracted it during their residence there. A case of typhoid in 1882 heralded years of trouble and one of the regular outbreaks in the next decade claimed the life of Dr Worthington's sister.

Every individual admitted to the HCA became part of this steadily expanding population and explaining the reasons for this expansion exercised the ingenuity of Lunacy Commissioners and asylum committees for many years. Was it due to an increase in the incidence of insanity? Was it due to the growing confidence of the population in the efficacy of the asylum regime? Or was the increase simply proportional to the general growth in the population?

In 1897, however, the Lunacy Commission was reassured by the results of a survey it carried out on the alleged increase of insanity. The rise in numbers in asylums, they asserted, was due, not to the increase of madness attributed to the stresses of urbanisation and the industrial workplace, but to greater acceptance by the public of the asylum as a suitable place to seek both care and cure. If industrialisation and urbanisation were at all relevant it was because both men and women now worked outside the home, “making it less possible to retain at home, persons suffering from even the less severe forms of insanity.”⁵ So the number of insane persons in the population was not increasing but, as their families were now more likely to take advantage of the asylum, they were more likely to be enumerated.

Dr Worthington, at Knowle, thought that numbers were increasing only in line with the population increase while the new superintendent at Portsmouth reported that his recent predecessor, Dr Bland, “was strongly of the opinion that there was no increase of insanity but only an increase of persons kept in asylums.”⁶

Between 13th December 1852 and the last day of the nineteenth century, 8704 admissions were registered at the HCA. 1854 was the first complete year in which normal procedures were followed and in this year there were 124 admissions.⁷ Although the numbers of admissions fluctuated year on year, the general trend was upwards and by 1899 the annual admissions figure had almost doubled as Table 4.1 demonstrates.⁸

The increasing admissions figures were, in themselves, not immediately considered a problem and were not unexpected. The population of Hampshire was also rising so that at the census of 1901 it stood at almost double the figure for 1851.⁹ If that were the only issue then careful calculations of projected numbers, associated with an ongoing building programme ought to have kept pace with the demands on space. Yet

⁵ Special report of the Commissioners in Lunacy to the Lord Chancellor on the alleged increase in insanity, 1897, p23.

⁶ Special Report, 1897, p 61.

⁷ Between Dec 1852 and March 1853 groups of patients from the county’s workhouses and private asylums were admitted at pre-arranged times. After this date, individuals, certified within the community were admitted on an ad hoc basis.

⁸ The figures here refer to the number of incidents of admission rather than the number of individuals admitted.

⁹ Population of Hampshire 1851 was 405370 and in 1901 it was 799582. Figures derived from General Reports on the Census of England and Wales, 1851 and 1901, HMSO 1852 and 1902.

this never happened, in spite of the best calculations. This was because the ever-growing resident population caused the real accommodation problems. Thus the resident population of the HCA reached its initial capacity within four years, rather sooner for women than for men, though relative admission numbers fluctuated. Figure 4.1 below shows the growth of the male and female populations of the HCA in its first fifty years of operation.

The growth of the HCA population relative to the county population can be shown by a comparison with the enumerated population in the decennial censuses from 1851 to 1891. Table 4.2 below shows a steady increase in the resident population of the HCA. These tables show that in 1891 the number of asylum patients per thousand of the Hampshire population on census day was more than three times higher than it had been forty years earlier. Since this cannot be attributed to a similar increase in admissions it must be result of the gradual accumulation of long-stay patients.

If only a small number of each year's intake remained to become long-term inmates it would be sufficient to cause a problem. Figure 4.2 below shows that there were rarely big differences between admissions and discharges from year to year but that the general tendency was for admissions to outnumber discharges. Notwithstanding a significant proportion of early deaths and short but repeated stays there was a small but growing population of patients who experienced an extended stay, sometimes amounting to many years, and the effect of this on asylum accommodation was cumulative. The increasing number of officially recorded lunatics therefore had more to do with the growth of the asylum population than with the growth of asylum admissions. Circumstances surrounding individual discharges may therefore have been more relevant to the 'alleged increase in insanity' than the circumstances of admission.

At the point of entry, the asylum authorities had very little say in who was admitted to their institution, as long as the paperwork was correct. It appears that no one was ever turned away as long as the legal and medical procedures were satisfactory. There were times, however, when the pressure on space was such that the transfer of less troublesome or less eligible patients to other institutions was arranged in order to make space. The boroughs of Southampton, Portsmouth and Andover and the city of Winchester had no automatic entitlement to send patients to Knowle and contracts

were negotiated separately at a higher rate. When, rarely, there was excess capacity, patients were even accepted from outside the county. However, when overcrowding became dire these were the first authorities to be asked to remove their people. In 1859 the annual report stated that no county or borough patient had been turned away in spite of the pressure on accommodation but in the same report the medical superintendent speculated on the feasibility of removing chronic harmless patients to workhouses.¹⁰ The acute and dangerous cases were often those with the greatest chance of recovery and when stressing that they should have priority for asylum places the officials were showing their concern, not only for the fate of the individual but for the HCA's overcrowding problem and its recovery statistics.

By the end of the HCA's first decade space to accommodate additional patients was constantly being created by means of alterations and additions, particularly in the female section. It took the wholesale exit of a large number of patients chargeable to the Portsea Island Union, who were moved to the workhouse or to the private asylum, Fisherton House, at Salisbury, to clear the wards for a short while in 1863.¹¹ The Visiting Committee also periodically sent reminders to Poor Law guardians about the type of cases the asylum should expect to receive. Throughout the period the medical officers saw themselves as in danger of being overwhelmed by unsuitable cases, who nevertheless needed specialised attention. It was this kind of activity that contributed to the confusion over what type of institution this was. The HCA's officers did not consider such chronic, but harmless cases suitable for asylum treatment. Yet the Poor Law officials no longer felt able to provide the levels of care and supervision required of them. Both institutions recognised the need for a different type of establishment for such cases and in its absence each was prepared to nominate the other for the job of filling the gap.

¹⁰ Annual Report to Quarter Sessions, 1859.

¹¹ Annual Reports to Quarter Sessions, 1859 and 1864.

	male	female	%male	%female
1854	59	65	47.6	52.4
1855	44	53	45.4	54.6
1856	87	95	47.8	52.2
1857	85	117	42.1	57.9
1858	50	90	35.7	64.3
1859	62	63	49.6	50.4
1860	58	86	40.3	59.7
1861	65	97	40.1	59.9
1862	91	100	47.6	52.4
1863	63	80	44.1	55.9
1864	87	75	53.7	46.3
1865	91	87	51.1	48.9
1866	78	85	47.9	52.1
1867	76	95	44.4	55.6
1868	73	84	46.5	53.5
1869	83	88	48.5	51.5
1870	70	83	45.8	54.2
1871	73	104	41.2	58.8
1872	76	67	53.1	46.9
1873	71	78	47.7	52.3
1874	76	84	47.5	52.5
1875	84	82	50.6	49.4
1876	71	88	44.7	55.3
1877	91	93	49.5	50.5
1878	107	122	46.7	53.3
1879	97	112	46.4	53.6
1880	77	91	45.8	54.2
1881	104	96	52.0	48.0
1882	95	84	53.1	46.9
1883	87	85	50.6	49.4
1884	83	134	38.2	61.8
1885	90	94	48.9	51.1
1886	86	95	47.5	52.5
1887	96	91	51.3	48.7
1888	76	97	43.9	56.1
1889	75	82	47.8	52.2
1890	103	107	49.0	51.0
1891	91	124	42.3	57.7
1892	99	121	45.0	55.0
1893	92	134	40.7	59.3
1894	107	126	45.9	54.1
1895	111	114	49.3	50.7
1896	120	127	48.6	51.4
1897	134	131	50.6	49.4
1898	124	142	46.6	53.4
1899	120	127	48.6	51.4
total	3938	4475	46.8	53.2

Table 4.1 Admissions to HCA 1854 – 1899.

Source: HCA database

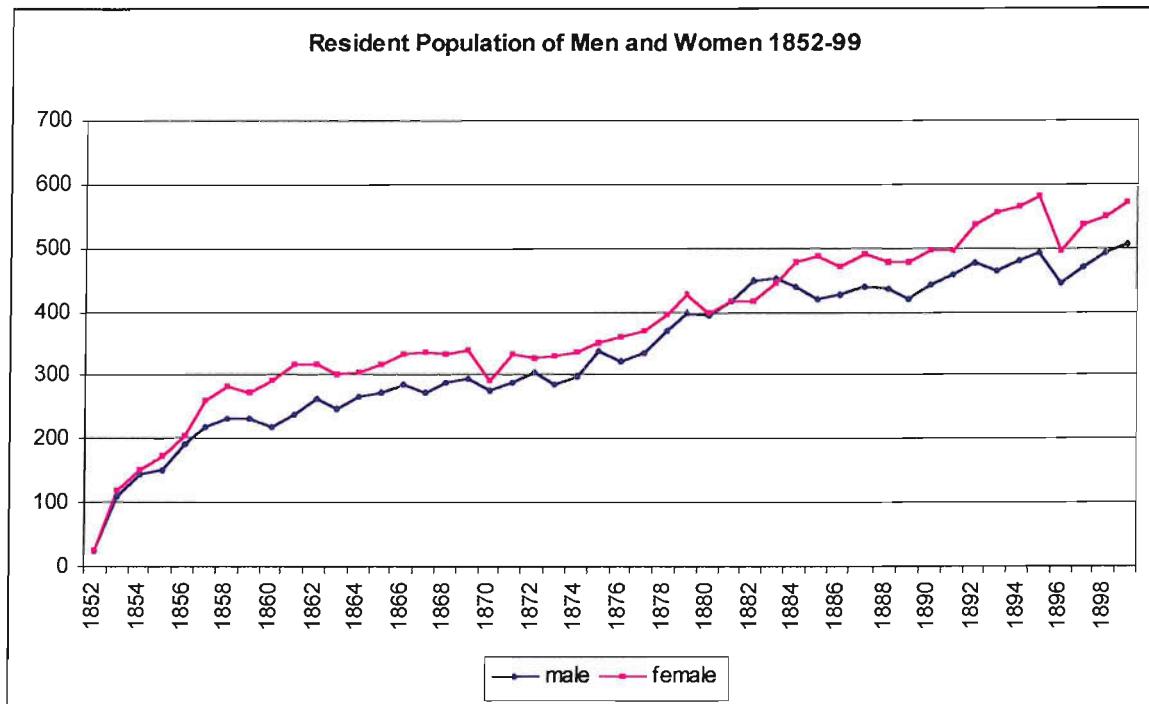


Figure 4.1: Resident population of asylum on December 31st, 1852-1899.

Source: HCA database

	HCA population			Hampshire population			Asylum patients per 1,000 of the county population		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1854*	111	131	242	215,385	212,918	428,303	0.51	0.61	0.56
1861	228	300	528	246,585	235,230	481,815	0.92	1.27	1.09
1871*	285	312	597	206,922	224,166	431,089	1.37	1.39	1.38
1881	381	436	817	223,415	242,033	465,448	1.70	1.80	1.75
1891	433	507	940	255,732	277,045	532,777	1.69	1.83	1.76

Table 4.2 Comparison of population of HCA with population of Hampshire

1854 – 1891

Source HCA database and Census Reports for Hampshire 1851 – 1901

*The population of Hampshire for 1854 has been estimated using the following formula, $\text{Pop}_{1854} = \text{Pop}_{1851} + (0.3 \times (\text{Pop}_{1861} - \text{Pop}_{1851}))$

*The population figures for Hampshire for 1871, 1881 and 1891 exclude the population of Portsmouth, which had by this stage made alternative arrangements for its pauper lunatics and only 13 from this area were admitted to the HCA between 1870 and 1900.

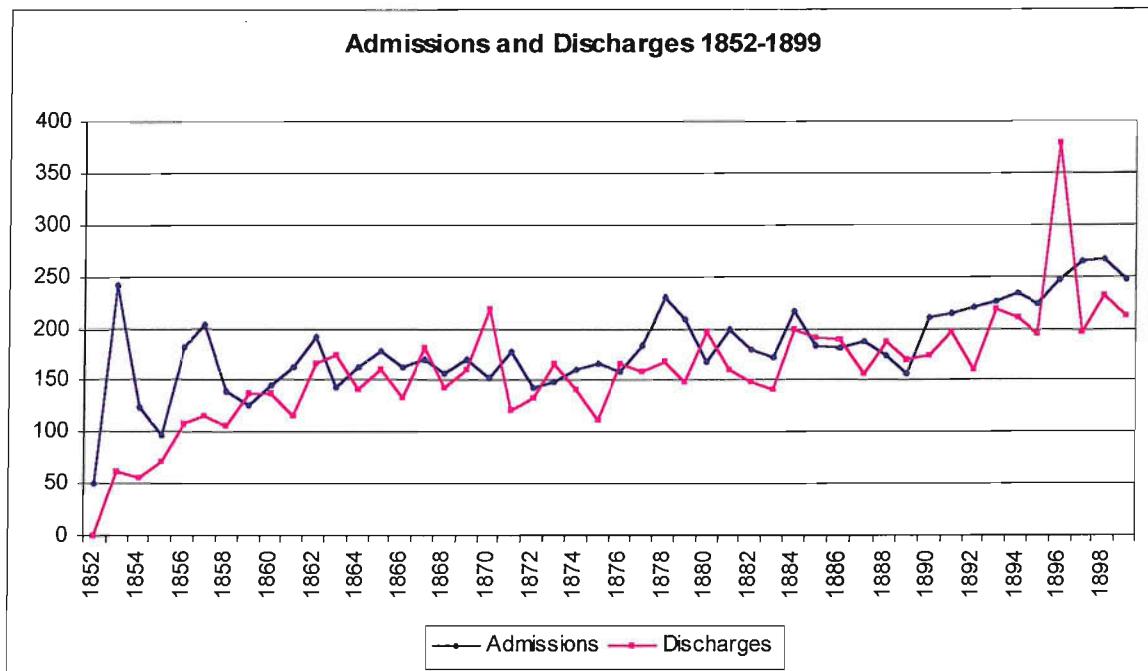


Figure 4.2 Admissions and Discharges at the HCA 1852-1899*

Source: HCA database

*Sudden peaks in discharges usually represent a large group transferring en masse to another institution. The peak of 1896 reflects the movement of patients to the newly opened Isle of Wight Asylum.

	Male		Female	
	Hampshire	HCA	Hampshire	HCA
1854*	50.2	45.8	49.8	54.2
1861	50.2	43.2	49.2	56.8
1871*	47.9	47.7	52.1	52.3
1881	47.9	46.6	52.1	53.3
1891	47.9	46.0	52.1	54.0

Table 4.3 Percentages of males and females in the HCA population compared with percentages in the Hampshire Population.

Source: HCA database and Census reports.

*1854 population calculated as on p 88.

*As in table 4.1 the figures for Hampshire from 1871 exclude the population of the Portsea Island Union.

Table 4.3 shows that there was always a larger proportion of women and a smaller proportion of men in the HCA than in the population of Hampshire. All the problems of overcrowding were always worse on the female side of the asylum than on the male, a problem that seems to have been unexpected as an equal number of places had initially been provided on each side. From the start the annual female admissions outnumbered the male admissions. As table 4.1 shows, when men outnumbered women, as they did in ten of the forty-seven years, it tended to be by a handful, whereas female admissions greatly outnumbered male admissions in many years. The annual reports of the HCA visiting committee note the problem of the over representation of women from the very early years of the asylum. By the end of 1858 consideration was being given to transferring manageable cases into local workhouses. By 1862 careful re-organisation of space meant that 323 females and 249 males could be accommodated though this resulted in severe limitations of space in day rooms and rooms used for visitors.¹²

¹² Annual Reports to Quarter Sessions, 1858 and 1862.

If the asylum itself had any control over the numbers resident it was much more likely to be through the discharge process, a balancing act involving assessment of progress made in the asylum and the willingness and ability of family and community to receive the patient back into its midst. In this process, though the visiting committee made the final decision, its members usually deferred to the opinion of the medical superintendent, though they were not afraid to exert some pressure when the patient's family was particularly persistent. John Manley, medical superintendent for thirty years, complained on occasion that friends were being allowed too much say in whether or not people were discharged and that this simply resulted in the readmission of the patient in an even worse state,

removal from the asylum would materially retard, if not totally annihilate all chance of recovery in one who was improving, while the anxiety arising from the too early return of such a patient to the struggle of life and the annoyances and difficulties he would too often have to contend with, would doubtless in most instances, reproduce insanity in all its active stage and terminate either in chronic lunacy, in suicide, or in the commission of some heinous crime.¹³

Nevertheless, relatives such as William Neal who applied for his wife, Hannah to be discharged, regularly at committee meetings for five years from 1857 to 1862, could often eventually take their relatives home even against the medical superintendent's advice¹⁴. In the case of Sarah Neal, whose husband achieved her discharge by making a scene at a Committee meeting in 1854, the Superintendent found his reluctance to discharge her justified by her readmission from the Surrey asylum two years later.¹⁵

Admissions for both men and women, therefore, increased only in proportion to the general increase in population. Numbers of discharges, however, were lower than numbers of admissions in thirty-three of the forty-seven years and so the resident population, steadily increased. The ratio of lunatics to the population of Hampshire had increased threefold by the end of the century.

¹³ Annual Report 1859, p 22.

¹⁴ Committee of Visitors Minute Book, 13th September 1862.

¹⁵ House Committee Journal, 19th September 1854. The two women came from different parts of Hampshire and are not known to have been related.

The HCA authorities had no control over who was admitted to the asylum. Their influence came at the point of discharge, though it was not total. The family and the asylum visiting committee could also have a say in the decision and it was asylum policy not to release someone who had nowhere to go. The visiting committee stopped short of making any kind of financial allowance though this was occasionally suggested.¹⁶ The size and nature of the asylum population therefore was closely connected with the actions of people outside the HCA, but also with the length of stay and outcome of the admission.

4.2 Length of Stay and Outcome

It only took a slight imbalance towards admissions in their relationship with discharges to trigger an accumulation of chronic cases within the wards. David Wright suggests that this is compatible with a rapid turnover of short-stay patients as when there were fewer spaces available it became necessary to make space quickly.¹⁷ This is certainly a picture which emerges from the HCA database and though it could provide evidence for a purely custodial attitude within and towards the asylum it also reinforces the idea of two different types of patient: those acute and sometimes dangerous individuals whose cases could benefit from immediate and active intervention and those who presented no danger and little hope of recovery who could be looked after by carers anywhere, but particularly in a workhouse.

When considering this subject it is important to put aside modern interpretations about what constitutes a long or short stay. The process of admission, assessment and discharge from an asylum was nothing if not bureaucratic, and the gears of bureaucracy ground slowly. The admission itself could take several days while various legal and medical authorities were consulted. Individuals were also often discharged for one month's trial at home or in the workhouse and so remained on the asylum's books for three or four weeks after their physical removal.

¹⁶ Appendix to the 46th Report of the Commissioners in Lunacy 1891, p185.

¹⁷ David Wright, "Getting out of the asylum: Understanding the Confinement of the Insane in the Nineteenth Century." *Social History of Medicine* 10, (1997), pp137-155, (p144).

Discharge only came about after application to the management committee, which met fortnightly and would often postpone such decisions until a future meeting. Even someone whose admission was clearly acknowledged as wrongful, and there were a few, might have to wait at least a month before being discharged. Emily Charlotte Harvey alias Kate Macdonald, a prostitute admitted from Portsmouth in July 1875, showed no symptoms of insanity as far as Dr Manley was concerned. Nevertheless it was five weeks before she was discharged as recovered. With very few exceptions the only people who were resident for less than a month were those who were at death's door on admission though the two medical superintendents of the period, Doctors Manley and Worthington, did what they could to discourage the admission of these cases. For the purposes of this study, therefore, and probably in the minds of the nineteenth-century asylum staff, a short stay would have been one which lasted between one and six months. A stay of less than three years might still have had a favourable outcome. Only after three years did the possibility of recovery give way to the probability of death as a dominant cause of exit.

Figure 4.3 shows that half of all those admitted remained resident in the HCA for a period of one year or less and, of those, half were resident for under six months. This is true for both men and women. Sixty-seven percent were in residence for less than three years. The thirty-three percent who were resident for over three years, and in particular the eight percent who remained for longer than twenty years contributed to the HCA's problem of overcrowding. However, the fifty percent who were admitted and discharged within twelve months constituted a different group with a completely different asylum experience.

Length of stay was closely linked to outcome and the outcome of any admission had a direct bearing on the state of overcrowding in either wing of the asylum. The capacity of the asylum could also have an influence on the outcome of an admission. The tendency to remove groups of patients from non-contributing boroughs has already been mentioned.

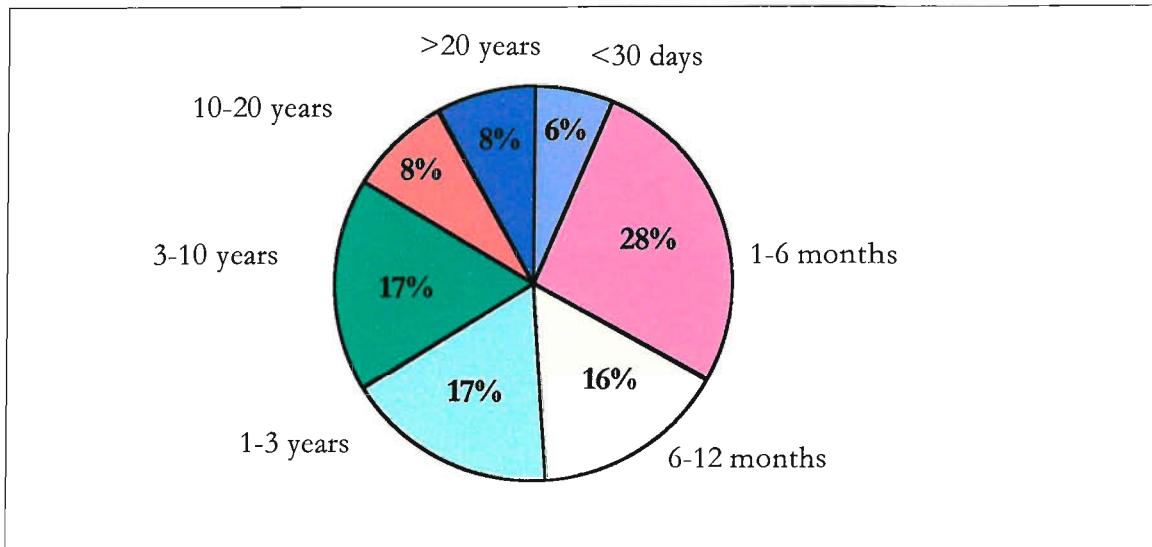


Figure 4.3: Length of stay of all admissions to the HCA 1852-1899.

Source HCA database

* Length of stay was calculated in days and converted into approximate equivalents in months and years to make the data more accessible. The equivalents are given in Appendix 1.

There were four categories of outcome. “Died” needs no explanation. “Relieved” (Rel.) tended to be used rarely, when a patient was transferred from this asylum to another asylum or a different institution. It acknowledged that some professional help had been given and that the receiving institution could therefore justifiably hope for further improvement. “Not Improved” (NI) was equally rare and in Dr Manley’s time might have been applied to a person who had been discharged to the care of his or her friends against the better judgement of the medical superintendent. Later it was used interchangeably with “Relieved” to denote a patient who required further care in an institution. Both terms were used as a precautionary form of self-justification if it was felt a readmission might become necessary. In fact those patients who were readmitted were much more likely to have been discharged as “Recovered” (Rec.). This was the most difficult category, applying not so much in the sense of a medical condition cured as a return to consistently ‘normal’ or at least quiet behaviour, which would facilitate re-integration into family and community. Its criteria varied from

patient to patient, from doctor to doctor and perhaps even from day to day. There were significant differences in outcome for men and women.

	Male	Female	Both
Died	58%	46%	51%
Rec.	28%	39%	34%
Rel.	6%	7%	7%
N.I.	8%	8%	8%

Table 4.4: Outcomes as percentages of all admissions.

Source: HCA database.

As table 4.4 demonstrates just over half of all admissions in this period therefore, ended in death in the asylum and more than one third of those admitted were considered to have recovered. However, these totals mask more dramatic differences for men and women in these two categories and the nature of these differences is discussed below. As individuals, about five percent will have been included in more than one category because they were admitted more than once.

Table 4.5 below shows that when length of stay is linked to outcome some interesting differences between the experiences of men and women can be seen.

The slow process of discharge meant that patients who were resident and discharged in under one month tended to be a special group whose members had been admitted either mistakenly or when they were at death's door. Doctors Manley and Worthington would have described these cases of immediate death as mistaken admissions also. Those who were resident between one and twelve months were more likely to be discharged as recovered than to die. They were also more likely to experience a favourable outcome than people who were resident for longer than a year, even when the time period was only slightly longer than one year. Figures 4.4 and 4.5 show the association of outcome and length of stay for men and women.

Length of Stay	Outcome							
	Rec.		Died		Rel.		NI	
	M	F	M	F	M	F	M	F
<30 days	27	15	284	162	11	5	33	27
1-6mths	517	781	498	304	61	55	49	50
6-12mths	285	533	235	173	38	58	42	24
1-3 years	196	338	380	370	48	60	32	53
3-10years	91	110	449	557	68	86	80	90
10-20years	8	10	246	275	29	35	66	59
>20years	4	4	273	281	9	8	51	67

Table 4.5: Outcomes for men and women linked to their length of stay. 1852-1899.
Source: HCA Database.

For both groups the one to three year period still carried a chance of recovery though this was better for women than for men. After three years both groups were more likely to end their days in the asylum than to recover or be discharged. The absolute numbers at this stage are very similar so, if anything, women were relatively less likely than men to be long-term residents of the HCA.

Both men and women were equally likely to reside in the HCA for less than twelve months but the outcomes were very different. Though more women than men were admitted in this period and the asylum female wing was more overcrowded than the male for the whole time, these figures confirm Dr Manley's opinion that the prognosis for women, on admission, was more optimistic than for men.

It will be seen that although the rate of recovery is higher among females than males the mortality is so much greater among the latter that the females largely preponderate over the males in the total number under care.¹⁸

¹⁸ 32nd Report of the Commissioners in Lunacy, 1878-79, p342.

More men than women were admitted in such a poor state of health that they died within a month of admission. Women, on the other hand, seemed more likely to have been admitted for conditions that were neither life threatening nor permanent. In the following five-month period, women were more than twice as likely to be discharged as recovered, as they were to die, whereas men had only a slightly better chance of recovery than death. The gendered nature of insanity therefore lies as much in the different kinds of illness suffered as it does in the social understanding of men and women. The different types of condition suffered also meant that their experience of the HCA and the outcome of their stay also differed. The outcome for most women was, on the whole, more optimistic than for most men. The circumstances surrounding admission are discussed in chapter six.

Those, whose admission had a favourable outcome, in that they recovered after a relatively short time, experienced the HCA in a different way from those who stayed until they were transferred or died. The former group, once their progress was recognised, could expect to be placed in wards on which a degree of trust was operated and from which they could go to work in the asylum and its grounds, or even further afield. From here they could expect to be sent home for a trial period before being completely discharged.

On the other hand the so-called 'unfavourable' cases presented little prospect of recovery or of employment and were generally pitied, though considered burdensome. Though they were labelled as hopeless this does not mean they had been dispatched to asylum or workhouse at the first opportunity. Individual records, discussed in chapter six, indicate that many families coped at home for a considerable time before seeking help. Most of these patients either died shortly after admission or lived in the asylum until they died. Few were discharged.

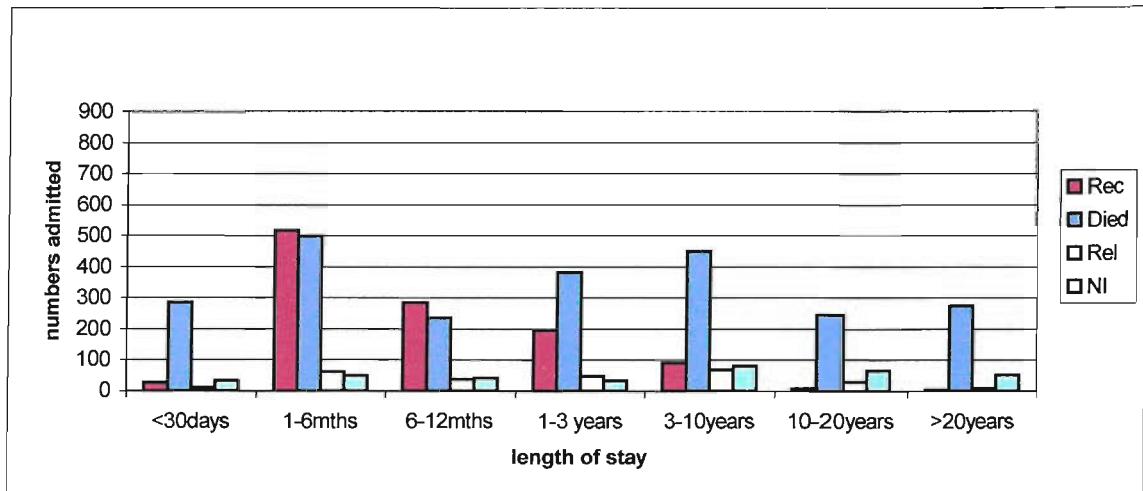


Figure 4.4: Outcomes for men linked to their length of stay.

Source: HCA database

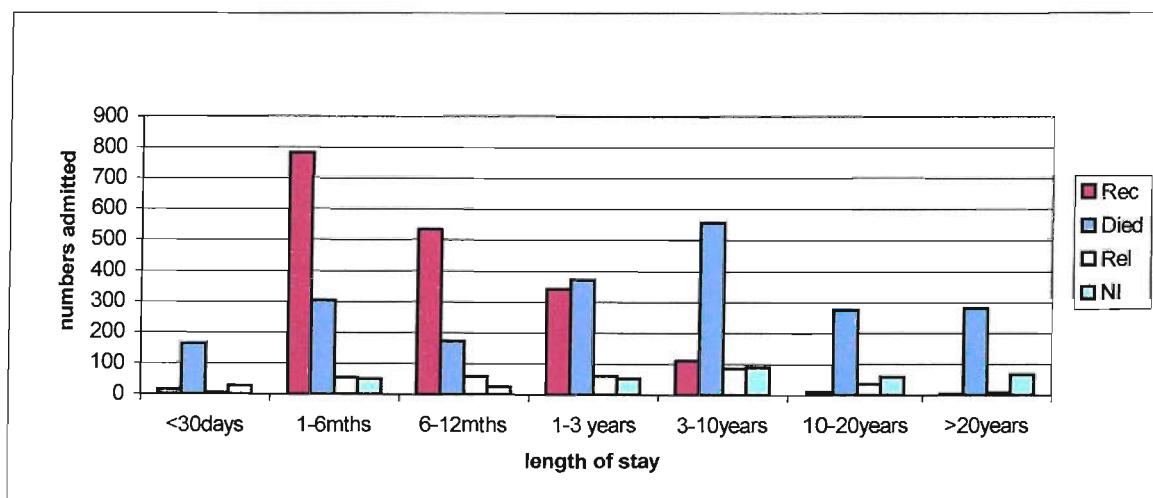


Figure 4.5: Outcomes for women linked to their length of stay.

Source: HCA database

4.3 Readmissions

Medical superintendents and the Commissioners in Lunacy attempted to relate all the aforementioned factors to the phenomenon of readmission. The careful cross-referencing of cases in the HCA registers makes it possible to determine the number of individuals admitted as distinct from the number of admissions. Table 4.6, below shows that almost 14% (1207) of all admissions to the HCA in this period were readmissions.

	Male	Female	Total
Admissions	4085	4619	8704
First admissions	3599	3898	7497
Readmissions	486	721	1207
Individuals readmitted	340	473	813

Table 4.6: First admissions and readmissions, 1852-99.

Source HCA database.

Women had a higher rate of readmission than did men. 12.1 % of all women and 9.4% of all men were readmitted. So women were more likely than men were to experience a cycle of admissions and discharges. As noted above the medical profession at the time preferred to see this in terms of the fewer fatal outcomes of women's illness combined with their greater longevity.

Though a higher proportion of women than men experienced multiple admissions, the average number of admissions for each readmitted patient was comparable: 2.4 for men and 2.6 for women. Most people in this category were therefore unlikely to be admitted more than twice, some came back for a third time, and a few unfortunate souls returned time and time again, one or two as many as ten times. While women were more likely than men to be admitted several times the most usual experience of

readmission was to be admitted, discharged and readmitted on one further occasion, anything from a week to a decade later.¹⁹

Just over half of those readmitted during this period eventually died within the asylum, a figure that is consistent with the general asylum death rate. Some individuals continued to be admitted after 1900. Helen Townsend, for example, having been admitted on eight occasions between 1873 and 1897 was admitted on three further occasions in 1902, 1904 and 1911 before dying in the asylum in 1912, at the age of fifty-nine. The possibility that readmission might have been part of a family survival strategy is discussed in chapter six.

4.4 Age as a factor in admissions

Most people's ages were included in the registers though it would be fair to say that they were often only approximate. Date of birth was never recorded in asylum registers at this time and the informant was often someone other than the patient.²⁰ Because of this I decided to focus the analysis on age groups rather than on individual ages.

This section looks at the extent to which the age-profile of inmates of the HCA reflected that of the wider community from the point of view of admissions to the asylum and of the age composition of the resident population at a specific time. Data from 1871 and 1891 and the decades around those dates will be used for this discussion. Figures 4.6 and 4.7 show the age-group profile for the county at the 1871 census taken on April 2nd of that year and the profile of the HCA population on that day.

The largest single group in the county population in 1871 and at all other censuses was aged under fifteen, while the asylum population at all times was overwhelmingly adult. The census report for 1851 defined fifteen as the age at which childhood ends and

¹⁹ The sample group of individuals admitted on five or more occasions consists of 21 women and 10 men.

²⁰ The only occasion on which large numbers of patients' ages went unrecorded was in the first four months of admissions from 1852 to 1853 when individuals were admitted directly from workhouses.

adulthood begins. Not only was fourteen “the age at which English law regards ...a person is competent to distinguish right and wrong”, but it was also accepted as the age at which the second ‘immature’ stage of human development terminated with puberty.²¹ So at fifteen a young person was considered physically to be an adult and to be able to shoulder adult responsibilities, although in law the age of majority was twenty-one.

It is clear from the asylum records that a similar rule of thumb applied to admissions. Very few children were admitted to the HCA, in any period, and the diagnosis was almost always a mental handicap of some kind, usually congenital. From fifteen years onwards the numbers of admissions rose and though the next age-group often also contained many people with a diagnosis of mental handicap or idiocy there was a much stronger possibility of an adult diagnosis, with particular emphasis on the disorders classified as mania. Fifteen seems to have been a clear boundary after which the asylum became one option in cases of anti-social, disruptive or unusual behaviour. In view of this it seemed reasonable to remove children in this youngest age group from the numerical comparison and to confine general comments to the adult component of each group. Child admissions to the HCA form part of the discussion of the care of those with a life-long or long-term mental impairment in chapter five. Tables 4.7 and 4.8 below show the percentage of each age group in the adult male and female populations of Hampshire and of the HCA in the 1871 and 1891 censuses and of those men and women admitted to the HCA between 1865 and 1874 and 1885 and 1894.

Even when children were removed from the population totals for Hampshire around a third of the county’s remaining population in 1871 and 1891 was under twenty-five. Yet in 1871 less than ten percent, and in 1891 less than twenty percent, of the HCA population fell into this age group, which the observations on the 1851 census called “the age of crime, of passion, of madness”.²² Amongst admissions the percentages in each age group remained constant in both periods and the emphasis within both admissions to the HCA and among the resident population in both periods was on the

²¹ Results and Observations on the 1851 census, (London, HMSO, 1854), vol. 1, xv-cxx.

²² Results and Observations on the 1851 census, (London, HMSO, 1854) vol. 1, pxiv.

mature adults, who were at a stage in life where they would be expected to be both fertile and economically productive.

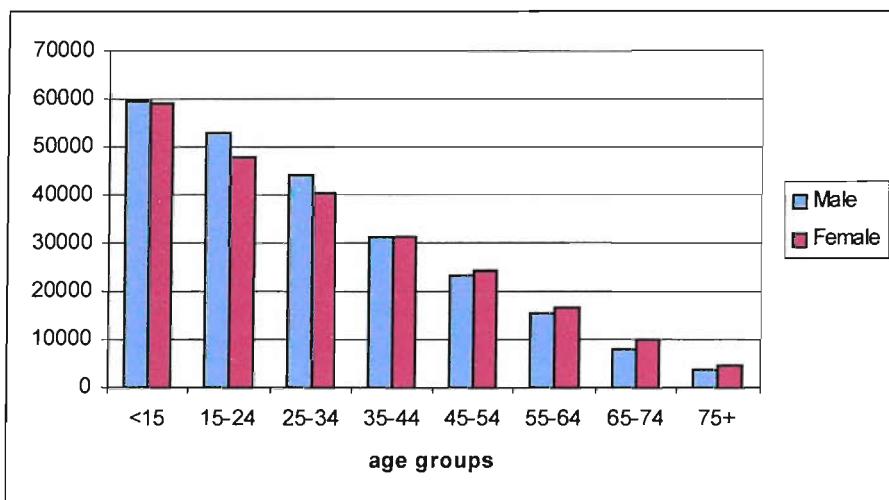


Figure 4.6. Age profile of Hampshire at 1871 Census.
Source: Report on the 1871 Census.

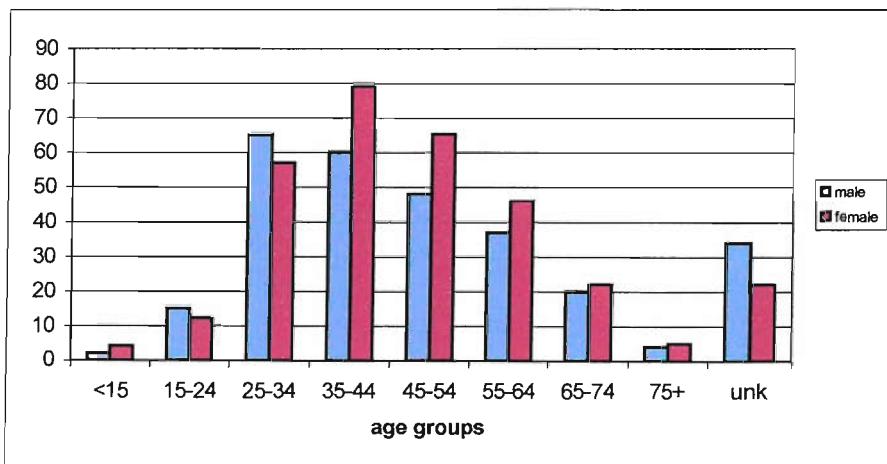


Figure 4.7. Age Profile of HCA patient population on Census Day 1871.
Source: HCA database.

Age group	Hampshire pop.		HCA patients		HCA Admissions	
	Census 1871		Census 1871		1865-1874	
	Male	Female	Male	Female	Male	Female
15-24	29.6	27.3	5.3	3.9	12.0	13.5
25-34	24.6	23.0	22.9	18.5	20.2	22.9
35-44	17.5	17.8	21.2	25.6	23.1	21.5
45-54	12.9	13.9	16.9	21.1	16.8	18.6
55-64	8.6	9.5	13.1	14.9	13.5	11.5
65-74	4.4	5.6	7.1	7.1	9.4	7.1
75+	2.1	2.5	1.4	1.6	3.2	3.7
unknown	0	0	12.1	7.1	1.7	1.2

Table 4.7. Percentage of each age group in the male and female adult population of the HCA and the county of Hampshire on Census Day 1871 with percentage of each age group in 1865-1874 admissions.

Sources: Report on the 1871 census and HCA database.

Age-group	Hampshire pop.		HCA Patients		HCA Admissions	
	Census 1891		Census 1891		1885-1894	
	Male	Female	Male	Female	Male	Female
15-24	30.2	29.2	5.1	5.1	12.9	15.1
25-34	23.2	23.2	16.9	15.7	21.3	22.6
35-44	17.9	17.4	18.8	18.9	21.9	20.9
45-54	13.2	13.2	25.2	23.7	17.8	17.3
55-64	8.5	9.0	18.1	18.3	12.2	10.4
65-74	4.9	5.5	10.0	13.3	9.9	8.8
75+	1.8	2.2	3.9	4.2	3.4	4.5
Unknown	0	0	2.1	0.8	0.7	0.4

Table 4.8. Percentage of each age group in the male and female adult population of the HCA and the county of Hampshire on Census Day 1891 with percentage of each age group in 1885-1894 admissions.

Sources: HCA database and Report on the 1891 Census.

Tables 4.7 and 4.8 show that in the general population of Hampshire the proportion of each age group decreases with age. Amongst admissions to the HCA the proportion increases with age, peaking between thirty-five and forty-four. In the asylum population for 1891 the peak comes in the forty-five to fifty-four age group and although the peak appears to come earlier among the 1871 population the high percentage of unknowns in 1871 makes this less clear for that period. It is, however, unlikely that many of these were members of the youngest age group as three quarters of them had been admitted at least eighteen years previously. In 1891 ages were unrecorded for only 13 of 940 people resident and all but two had been admitted at least twenty years previously.

The peak in age was earlier for admissions than for the resident population, reflecting the ageing process and the part played by length of stay. By definition young people in the asylum cannot have been there long whereas the ageing of younger patients who had not been discharged speedily was constantly reinforcing the older age groups of the asylum patient population. The increased percentage of patients in the oldest age groups between 1871 and 1891 is partly accounted for by the fact that the large number of unknowns in 1871 were probably members of this group.

If a general explanation for the emphasis on the middle aged were to be sought it could be that, as in the case of physical illness young people tend to be healthier than older ones. In their late teens and early twenties they had escaped the dangers of illness and accident in childhood and adolescence and had not yet had time to succumb to the health problems of middle-age or the difficulties of the family life-cycle. However, an intuitive explanation such as this combines all the various types of explanation of mental disorder to be found in both medical and historical literature. It would be necessary to evaluate the onset of mental illness in different age groups and to decide on the nature of the illness in individuals. Whether this is possible is doubtful and is not the purpose of this discussion. Chapter five discusses the importance of behaviour as grounds for asylum admission. If certification were based on the information that an individual was behaving in a way which was not considered normal or safe it might be expected that younger people would be more likely to be admitted because those making the decision were older and more likely to seek to maintain an orderly and

normal family or community. These figures however, do not suggest the asylum was being used automatically as a part of a range of sanctions dealing with erratic or difficult behaviour. Such behaviour was either less common among young people, which seems unlikely, or it was more likely to be excused or controlled in other ways, such as through the justice system or through social sanctions. And perhaps the allowances that adults normally made for the erratic behaviour of children and adolescents were extended to a certain degree into this age group.

The over-representation of people in middle age is a complex issue. The mean age on admission throughout the whole period and in each decade was forty-two and this was the same for men as for women. The median age was forty as was the modal age and again this applied to the whole period, to each decade and to men and women.²³ At forty individuals were under considerable strain in their lives. They might have both emotional and financial responsibility both for their children and their parents. The household to which they belonged might have balanced quite precariously upon their ability to maintain themselves in paid work, or to carry out the daily tasks of household management. Decisions about care when a key member of the family became ill might mean a delicate weighing up of many factors along with the symptoms of mental illness. At the same time it was an age where women could still be subject to the complications of childbirth and men might start to exhibit the symptoms of general paralysis of the insane (GPI).

It is difficult to decide on a definition of 'elderly'. In an age where there was no sense of a time for retirement for older working people, it was necessary for individuals to continue to take work for as long as it was available to them. In rural areas, such as Hampshire, both men and women worked on into old age, though their income decreased as the tasks they were able to undertake became less demanding. Retirement as such was brought about by infirmity rather than inclination.²⁴ Not until 1881 did the census refer to people as 'retired'.²⁵ On the other hand the nature of much agricultural and domestic work and the hard conditions under which many people lived might mean that someone who was over fifty-five could readily be considered elderly. In the

²³ However, specific ages can only be used as a guide. The extra large number of people whose age was given as exactly thirty, forty, fifty etc suggests that a certain amount of age-heaping was going on.

²⁴ John Macnicol, *The Politics of Retirement in Britain, 1878-1948*, (Cambridge: Cambridge University Press, 1998), pp49-51.

²⁵ Pat Thane, *Old Age in English History*, (Oxford: Oxford University Press, 2000), p 279.

context of this research it refers to those who were over sixty-five. Research in the neighbouring county of Dorset shows that the earnings of men started to decline from 60 onwards.²⁶ In both 1871 and 1891 there were slightly more women than men in this age group in the Hampshire population. In the HCA population of 1871 proportions of men and women were approximately equal and in 1891 the proportion of men was higher. Among admissions in the earlier period slightly higher proportions of women than men were admitted. In 1891, although the proportions of people admitted over the age of sixty-five were equivalent for men and for women, the women tended to be older on admission than the men. This suggests either that they stayed free of dementia longer than men, or that their families were willing to look after their elderly female relatives for longer than their elderly male relatives. This is explored further in chapter seven.

4.5 Marital Status

Marital status was one of the most comprehensively recorded categories in the admission registers and the close relationship to the patient of many of the lay informants in the Reception orders from which they were compiled suggests that it is likely to be accurate. After 1853 marital status was recorded in 98% of all entries. In constructing a social profile of an asylum population and looking at circumstances leading up to admission the marital status of a patient helps to define his or her relationship with family and community. Marital status is also linked to the age group of the patient and often both marital status and age group are relevant to the diagnosis of the type of condition from which the patient might be suffering. For example the onset of a mental problem in a younger person might affect marriage prospects. In the detailed profiles of repeated admissions there are only three cases of a marriage taking place after the first admission.²⁷ On the other hand the mental problems of old age, collectively known as dementia, made themselves evident long after the marriage and family years of the life course.

²⁶ R. Wall, "The residence patterns of elderly English women in comparative perspective," in *Women and Ageing in British Society since 1500*, ed. by Botelho, Lynn and Pat Thane, (London: Longman, 2001), p139.

²⁷ Emily Lawford, Ellen Clark who married twice and was admitted on separate occasions as single, married and widowed, and Edward Horne who married in middle-age after a number of admissions.

Table 4.9 shows that the greatest proportion of those admitted was married but that the emphasis was shifting so that, among both men and women, the proportion of married people was declining and the proportion of single people was increasing. The proportions of widowed people being admitted remained constant throughout the period, with widowed women forming a greater proportion of the female population than widowed men of the male population.

But this demonstrates a shift in emphasis rather than an outright change in priorities. When compared with the proportions of each group in the relevant census data, for 1871 and 1891, the proportion accounted for by each marital status group among the admissions was close to the actual proportion occupied by each marital status group in the population.

In figures 4.8 and 4.9 below marital status has been broken down according to age group. As might be expected younger adults were more likely than any other age group to be single, particularly if they were male, just as the elderly were more likely than the young to be widowed. This ought to have had implications for their length of stay and for overcrowding in the male wing of the asylum as single people were less likely to be discharged quickly than married people. However, the higher mortality rate among men helped to ensure that overcrowding remained less of a problem in the male wing than in the female.

In the youngest age-group many of those admitted were below the age at which marriage usually took place, particularly for men, who tended to marry when they were older than the women. The median age for marriage in the mid-nineteenth century was 24.4 for men and 22.9 for women.²⁸ In the twenty-five to thirty-four age group slightly more women were married than single but two-thirds of the men were single. From the age of thirty-five onwards the proportion of single women was larger than the proportion of single men in each age group.

However, the resident population of the HCA on the two census days was overwhelmingly single, especially on the male side. This was particularly noticeable in

²⁸ Michael Anderson, "The Social Implications of Demographic Change", in *The Cambridge Social History of Britain, 1750-1950, Volume 2*, ed. by F.M.L. Thompson, (Cambridge: Cambridge University Press, 1990), 1-70 (p32).

1891 but the 1871 figure has probably been depressed by the high percentage of unknowns associated with the long-stay patients admitted in the 1850s. Many of these early patients were admitted directly from local workhouses, without any apparent family connections and were likely to have been single.

The importance of marital status to the relationship between the HCA and the community therefore appears to be not so much in the admission as in the discharge procedures. This is borne out by an examination of the marital status of those who were discharged as recovered from each of the above periods for admissions. Table 4.10 demonstrates that in the earlier period the proportion of married men and women amongst those who were discharged as recovered is much greater than the proportion of single people similarly discharged. This also generally means that they were discharged after a few weeks or months. In the later period the difference between discharges and admissions had decreased for both single men and single women while for men discharges reflected admissions, and for women the discrepancy continued.

To the census officers in 1851 marriage and the family were the foundations of a stable society,

On the conjugal state of the population, its existence, increase, and diffusion, as well as manners, character, happiness and freedom, ultimately depend.²⁹

F.M.L. Thompson has discussed how the later nineteenth century was increasingly a period where respectability was the aspiration of every class and part of this ideology was the cult of work and of self-reliance.³⁰ The same culture both glorified and isolated the nuclear family and single people therefore stood in a difficult position. Unable to find a comfortable place in the family unless they made a financial contribution and less likely to be able to call on the strategies of mutual aid, they were also restricted by the social and moral codes of the time. Single men were considered unreliable and especially susceptible to the effects of drink and wild living. Single women, unless possessed of adequate means, were very susceptible to the economic

²⁹ Results and Observations on the 1851 census. p xxviii.

³⁰ F.M.L. Thompson, *The Rise of Respectable Society: A Social History of Britain, 1830-1900*, (London: Fontana, 1988).

pressures of life and even if well provided for sometimes found themselves the objects of suspicion. They were, therefore, unlikely to be released from the HCA without some means of support in the form of employment or a family with which to live. Single men, however, were more likely to find means of being self-supporting. It seems likely that this situation became even more firmly established as the nineteenth century moved to a close and ideals of women as housewives became more widely accepted.³¹

In practical terms, when the time for discharge came single people often had nowhere to live and no job to do. Asylum authorities were reluctant to release them without a guarantee that they would be cared for and so they were ideal candidates for the workhouse. In the home of a married person, for a while at least there was a space for a former asylum patient to step back into and a job for them to do. They were more likely to be welcomed back than the single.

However, other factors should also be considered. Early onset of mental illness might make marriage less likely and this would lead to over representation of single people. Some conditions were and still are linked to adolescence and early adulthood and some admissions of young adults were linked to mental handicap and the failing powers of older adult carers. Also the stigma attached to an asylum admission might damage future marriage prospects meaning that those readmitted were more likely to be single. Ernest Higgs was engaged to be married prior to his third admission in 1877, eleven years after his teenage admissions but although he was discharged as recovered within a few months the marriage did not take place and on subsequent admissions his distress at his single condition was recorded. Unmarried patients, like Ernest Higgs and his brother Albert from the Isle of Wight and Helen Townsend from Swanmore, were lucky in being able to live with or close to family members for most of their lives outside the asylum. However, many single people found themselves in workhouses or cheap lodgings on their release, where strange behaviour might be less well tolerated and readmission become more likely.

³¹ Horrell, Sara and Jane Humphries, "Women's labour force participation and the transition to the male breadwinner family, 1790-1865", *Economic History Review*, XLVIII, I (1995), 89-117, (p112).

In the oldest age-group ninety-three percent of all those admitted were or had been married. The largest proportion of this group, seventy-five percent of women and sixty-two percent of men were widowed. Widowed people were, in a sense, both married and single, and generally they could expect to find a greater level of family support across more generations than those who had never been married or who were childless. In all age groups the proportion of widowed people most closely resembled the proportion in the general population. For example, amongst those aged fifty-six to sixty-five, thirteen percent of men and thirty-one percent of women were widowed, closely resembling the fourteen and thirty percent of the general population, quoted by Anderson.³²

The proportion of widows was double the size of the proportion of widowers in every group except the very oldest where the women still outnumbered the men. Widowhood was not necessarily a permanent state for either men or women especially for those who were widowed young. Nineteen percent of marriages contracted in the 1850s would have been ended by the death of one partner in under ten years.³³ When Henry Vollow married Rhoda Hatton in 1844 he had already been widowed and lost two children in infancy.³⁴ Benjamin Watton found himself a widower with seven children in December 1861 and his marriage to Sarah Duffet took place six months later. Sarah brought up his children, had four of her own and looked after Benjamin as his mental health deteriorated and his two families squabbled.³⁵

In many cases, therefore, rapid remarriage was essential to prevent the disintegration of the family. In her study of Colyton in the mid-nineteenth century, Jean Robin discovered that almost all the children in the village were living in a household which was headed by two adults though both were not necessarily the child's biological parents.³⁶ At this time about fourteen percent of males and nine percent of females who married were widowed.³⁷ Men were more likely therefore to remarry than women were but both groups recognised that the strongest form of support in adversity came

³² Michael Anderson, "The Social Implications of Demographic Change," (p31).

³³ Michael Anderson, "The Social Implications of Demographic Change," p31.

³⁴ Crondall marriage register 1832 and 1844: burial register 1836 and 1837: baptism register 1835 and 1837.

³⁵ Information supplied by Janet Morton, Benjamin Watton's great great granddaughter.

³⁶ Jean Robin, *The Way We Lived Then*, (Aldershot: Ashgate, 2000), p29.

³⁷ Michael Anderson, "The Social Implications of Demographic Change", p31

through marriage and the nuclear family. The greater longevity of women combined with fewer opportunities for remarriage resulted in “the presence in society in old age of a very large surplus of widowed women, most of whom were dependent on other than earned income for their support”.³⁸ This surplus is certainly reflected in the admissions to the HCA. In general it seems that the men often married women younger than themselves who were able to care for their ageing husbands but who, as they grew older, would find themselves widowed and having to look to wider family for support.

The existence of a conjugal relationship can also be seen to have been important when assessing the likelihood of an early discharge. The minutes of the HCA’s Visiting Committee record the persistence of husbands and wives in insisting on their spouse’s discharge. In February 1856 Ann Welch, Hester Clark and Jane Duncan were discharged “to care for their families”. None was ever readmitted.³⁹ Later that month Louisa Blevins, having been brought in by her husband the previous November, was removed by him, on his undertaking to look after her, although her self-inflicted blindness meant she would be completely dependent on him.⁴⁰ In March 1860, though Thomas Smith’s wife was thought fit to care for him she could not guarantee that he would not again become chargeable to the Fordingbridge Union. When, in October, her brother was found suitable to be her guarantor, Thomas was discharged to his wife’s care. Unfortunately he was almost immediately readmitted and died not long afterwards.⁴¹ Finally, in 1881 Mary Jones was refused permission to remove her husband Thomas but encouraged to apply again at the next meeting.⁴²

Requests for discharge noted in the committee minutes are more likely to be those that were rejected or which were granted after persistent attempts such as those of William Neal for the discharge of his wife Hannah. However, married people were often discharged at the request of and into the care of a spouse as long as the medical superintendent was satisfied that they posed no danger to themselves or to others and if there was the financial means to support them. Unlike some other asylums and in spite of repeated heavy hints by the Commissioners in Lunacy, the HCA rarely offered

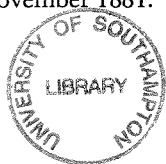
³⁸ Michael Anderson, “The Social Implications of Demographic Change”, p30

³⁹ Visiting Committee Minutes, February 9th 1856.

⁴⁰ Visiting Committee Minutes, February 23rd 1856.

⁴¹ Visiting Committee Minutes, September 29th and October 27th 1860.

⁴² Visiting Committee Minutes, 24th November 1881.



interim grants of money on release.⁴³ The support of a spouse did not prevent readmission but shows that for those who were married there was an interest and a willingness to remove them which could be based on affection or necessity or both.

The single were not so fortunate and their discharge appears to have been less straightforward. Some, particularly the young, had parents who wished to take them home. Although Edward Josiah Nicholas, aged 24, was described only as 'relieved' he was removed by his parents who undertook to look after him, in September 1863.⁴⁴ They managed to look after him for another three years and but he was readmitted in 1866. On his discharge in 1908 he was described as 'not improved'. His parents were probably dead by that time and it seems likely that his destination was another institution of some kind.

On the other hand William Pattenden,

was also reported as in a fit state to leave the Asylum but having no place of residence to go to where he could be kindly received, or any work elsewhere found for him, whereby he could hope to be able to maintain himself it was deemed advisable to postpone his discharge till further enquiries could be made respecting him and his prospects of being able to maintain himself when discharged.⁴⁵

This state of affairs continued for some time and eventually he took matters into his own hands and escaped in December 1860. When he was readmitted in 1861 the cause of his condition was said to be 'because he will not marry or settle in life'. After two further admissions, the last of which was from a workhouse, he died at Knowle in 1894. He never married.

⁴³ Appendix to the 44th Annual Report of the Commissioners in Lunacy, 1890, p194.

⁴⁴ Visiting Committee Minutes, September 12th and 23rd 1863.

⁴⁵ Visiting Committee Minutes, March 28th 1857.

	Married		Single		Widowed		Unknown	
	Male	Female	Male	Female	Male	Female	Male	Female
Hants Pop 1871	51.7	52.8	42.6	35.4	5.6	11.6	0.0	0.0
HCA Pop 1871	28.4	32.3	52.9	48.0	5.9	12.8	12.6	6.7
Admissions 1865-1874	47.9	45.2	40.4	38.0	8.7	15.6	2.9	1.1
<hr/>								
Hants Pop 1891	52.3	49.0	42.4	39.3	5.2	11.5	0.0	0.0
HCA Pop 1891	26.5	32.7	65.3	53.8	5.7	12.4	2.6	0.9
Admissions 1885-1894	45.2	42.2	43.6	41.6	9.6	15.4	1.5	0.7

Table 4.9. Marital status for males and females in the county of Hampshire in the Censuses of 1871 and 1891, as a percentage of the patient population of the HCA on the same two dates and as a percentage of admissions for the surrounding periods, 1865-75 and 1885-95. Source: HCA database. Sources HCA database and Reports on the 1871 and 1891 censuses.*

*This refers to the population of the whole of Hampshire, aged 15 and over. It was not possible to remove the populations of the major cities in this calculation and the marital status of their inhabitants was not recorded separately.

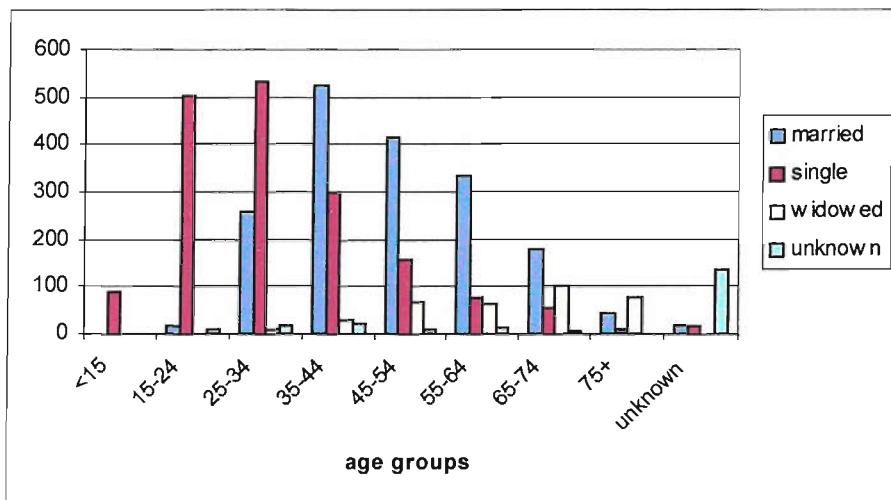


Figure 4.8: Age groups and marital status of men on admission to HCA, 1852-1899.
Source HCA database

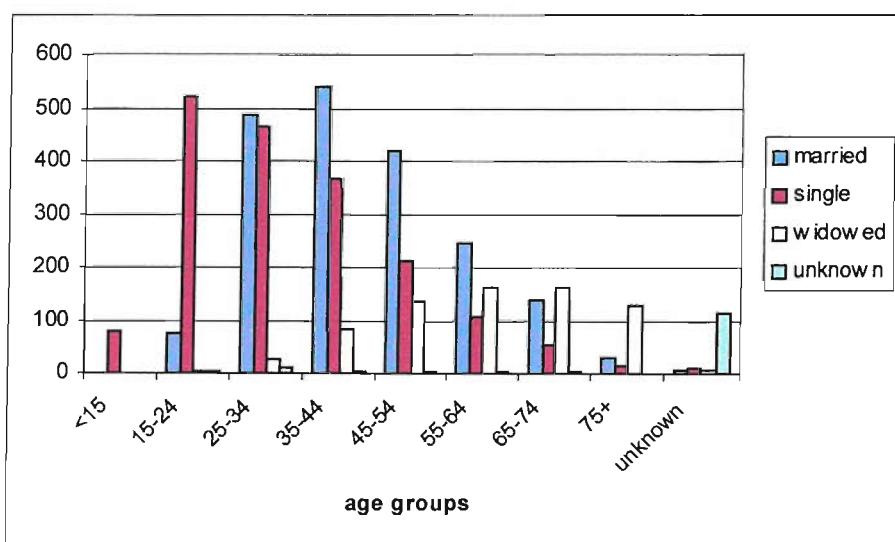


Figure 4.9: Age groups and marital status of women admitted to the HCA, 1852-1899.
Source: HCA database.

	Married		Single		Widowed		Unknown	
	Male	Female	Male	Female	Male	Female	Male	Female
Admissions 1865-1874	47.9	45.2	40.4	38.0	8.7	15.6	2.9	1.1
Discharged Recovered	55.8	56.7	35.6	32.6	7.0	9.4	1.4	1.1
Admissions 1885-1894	45.2	42.2	43.6	41.6	9.6	15.4	1.5	0.7
Discharged recovered.	45.5	51.7	44.0	38.0	7.3	9.3	3.1	0.9

Table 4.10. Admissions and Recoveries 1865-74 and 1885-94
shown as percentage of each type of marital status and according to gender.

Length of stay	Male				Female			
	Married	Single	Widow	Unk.	Married	Single	Widow	Unk.
<1 month	51.7	25.1	19.0	4.1	49.7	29.7	29.7	0.5
1-6 months	55.0	30.8	10.8	3.2	53.0	30.6	15.2	1.1
7-12 months	48.0	42.7	6.4	2.9	43.2	39.8	14.9	2.0
1-3 years	45.7	41.9	8.0	4.2	41.9	37.4	18.5	2.0
3-5 years	39.8	49.8	7.1	3.2	36.4	41.4	18.2	3.9
6-10 years	32.1	50.5	33.2	11.5	33.6	45.3	13.6	7.3
11-20 years	27.2	56.8	5.7	9.7	31.1	47.4	14.0	7.3
>20 years	18.2	70.3	2.1	8.9	28.1	58.7	7.7	5.2

Table 4.11. Marital status of males and females related to length of stay.

Source: HCA database

These examples from the written records of the Visiting Committee serve to illustrate the clear evidence from the admissions database shown in table 4.11, that single people were much more likely to be long-term residents of the HCA than were married people. If there were difficulties related to their discharge they were more likely to remain in the asylum. Those who remained in the asylum for the longest time were those who were single on admission. Their difficulties were compounded by the fact that as single people they were less likely to have children so after a long period in an asylum during which parents and siblings might have died there was no younger generation to shoulder the responsibility. The youngest age group was most likely to be single and so had the greatest possibility of a long stay simply by virtue of having longer to live.

4.6 Occupations

One way of looking at the social and economic status of individuals admitted to the HCA is to look at their occupations although the data present a number of problems. No occupation was recorded for nineteen percent of individuals admitted, and only a careful examination of reception orders and case notes can confirm whether or not they were working immediately before admission. Often the fact of illness having been brought on by the nature of their employment or of having prevented them from working is mentioned. The fact that an occupation was recorded does not indicate that an individual was actually employed in that capacity immediately prior to admission as it was often inability to work that disrupted family life. Discharged patients were not always able to return to their previous occupation. Thomas Marriott, formerly a gun-maker, took to selling coals from a barrow plastered with religious mottoes and George Scorey no longer worked as a baker after his discharge but delivered the village mail until his condition made him unable to read the addresses on the envelopes.

There appear to be two principal reasons why occupation or lack of it was recorded in these registers. First it was an official requirement and it was to be used by the statisticians in assessments of the social constitution of the asylum. Though almost a fifth of the entries show that a person had no occupation only six percent have been left completely blank. Second it was useful in helping asylum medical staff to decide

on how their patients could be usefully employed. Employment was a part of the cure and an indication that a person was ready for discharge.

Occupations of married women were rarely recorded although sometimes their husband's occupation was included. Though Hampshire women often contributed to the family income the type of work they did was likely to be casual or seasonal and thus go unrecorded by the asylum officers. Occupation was one of the categories of information specified in the official registers and was used by the commissioners from time to time to assess the social constitution of the asylum, but it also seems likely that, as much as anything else, the recording of occupations was done to assist the asylum staff in assigning employment within the institution. It was assumed that women could sew and carry out domestic duties and it would have been these tasks that fell to them within the asylum, so there was no real need to enquire into their occupations. In 1855 Dr Manley stated that "There has never been any difficulty to find employment for the female patients – sewing, washing, making clothes and the various other domestic occupations for females, fill up their time."⁴⁶ There was little change in this attitude throughout the period and Diana Gittins's account of Severalls Hospital reveals that this type of work for women was continuing well into the twentieth century.⁴⁷

Men were most useful in the asylum if they had a skill. They could then be employed in the workshops and these kept the institution supplied with clothing, shoes and other necessities. In 1856 Dr Manley commented that very few artisans were being admitted "the want of which in the shops is considerably felt".⁴⁸ Though there was work for labourers on the asylum estate it was more difficult to employ men in this way because of the degree of trust necessary and so men were not so easy to keep employed as women. The lunacy commissioners considered ward cleaning a poor substitute for skilled or physical labour.⁴⁹

A very general summary of the information supplied in the HCA registers shows that forty-nine percent of those admitted were working as labourers or as domestic

⁴⁶ Medical Superintendent's Annual Report 1855, p4.

⁴⁷ Diana Gittins, *Madness in its Place*, (London, Routledge, 1998), pp45-52.

⁴⁸ Medical Superintendent's Annual Report 1856, p22.

⁴⁹ Appendix to the 27th Report of the Commissioners in Lunacy 1872, p209.

servants or were married to labourers or servants. This was the largest section of the employed population in Hampshire at this time and was also the group that might be expected in the HCA. Their wages were barely enough for subsistence and there would have been no spare money to pay for medical treatment or institutional care. They were not destitute as long as they were working but they qualified as pauper lunatics as soon as they became in need of treatment. Of the remaining thirty two percent, half had some sort of small business or had received training that led them to a trade. This was the group that Dr Manley worried about. Initially the family might have enough money to pay for asylum care but it could very soon run out, particularly if the person who was ill was either the wage earner or his spouse. Other occupations such as schoolteacher or clerk could come into this group as well as those living on pensions or, in a very few cases, of independent means. Their fear of the stigma of pauperism might mean that they did not seek help soon enough.

There is no question therefore, of the asylum population containing more than a handful of individuals who were of a higher social class. Fifteen of the families located in the 1881 census included a resident servant but even so the very few private admissions were of people from farming, commercial or artisan families or from the edges of the professions such as school teaching. But neither was this asylum filled with society's outcasts, a so-called residuum, which it suited those in power to hide away. Less than two percent of the cases admitted were vagrant or following careers that might make them vulnerable to any sort of social meddling. As well as tramps and gypsies this varied group included a dissenting minister, an actress, assorted itinerant musicians, a knife grinder and a Polish refugee. Of the group said to have no occupation, only just over a hundred individuals were described as paupers or poor, implying a more permanent state of destitution than that caused by the onset of illness. But even families resorting to the workhouse could subscribe to the norms of society and hope to resume a normal life outside as soon as possible. Such families lived from one day to the next but aspired to sustain their households and belong to a community. For them the removal of an awkward member might have as much to do with family survival as anything else and there must have been a keen financial understanding of the situation alongside any worries about the safety and health of the affected member.

4.7 Conclusion

One of the dangers in trying to understand the process of admission and discharge over a fifty-year period is that of taking any one of the variables to be independent. For example, the building itself, which was in use as a residential facility for the mentally ill continuously from its opening in 1852 to the final years of the twentieth century, did not remain unchanged. Alterations and additions took place almost from the very beginning as the size of its population increased, the original structure deteriorated and ideas about what was appropriate accommodation for different types of patient were revised. Similarly, though admission and discharge processes appear to have changed very little over the period, they were not operating within an unchanging society, either in or out of the institution. Analysis of the HCA database, therefore, points out the complexity of the group of people admitted in the second half of the nineteenth century.

During this period numbers of admissions were increasing only in line with population growth, for both men and women. However, the resident population at each year's end increased relative to the increase of population in the county and this increase was greater for women than for men. This suggests that attitudes towards gender did not directly influence the actual admission of individuals. However, the length of stay and outcome of admissions was different for men and women and this is reflected in the way the female population of the HCA rapidly outstripped the male. The result was that accommodation for women was under greater strain than that for men, in spite of building programmes, which tried to redress the balance. Increased numbers of female residents did not usually affect the number of men who could be accommodated because the HCA was essentially two separate establishments.

The effect of this ever-increasing population was to exacerbate the sometimes tense relationship between the asylum and the local Poor Law unions. Though frequently expressing disapproval of workhouses as suitable places for the insane, the asylum officials found themselves compelled to transfer patients there from time to time and then to find reasons to justify their actions. The only way the asylum officials had of influencing the numbers resident was in the process of discharge but they had to take

into account not only the mental and physical state of the patient but also the willingness of family and community to re-assimilate an individual who might need some degree of care.

The two populations of men and women were each therefore sub-divided into three further populations of those who recovered and were soon discharged, those who died very soon after admission and those whose admission was the start of a long career in this and other institutions, which would probably end only in death. For all except those admitted *in extremis*, it was not the circumstances of admission that mattered, but the possibilities for discharge. The linking of length of stay, outcome and gender shows that though women formed a greater proportion of long-stay patients, the prospect for the men admitted was altogether more dismal. They were more likely than women to die shortly after admission or in the following twelve months and were less likely to experience a recovery. However, if they did recover they were less likely than women to experience multiple readmissions. The outcome of admission and the bodily health of patients on admission are discussed elsewhere in the thesis.

Age and marital status as well as gender of those admitted influenced which of these groups individuals were most likely to belong to. Women, young adults and the middle-aged - particularly the married - found themselves in a majority in the first group. Men and the very elderly dominated the second group and of those who experienced a lengthy residence, the majority were single. These factors are relevant to both admission and discharge as both affected the way in which an individual was able to assume a place in the family and community.

Finally, whilst they were not, on the whole, destitute or criminal (in fact the medical superintendents fought continuously not to have to admit criminal lunatics) they represented, as would be expected, those on lower rungs of the social ladder and those whom circumstances placed precariously just above. Based on this data the HCA community cannot be said to have been a microcosm of the wider community. Age groups, sexes and marital status were represented in different proportions from those in the population of Hampshire and socially, only a section, albeit a large one, of the wider community was represented. The association of asylums with some aspects of the Poor Law remained strong and a proportion of the asylum population consisted of

individuals whom many would have considered could have been equally well cared for in a workhouse. This does not mean, however, that the decision to make use of the HCA in particular cases was taken independently of the family. As Lees has pointed out, “a choice between several unpalatable alternatives remains a choice.”⁵⁰

The use of a large amount of data such as that contained in the HCA database can both simplify and complicate the issues. While painting a broad picture, it cannot fill in the detail or offer reasons for the situations it describes. The many variables influence each other and it gradually becomes clear that no one factor directly influences another. To move beyond this it is necessary to think about the circumstances that were experienced by individuals and small groups.

⁵⁰ Lynn Hollen Lees, *The Solidarities of Strangers: The English Poor Laws and the People, 1700-1948*, (Cambridge: Cambridge University Press, 1998), p37.

Chapter 5

Role of family in admission and discharge

When Dr Thomas Worthington entered the room used for admissions at the HCA on March 31st 1890 he saw before him a tall slim young man in his late twenties. George Hall stood over six feet tall in his socks, had light blue eyes, fair hair and a moustache, and was accustomed to smoke a pipe. When in health he was known to be a cheerful and agreeable young man, a hard worker and in fine physical shape from his work as a bricklayer. At this moment he looked dazed and confused, was suffering from a nasty bite on his tongue, and his hands and feet were confined by leather straps. Though he was “a finely developed, muscular man”, he was found to be rather underweight and his father, Edmund Hall, reported that he had not eaten or drunk since becoming ill a few days previously.

From the notes recording his previous admissions and the documentation that accompanied him to the asylum, Dr Worthington knew that George was formerly a soldier who had served in India. He had been discharged on health grounds because, after a severe attack of sunstroke, he began to suffer epileptic attacks of a violent nature. These became very frequent and severe when he had been drinking and could lead to murderous attacks on those around him. He was unmarried and on his return to England he moved into the family home with his parents and younger siblings. They did their best to look after him and the fact that he was described as in good health and well nourished confirms this. But when he had one of his attacks they lived in fear of his violence, found themselves calling on others to help restrain him, and had to sit up all night to watch over him.

This research was designed to explore the processes by which individuals such as George Hall became patients at the HCA. What choices had to be made before admission and what were the effects of those choices on individuals and their families? The quantitative analysis of the previous chapter was useful in establishing a context for their choices. The HCA community could be compared with the wider community

from which it was drawn. The database also made it possible to identify themes, which would repay further study, as well as to select individuals whose experiences could be seen as both representative of a wider group and as illustrative of the unique nature of each case.

In this chapter reception orders and case notes relating to 186 individuals were selected by using the database and in the ways described in chapter two. Information in reception orders and case notes helped the asylum staff to build up a picture of the patient and his or her condition. They copied information from reception orders into casebooks and other details were added. The history was written up as a formal narrative for the first couple of years of asylum record keeping but later entries consist of notes rather than a coherent story. This probably made it less useful to the doctor but the sheer burden of record keeping on the medical staff made any other course of action impossible. For the historian this is an advantage. Though removed from the original informant by the act of transcription, the information remains fresh and is sometimes reported verbatim, making it possible to begin to infer a personal history from these case histories.

The documents associated with the admission process can therefore cover the patient's family and personal background, the events leading up to admission and the presentation of the symptoms in the week immediately after admission. Examining a number of individuals through these documents offers an opportunity to try to understand how the perception of insanity affected family life and led to a decision to seek certification.

George Hall's problem was epilepsy, a known medical condition, but epilepsy alone was not always sufficient to justify admission to the HCA. George experienced fits on many occasions that did not result in admission. However, when the attacks were frequent or very severe, or if mental impairment or violence followed there might be problems for family and community. On this occasion George had been shouting all night, had threatened to harm his father and had kicked in the panel of a door. The asylum doctors might have been interested in trying to treat his epilepsy; various treatments were tried at the HCA, with very little success, but it was his behaviour at home that determined that he should be admitted to the asylum.

Certification therefore, was as much a social as a medical act. Doctors, Poor Law officials and families were involved in a process, which was completed outside the asylum and thus appears to have been a process of 'casting out' by the family, rather than of drawing in by the HCA. In order to understand the roles of different people in this process, this chapter looks in detail at the factors that precipitated admission, and the way a case history was prepared.

There were three stages to this. Firstly, before the admission took place, family members and others who knew the person were invited to give their version of recent events on the reception order, with the purpose of making a case for asylum admission. Secondly, the person accompanying an individual to the HCA might be asked to contribute information of personal and family history, which the medical superintendent could use in getting to know the patient and forming a diagnosis. The third stage of the process was the superintendent's own diagnosis, based on information gathered during earlier stages as well as several days of personal observation on the admission ward. At this stage the doctor visited the patient on a daily basis and made entries in the casebook accordingly. The comments recorded at each stage present a picture of what were considered to be circumstances justifying an asylum admission and therefore give a unique insight into what might or might not be tolerated at home and the actions that might be taken before an asylum admission was considered.

5.1 Factors indicating insanity

The reception order was not completed until after the decision to send a person to the asylum had been made. Its job was to justify this decision to the asylum authorities and to the Commissioners in Lunacy and to do so in correct legal form. Once it was received at the asylum the patient could not be refused admission on clinical grounds but only if the document itself was inadequately completed. However, he or she could be retained in the asylum while the authorities were given time to correct the paperwork, as happened in the case of Eliza Ann Coles, a governess, sent from

Southampton in 1857.¹ In the early admissions the procedures were sometimes misunderstood or confused with earlier rituals, and documents were sent back because spaces had been left or signatures omitted or too much time had elapsed between the completion of the order and the arrival of the patient at the asylum. These misunderstandings continued to occur from time to time.

The reception order, therefore, dealt with the situation that had precipitated the decision to commit the person to the asylum, although there were sometimes references to earlier events. Its purpose was to establish the presence of insanity and information was given, not only by a medical practitioner but also by lay people. The latter were usually relatives but could also be friends, neighbours, Poor Law officers or workhouse employees. It offered names and addresses of relatives, some general information about the patient and opinions regarding his or her insanity.

The most important parts of the reception order were the sections dealing with ‘Factors indicating insanity’ as they gave both the lay and the medical view of the symptoms and behaviour demonstrated by the affected person. Information from 186 sets of reception orders and case notes was used for this part of the research. Of these documents, 146 were reception orders in which medical and lay sections were clearly distinguishable. Forty documents were male case notes; included to compensate for a bias towards female cases noted in the reception orders. For the most part medical and lay comments were also distinguishable in these records. Altogether 847 statements from these documents were recorded.

5.2 Informants

There were two types of informant on the reception order, the medical men and the lay informants. Lay informants in the documents in the sample cases fell into four general categories, family members, neighbours, Poor Law or workhouse officials and employees and officials of other institutions such as prisons and hospitals. Police officers were also sometimes involved. Family members formed by far the largest group of informants. They account for sixty-one percent of all lay informants and over

¹ House journal, March 28th 1857.

a third of these were spouses. The remainder was usually closely related, being parents or adult children of the patient. They were usually living at the same address as the patient. When a more distant relationship such as aunt or cousin was involved they were usually cohabiting or close neighbours, or there had been recent very close contact. In ten percent of cases information was given by neighbours, sometimes in conjunction with family members.

Poor Law officials such as workhouse masters and matrons, or relieving officers made twenty-five percent of statements. Where the relieving officer was the informant it is likely that he collected information from family and friends and the statements given when the relieving officer accompanied a person to the asylum reception often show a detailed knowledge of an individual's family history and circumstances. In four percent of cases, police officers gave information. One or two of these cases involved vagrancy but others such as Joseph Battman were well-known local characters and in their cases the involvement of the police appears to indicate the culmination of a fairly lengthy period of eccentric behaviour.

Figure 5.1 below shows the relationship of lay informants on reception orders to the patients admitted and shows that the largest group of lay informants consisted of those with the closest emotional ties to the sufferer. They were, of course, the people whose daily lives were most affected by the problems created by their mentally troubled relative. In five of George Hall's seven admissions the informant was one of his parents. His brother and local workhouse staff were the informants on the remaining two occasions. The family members were more qualified than anyone to notice if attitudes and behaviour had changed and if the person posed a threat to themselves or others or required supervision at a level not possible within the home. The next group consisted of those in the community who became involved when extra help was necessary, neighbours, friends, clergymen and Poor Law officials and employees. More distant contacts such as officers of the law or magistrates were only rarely directly involved.

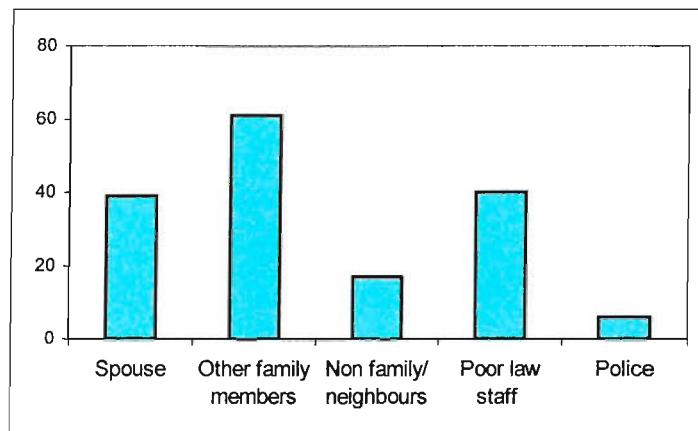


Figure 5.1. Lay informants on HCA reception orders of sample cases

Source: Reception orders from the HCA 1852-1899

(*There are more informants than reception orders because sometimes there was more than one on a single document.)

The medical informants were usually qualified physicians acting in their capacity as Poor Law medical officers. In the early years surgeons and apothecaries also recorded medical information. In the case of repeat admissions a doctor might become familiar with an individual and the medical superintendent had to ensure that the information referred to current events and not to past history. Dr Mahomed, in Bournemouth, certified George Hall as 'of unsound mind' on five occasions between 1888 and 1899. For private admissions two doctors were required to sign and they had to find a way of agreeing with each other while simultaneously showing that these were independent assessments.

Doctors were responsible for entering their own comments as well as those of the relatives. While relatives listed the factors that made a person's continued presence at home unendurable, the doctors sought, often with apparent difficulty, to establish that insanity was at the root of abnormal behaviour. This was a difficult job and it is possible to argue that they were not much more capable than their lay informants of forming a judgement about the supposed sanity of an individual, though they were expected to be able to express a considered medical opinion.

Despite the move towards the treating insanity as a disease, the local doctor's experience of its diagnosis and treatment was probably limited. His training was unlikely to have covered the subject in any depth and if he lived more than a few miles from Wickham, the market town closest to the HCA, he was unlikely to have visited the local asylum or to have benefited from contact with its medical staff.

Moving briefly from the sample to the whole database it can be seen that between 1852 and 1899 approximately 620 doctors, in Hampshire or on its borders, were responsible for certifying 7,600 patients, an average of 12 cases per doctor.² In fact some doctors certified many cases over an extended period of time, often over the whole period, while the names of many others appear only once.³ Dr William Kerr Loveless of Stockbridge signed seventy-two certificates between 1853 and 1899, while Dr W Frazer of Christchurch, who made his only appearance in the registers when he signed Thomas Candy's medical certificate in 1882, may be taken to stand for the 252 doctors who also appeared in its pages on only one occasion. Even doctors who signed many certificates in total may not have experienced many instances of certifiable lunacy, spread out as such occasions were, over many years, and this was true in both the urban and rural areas. At the beginning of the period thirty Poor Law unions in Hampshire and on its borders sent their lunatics to the HCA.

The well-populated area of the South Stoneham union, on the outskirts of Southampton, sent 716 persons to the HCA in the forty-seven years of this study: just under 1.3 per month. In the Shirley and Millbrook areas of Southampton, which formed part of this union, long-serving medical officers, Doctors Henry and Barnfield Dayman signed 186 certificates in a forty-year period. Alfred Pern signed a further 103 between 1867 and 1899. The remaining 427 were shared between forty different doctors practising in the South Stoneham union between 1852 and 1900. On the eastern edge of the union in Bitterne, Netley, Bursledon and Hamble, Doctor John Osborne signed thirty-six certificates in twenty-one years. In the outlying village of Botley, which was also part of this Poor Law union, Dr Robert Bates signed eleven

² The entries in this category are not complete because the complete database was built on an earlier version in which doctors' names were not recorded. This affects admissions from March 1853 to February 1855, January 1872 to December 1873 and January 1892 to December 1893.

³ Dr A. S. Mahomed, who certified George Hall, appears as the medical authority on seventy-one certificates over a period of fourteen years.

certificates in a period of eight years. These doctors therefore, saw only one or two cases a year, which, in their opinion, warranted an asylum admission.

In contrast to the partly urban South Stoneham union, the Kingsclere union, in the north of the county was a similar size geographically but very different in character and population. In 1801 the populations of the two districts were very similar at around 6000.⁴ By 1851 the population of Kingsclere had risen by only three thousand to 8909 while that of South Stoneham had more than doubled. By 1891 the population of South Stoneham, now rapidly being absorbed into Southampton in a maze of terraced streets, was over fifty thousand, while the population of Kingsclere had fallen by a few hundred and remained well under nine thousand. In Kingsclere union twenty-four doctors signed certificates of insanity for one hundred and seventy two individuals between 1852 and 1900, an average of 3.6 per year. Dr Oliver Fowler signed twenty-eight of these between 1857 and 1872, almost two a year. Dr George Thomson of the same union signed twenty-six certificates between 1858 and 1899, less than one a year. The remaining 122 certificates were signed by twenty-two doctors over forty- seven years. So whether they practised in urban or rural parts of the county local doctors were not likely to have extensive experience of the diagnosis of certifiable insanity. Nevertheless, as the analysis of their comments will show, they did their best to offer the medical perspective required.

On what knowledge, then, did local doctors base their decision to certify that an individual was 'a fit case for treatment in the asylum'? At the beginning of the period, the formal training of doctors was unlikely to have included the study of insanity and its diagnosis in any great detail. At some medical schools, lectures such as those given in London by Sir Alexander Morison were available to those who were interested and Kathleen Jones points to his lectures at the Surrey Asylum as evidence that asylum staff received training.⁵ Morison's lectures were not based on much personal experience, however, and attendance was not compulsory. Scull sees them as a means of establishing the claims of mental science to form a branch of medicine, rather than as a bona fide way of training doctors. Throughout most of the period 1852-1900 the only formal training in the care and treatment of insanity took place on the job, within

⁴ South Stoneham 6074 and Kingsclere 5707. Source: Census Report 1891.

⁵ Kathleen Jones, *Asylums and After*, (London: Athlone, 1993), p 72.

the large public asylums. Those who did not have this advantage could consult the large body of literature that had been available for most of the century. However, it is rarely possible to know the extent to which individuals were familiar with this material. Comments on reception orders were rarely couched in technical or medical terms and often relied more heavily on the local knowledge of individuals, families and communities than on medical knowledge.

Nevertheless a case for the existence of insanity had to be made while the patient was still in the community though both lay informants and local doctors had dubious qualifications for the task. Doctors were, in effect, being called upon to establish that the behaviour, which the families, neighbours or workhouse staff found impossible to cope with, was attributable to mental illness and not to bad temper, intemperance, or treatable physical illness, and to present this in a way that was acceptable to the lunacy experts. Lay informants described the behaviour and the reception orders and case notes examined make it clear that doctors had to be able to confirm that the problem could not be better dealt with by the courts, by the infirmary, by help at home or even by doing nothing.

The difficulties of such a task are shown in the reception order for the admission of Joseph Battman of Havant in March 1879. The doctor remarked only on his “imitating the crowing of a cock and singing songs during my visit to the workhouse on Sunday morning.” Dr Manley sent the reception order back with a note saying that “Mr Bannister should specify some fact indicating insanity observed by himself.” The doctor returned the form, having added a detailed description of Joseph Battman’s disruption of the workhouse that Sunday morning which concluded with a plaintive note stating that “his general demeanour was that of an insane man tho’ no one single act taken free may constitute a specific act of insanity.”⁶ Dr Bannister was in fact one of the more experienced physicians, having already been in practice in Havant for at least twenty-five years, and his name appears regularly in the registers throughout the whole period.

⁶ Joseph Battman, fourth admission, 4353, 10/3/1879.

5.3 Comments

I have considered the comments made by doctors and lay informants as 'factors indicating insanity' under twenty-four headings, grouped into six categories and these are set out in table 5.1 and figure 5.2 below. These seemed to be indicated by the material and were not chosen according to contemporary or modern formal diagnostic categories. Both medical and lay informants made use of all the categories to varying degrees. They are not exclusive and it is possible for comments under several headings to be assigned to the same person. They convey an impression rather than a definitive analysis and it is important to remember that the sample used here is not representative of all HCA admissions in the database. However, there is sufficient consistency of comment within each category of diagnosis to suggest that the results generated by a more strictly representative selection of examples would not have been very much different.

In both groups the greatest concentration of comments fell into the category which described stereotypical 'mad' behaviour, unnatural restlessness, agitation, incoherence and less often, extreme taciturnity and deep depression. Violence to persons and property and threat of violence came second for both groups and unusual social behaviour was third. The doctors then noticed bodily and physical factors and commented on suicide or attempted suicide and personal history last. Lay informants were much more likely to comment on self-harm, followed by personal history, noting particularly, previous confinement or illnesses and putting physical problems or symptoms last.

Violence	Actual and threatened violence to people and property. General comments about violent behaviour.
Self-harm	Threatened and attempted suicide. Self-harm caused by neglect or deliberate action such as refusing to eat.
Unacceptable behaviour	Unusual behaviour at home. Behaviour considered unacceptable in public such as behaving badly in the streets or at church. The use of abusive or obscene language.
Mad behaviour	Signs of excitement or depression, restlessness and inability to sleep, incoherent conversation, delusions
Bodily and mental impairment	Epilepsy, brain damage, mental handicap, childbirth, physical illness
Personal history	Previous attacks, family circumstances

Table 5.1: Types of comments used by lay and medical informants in the 'Factors indicating insanity' section of reception orders. Source: Reception orders and case notes of the HCA.

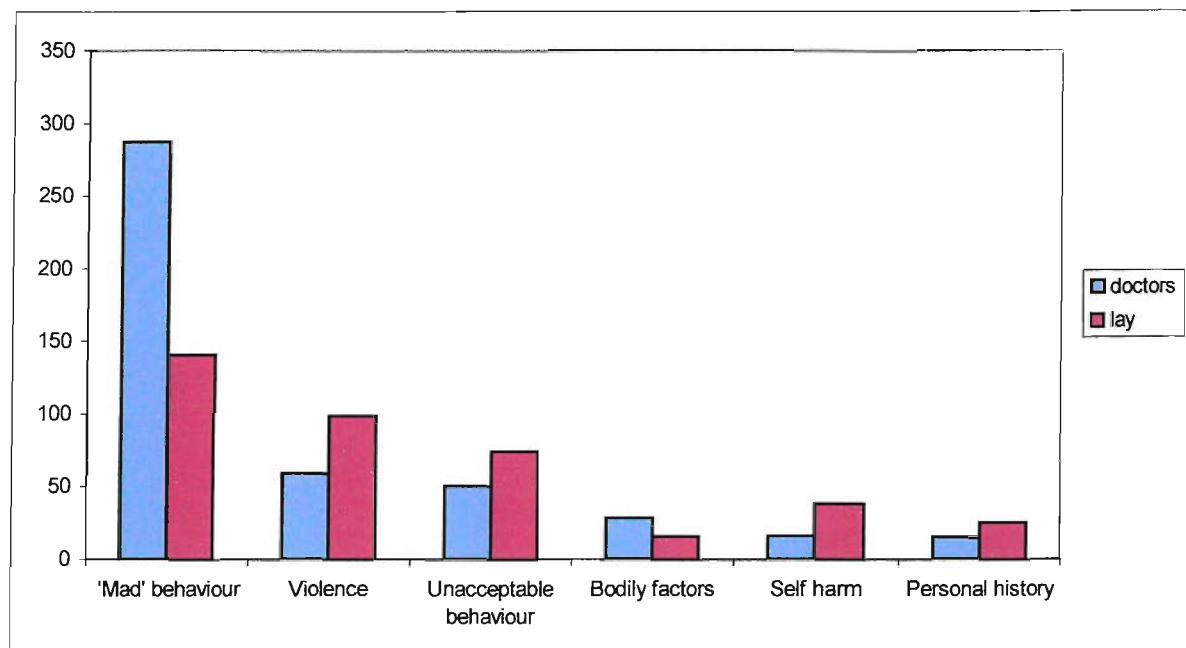


Figure 5.2: Allocation of 'factors indicating insanity' on reception orders.

Source: HCA Database: Reception orders and case notes.

5.3.1 Mad behaviour

The medical and lay sections of the reception orders show a similar concern to establish that the person concerned was behaving in an 'insane' manner as opposed to being drunk, bad-tempered or naturally moody. More than half the comments made by the doctors fell into this category and were frequently the only type of comment offered. Lay informants tended to add comments on state of mind to comments on abnormal behaviour. Both groups were conscious that it was necessary to establish that the patient was insane and a suitable candidate for an asylum but may have had different ideas about what information was appropriate.

Within this category doctors' comments emphasised confusion and incoherence, followed by delusions and aural and visual hallucinations. George Hall's doctor remarked on one of his reception orders that he was "strange in his manner...whistled

and grimaced and made incoherent exclamations.”⁷ On another he wrote that George showed “the strange and expectant look that I have noticed before, when I have seen him previously to an attack of epileptic mania”.⁸ Such comments were often supported by evidence of unusual talkativeness and excitement and an unnatural restlessness and inability to sleep, which might last several days and only be resolved by use of medication. Lay informants remarked on incoherence but only slightly more often than the other categories.

The symptoms reported in this category related most closely to mania. Symptoms of melancholia or depression were reported less often by doctors and almost never by lay informants. Though the perception of the appropriate treatment for insanity had changed during the first half of the nineteenth century the ‘fit object for an asylum’ was more often, it seems, raving mad, rather than melancholy or confused and the county asylum was still seen primarily as a place where the acutely ill could be both contained and cured. The wild and restless person is much harder to look after at home than the depressive who only becomes a problem when he or she slips into a semi-comatose state or is perceived as a suicide risk and families often sought to protect themselves as well as treat their relative’s mental condition.

The doctors themselves showed varying degrees of expertise in this category, with some listing difficulties and differences of perception while others resorted to reporting that the patient ‘looks mad’. In 1863, after Elizabeth Messum had violently attacked the daughter who was looking after her, the doctor contributed the following information to support her admission,

- 1) Perception defective and there is a great confusion as to time and dates.
- 2) Strong religious delusions, such as imagining the deceased husbands of herself and neighbours were translated by flight to become archangels.

⁷ George Hall, sixth admission, 7295, 20/4/1894.

⁸ George Hall, seventh admission 8510, 22/3/1899.

3) Incoherence of language.⁹

On the other hand, in 1870, Elizabeth Cook's doctor could do little more than describe the behaviour already remarked by the relatives and add the comment that she had a 'peculiar expression of countenance'.¹⁰

5.3.2 Violence

Violent behaviour was the second most frequently cited factor indicating insanity, though for doctors it was of similar importance to unacceptable social behaviour. It was considered much more important by lay informants, who mentioned violence or threat of violence to people and property about 100 times. Doctors tended to make general comments about the violent nature of an individual's behaviour. Lay informants were more likely to mention specific threats or incidents. Actual incidents were reported more often than threats and, not surprisingly, violence to people was mentioned more often than violence to property, with family members being affected more often than non-family. George Hall's parents were "frightened of him and unable to manage him", in 1888.¹¹ On more than one occasion they called in outside help to restrain him. Violence was most often experienced within the family, which is also where most of the care took place, often an explosive mixture creating an intolerable situation.

One of the problems with reporting violence of any sort in relation to madness was that of judging how this behaviour related to normally accepted levels of violence. In Henry Orchard's case, for example, the murderous attack he made on his wife, followed by his own attempted suicide was clearly considered the act of a mad man, though his case notes record that he was able to justify his actions, to himself at least.

⁹ Elizabeth Messum, fourth admission 1674, 27/2/1863.

¹⁰ Elizabeth Cook, third admission, 2832, 28/2/1870.

¹¹ George Hall, third admission, 6146, 19/9/1888.

Says now that his wife has not allowed him to touch her for two years (she had three or four children before that) and that he used to masturbate and that he intended to kill himself having first killed her to prevent her taking in anyone else in the same way.¹²

However, both sections of his reception order mention only his despair after the act: of feeling that his soul was lost.

In Eliza Moon's case, the degree to which she was prepared to beat her children was the issue as far as the neighbours were concerned. Some level of physical chastisement was acceptable in most families at every level of society but she was accused of "beating her children unnecessarily."¹³ Her doctor concentrated on her general restlessness and confused ideas.

However, as these cases show, descriptions of violence alone were not enough to justify admission in either a legal or a medical sense. In 1862, Eunice Douse's relatives had had enough. She threw "various things at the people about her....Has opened her windows and screamed violently without reason."¹⁴ Her doctor noted her violence of manner and incoherence in speech but went on to describe her sleeplessness, her inability to recognise people she should have been familiar with and her inability to maintain coherent thought processes, which would enable her to answer straightforward questions.

5.3.3 Self harm

The other category of violence was to the self, either as a threat to commit suicide, an unsuccessful attempted suicide, or behaviour which was perceived as harmful to the patient's health and well-being, such as refusing to eat or drink, or wishing to eat unusual substances. In 1891 Ernest Higgs was observed eating from the pig trough. Helen Townsend was described by her doctor as "emaciated [and] often refuses food and thinks herself stout".¹⁵

¹² Henry Orchard, 6520, 27/10/1890.

¹³ Eliza Moon, first admission, 1523, 10/5/1862.

¹⁴ Eunice Douse, fourth admission, 1498, 29/3/1862.

¹⁵ Helen Townsend, second admission, 4248, 19/9/1878.

Both doctors and lay informants noted suicide attempts but the threat to commit suicide appears, understandably, to have alarmed lay informants more greatly than doctors. In this category of self harm lay informants concentrated on active harm through neglect or self violence. Doctors also noted these things but gave most emphasis to describing anxiety and depression.

Susan Mitchell's doctor was called in May 1888, after she attempted to kill herself by drinking a teacup full of paraffin oil. He recorded that she told him that "her mental sufferings were intense and that she is depressed and very unhappy. She looks very gloomy and depressed."¹⁶ Elizabeth Watton's doctor was called in after she attempted to cut her throat in 1896. He had visited on several previous occasions, when she had threatened suicide, and had found that "she has been very depressed and shown signs of melancholia."¹⁷ Just as violent acts were often directed against family members unsuccessful suicide attempts often took place in or close to the family home leading to a breakdown of tolerance and of the family's confidence in its ability to cope.

As with violence the lay informants were influenced by actual episodes of attempted self harm while doctors who were usually called in after the event, tried to concentrate on the underlying condition such as depression and anxiety, which may have made self harm appear desirable.

5.3.4 Unacceptable social behaviour

Unusual behaviour inside and outside the home also provided scope for comment by both groups of informants though the lay informants, who presumably witnessed the behaviour, felt more inclined to comment than the doctors, who presumably just heard about it. Unusual behaviour at home might include changing normal routines or undressing at inappropriate times and can often be seen as an extension of the 'mad behaviour' noted earlier. Such behaviour, as long as it was not dangerous and remained private, could be tolerated for a while. Since it often involved undressing or appearing in inappropriate clothing, whether or not it was perceived as a problem

¹⁶ Susan Mitchell, second admission, 6076, 1/5/1888.

¹⁷ Elizabeth Watton, 7888, 27/10/1896.

could depend on the composition of the household. In 1860 Eliza Bedford's husband, William, tied her to the bed with a belt because she was, "striving to get up to leave the house naked."¹⁸ Ernest Higgs was seen by his cousin naked in his own house and this fact was reported by his doctor, "Elizabeth Peach, his first cousin, tells me that Ernest William Higgs stripped naked on Saturday and walked about his house in that state."¹⁹ In small houses with large families and in communities where houses were close together the potential for embarrassment and family disgrace was enormous. Doctors recognised this and they also sometimes had opportunities to see it at first hand.

Furthermore strange behaviour at home could be linked to the symptoms of insanity such as delusions or hallucinations, noted earlier. Unacceptable public behaviour was noted more than twice as often by family and neighbours than by doctors. Of course, when in a public place the potential pool of witnesses was larger and the potential for scandal much greater. Some committed minor indiscretions. Emily Brown "ran from the house with nothing but her nightdress on, went across the forest. Took her nightgown off and continued running rapidly in this state", but this incident took place at 3 a.m. when there were few witnesses.²⁰ While publicly embarrassing behaviour was often an aspect of insanity, sexual indiscretion or misdemeanour was almost never cited as a factor. Dorothy Stephens accused her father of sexual intimacy with her but this was taken as a symptom of her allegedly delusional condition. There are no examples of illegitimate pregnancy and very few of promiscuity as a stated reason for certification among this group.

Private indiscretion could be tolerated for a while, but others drew attention to themselves in style. In 1870, on the first of many such occasions, neighbours and many other witnesses reported that Caroline Beaton of Havant, was observed

exhibiting herself in the streets, dressed fantastically, carrying a basket on one arm and holding a jug in the other hand, with a whip slung over one shoulder at the same singing and capering about.²¹

¹⁸ Eliza Bedford, first admission, 1290, 3/11/1860.

¹⁹ Ernest Higgs, sixth admission, 6155, 8/10/1888.

²⁰ Emily Brown, second admission, 2867, 10/5/1870.

²¹ Caroline Beaton, first admission, 2951, 13/12/1870.

In nearby Bedhampton a few years later the local minister, Mr Snell, gave evidence of Joseph Battman's "unseemly conduct in disturbing the congregation in Bedhampton church on the 26th by addressing the congregation during the service."²²

Another aspect of this category was the use of abusive or obscene language, which both doctors and lay informants noted. For lay informants it was an aspect of unusual or disruptive behaviour; for doctors it could be associated with the general categories of incoherence and talkativeness, which were parts of a definition of madness. Bad language and personal abuse were noted sixteen times in relation to women and twelve times in relation to men. Lay informants noted it an equal number of times for both but doctors noted it in particular for women. Though this is a small sample it may give indication of the difference in expectations of appropriate behaviour between the two groups.

Finally, personal habits were more of an issue for families than for doctors, who did not have to deal daily with incontinence or strange eating habits. In this category twenty percent more comments were made by lay informants and tended to concern incontinence and personal hygiene. Ada Knight, an 'idiot' child resident in the workhouse, was not considered fit to stay there partly because she was "very dirty in her habits [with] no control over the calls of nature."²³

5.3.5 Bodily health

Doctors were more likely than lay informants to mention illness or impairment in their comments though relatives often noted earlier feverish or delirious illnesses or accidents to the head as a relevant factor in a history. Epilepsy or mental handicap were the most commonly mentioned factors in this category and in these cases doctors seemed to feel on more certain ground than with many other cases. In the 1890s George Hall suffered repeated attacks of epileptic mania which terrified his parents and resulted in physical restraint being used to control him. His doctor recorded that,

²² Joseph Battman, third admission, 3483, 27/4/1874.

²³ Ada Knight, 5466, 22/12/1884.

He has been in a state of semi-unconsciousness alternating with acts of violence....He has had repeated epileptic attacks and his hands and feet were confined.²⁴

Apart from events related to childbirth or to attempted suicide, however, even doctors rarely offered a physical explanation. Albert Higgs's father mentioned his 'brain fever' in a letter to Dr Manley but on neither of the two reception orders did his doctor mention this.²⁵

For some patients it became apparent as time in the asylum passed that their mental condition was only too obviously part of their bodily ill health. Eliza Whebell, from Romsey was in the terminal stages of phthisis when she was admitted and had already spent a considerable amount of time in hospital. Ellen Crump's mental distress turned out to be just one of her problems, which her mother could finally bring herself to describe only after a direct request from the asylum for information.

For about five years she has suffered form a violent discharge of blood from the bowels...For the last three years her courses have been irregular every ten or twelve days and very profuse...they stopped all at once about seven weeks before she left us.²⁶

The state of bodily health was recorded on admission. The expressions used were not precise but included phrases such as 'feeble', 'critical', 'indifferent', 'moderately good' and other similar descriptions. A rough assessment based on the use of such phrases suggests that only thirty-nine percent of those admitted were considered to be in good or moderately good health. Just over half were in poor health and nine percent were in reasonable health but perhaps, with one specific physical disability or health problem to contend with, either as the cause or the result of their condition. Women were more likely than men to be assessed as in poor or indifferent health on admission. However, of those in poor health, women were more likely to recover than men. Almost seventy percent of all men admitted in a poor condition died in the asylum, while only fifty

²⁴ George Hall, 6588, 18/2/1891.

²⁵ Albert Henry Higgs, 3692, 17/8/1875.

²⁶ Ellen Crump, 5449, 17/11/1884.

percent of similarly described women met the same fate. The most likely reason for this is that men were often suffering from the potentially fatal condition of general paralysis of the insane, of which insanity might be only one symptom, whereas women might be admitted in a generally low physical condition, which would respond to the use of a range of simple measures such as good diet, rest, and the passage of time. However, of those admitted in good health the women were also more likely than the men to recover and be discharged.

5.3.6 Previous attacks

Finally, previous attacks and asylum admissions were noted as evidence of insanity and in some cases as the sole evidence, particularly when the admission was yet another readmission of a familiar case. On his third admission Joseph Glasspool was recorded as “twice confined in lunatic asylums. Has been under my treatment for lunacy previous”.²⁷ Usually though, this information was supplementary, included to confirm statements regarding other behaviour and symptoms.

Previous admission to the HCA was often mentioned and may have been a reason why a subsequent admission was sought. A previous discharge usually suggests a previous recovery and although a readmission obviously meant a relapse, there could have been a certain amount of optimistic expectation of another recovery, which made the patient and his or her family more likely to acquiesce to another admission. There are a few examples of patients putting themselves forward for readmission. Helen Townsend asked her doctor “why you enquire about her health when it is her mind that is affected”, and said that she “wishes to go to the asylum”.²⁸ When Ellen Adams was admitted for the sixth time she had “said seventeen days ago that her illness was coming on.”²⁹

It might be said, therefore, that the reception order was a self-conscious document in that it was constructed to justify a prior decision. The two sections of the “factors indicating insanity” were complementary, as it was important for the document to record not just that a person was insane but that insanity was the cause of anti-social

²⁷ Joseph Glasspool, third admission, 2040, 1/6/1865.

²⁸ Helen Townsend, second admission, 4248, 19/9/1878,

²⁹ Ellen Adams, sixth admission, 2636, 12/1/1869.

acts, which might justify temporary removal from society. At the same time the anti-social or unsafe activities of the patient had to be explained by their insanity. Analysis of the comments shows a tendency among doctors and lay informants not just to describe unacceptable behaviour but to attempt to identify a condition called insanity among those they certified. In addition, and in spite of the document's administrative and legal functions, the comments of lay persons and medical men show clearly that almost all the events described took place in or near the family home, putting strain on an already tense situation. By calling in the relieving officer and the doctor families were asking for help beyond that which could be offered at home.

5.4 Past history

When Dr Manley and his successors attended the admission or re-admission of a patient they received the reception order containing information about the actions and state of mind which had resulted in certification. It was focussed, of necessity, not on normal life but on abnormal symptoms considered to warrant specialist treatment. In some cases, particularly when home treatment had been attempted, the physician may have written an accompanying letter, as Dr William Lush did for Emma Carter. When he signed her medical certificate in 1877 he stated that he had “ attended her for some weeks and ordered her a mixture of Bromide of Potassium and Chloral Hydrate and aperients when necessary”.³⁰

The medical superintendent waited a few days before entering a diagnosis into his records. Experience told him that the excitement engendered by an admission, particularly a reluctant admission, could mask or exaggerate the patient's true state of mind. Or a sudden frenzy could subside under the shock of admission and then resume later. By the time George Hall arrived at Knowle in leather restraints, in March 1890, he was quieter and rather dazed and confused. Dr Worthington had to rely on the reception order to understand what had precipitated the admission. Meanwhile apart from transferring information from the reception order to a fresh page in the case book he could add the evidence of his own observations and such additional information as he had been able to obtain from other sources. This was entered into

³⁰ Emma Carter, first admission, 3942, 3/3/1877.

another section of the case notes and might be derived at first or second hand from a variety of sources, which were rarely identified. However, the few clues remaining suggest that while letters such as Dr Lush's about Emma Carter sometimes accompanied a patient, the principal source of information about the patient's background was the tale told by the person or persons who escorted him or her to the asylum.

The two sections of the reception order relating to 'factors indicating insanity', which were completed by the medical officer on behalf of himself and those closest to the patient, tended to concentrate on the very recent behaviour, which made removal from the community desirable, or even essential. The history that the accompanying officer or relative gave on arrival at the asylum could fill in details going further back into the past and dealing with everyday life and family history. This could be a family member or neighbour but was often the relieving officer or a workhouse employee and the level of his or her personal knowledge of the individual varied from case to case.

The person accompanying the patient would be encouraged to tell what he or she knew of the family and medical history of the patient. The asylum medical officer recorded what he considered to be useful. This included comments about the patient's work, health, family life, personality and medical history and might include a detailed list of previous admissions or incidents and speculation about the cause of the mental condition. In George Hall's case his father was the informant on at least two occasions but on others information was taken from the relieving officer and workhouse staff.

Different official opinions about the importance of such material over the years are reflected in the varying layout of the casebooks throughout the period. In the early years of the 1850s, apart from sections for identifying details, the person's history was summed up in a piece of continuous prose. In later casebooks a space was allocated for a personal history. In the 1880s and 1890s the casebook pages were highly structured and requested specific information but in many cases someone found time to scribble a sentence or two of personal history. As with the reception orders the quality of the information given was variable, depending as it did on the interests and time available to the doctor who recorded it. In the 1860s and early 1870s record

keeping was very poorly done and the space assigned for personal information was very rarely used. Nevertheless in many cases the two types of information taken together can build a picture of an individual's life as well as the circumstances surrounding admission.

In the case of Ann Cox, for example, admitted in July 1858, the reception order offered very little information. The doctor noted that 'her mind is quite gone'. Her next-door neighbour, Mrs Lock stated that "she has observed an alteration in her manner for some time past. Her language is incoherent and unconnected."

Ann's next-of-kin was her mother, Temperance Briant and maybe it was she who in describing a family stretched to its limits, told Dr Manley that her daughter,

was confined of a child last January. Has since had a miscarriage but continues suckling the child. Has had two or three miscarriages. 4 children at present living. Knocked her mother down and tried to throw herself out of the window and appears to have been frightened from seeing one of her children fall down from a tree.³¹

When re-admitted in 1861 after raving and violent behaviour and delusions her history stated that the attack "arose from over fatigue from working in the fields during a very hot day." By her fifth admission in 1877, when she was in her fifties, Ann's reception order stressed her excited behaviour, her delusions and her threatened violence. Her history recorded the information that she had seven children of whom the first was illegitimate. She herself also contributed by suggesting that getting wet while working in the fields may have triggered the most recent attack.

Louisa Painter was another person whose past family and medical history seemed as important as her immediate symptoms. Admitted in a state of great anxiety and depression, she was a single woman of fifty-eight, who had been finding it increasingly difficult to work since breaking her arm three years before her admission in 1879. Until a fortnight before her admission she had been taking in laundry and she had

³¹ Ann Cox, first admission, 986, 31/7/1858.

continued to live at home although she was ill. Her anxiety about receiving poor relief in the form of extra nourishment, on the doctor's orders, was quoted as one of the symptoms of her condition. She had saved £3 and feared she would be punished. She had a congenital harelip and double cleft palate as well as symptoms of phthisis and so her hard life and bodily ill health were suggested as the cause of her increasingly depressed condition. This was also noted as hereditary as her father, Jarvis Painter, had died in the HCA twenty-three years earlier.

Alfred Stockwell made a determined attempt to kill himself; he cut his throat and then tried to drown himself in the well, but got stuck before he could get his head under water. This caused a flurry of interest in the press especially as it came in the wake of his wife's admission to the HCA on the previous Friday. However, his reception order mentioned only "his greatly altered appearance and alarmed look", and that he "refused food ... and was sullen and silent." Almost as an afterthought the doctor noted a "self inflicted wound on the front of his throat", though he was covered in bruises and had four wire sutures in the wound. It was left to his daughter and the local police constable to fill in the more gruesome details for Dr Manley.³² In this, as in the other two cases, the symptoms of supposed insanity were linked to the circumstances of life and Dr Manley, in particular, often noted how closely connected he believed the two to be.

5.5 Diagnosis

It has already been stated that, in almost all cases, the medical staff at the HCA played no part in the decision to admit a person. Some brief correspondence about the practicalities was usually the limit of contact before an admission. Thus, the Reverend William Druitt sent a telegram on February 25th 1870 requesting the admission of Elizabeth Cook, to which Dr Manley immediately replied, and her admission took place three days later but the correspondence was limited to administrative detail and did not extend to medical matters.³³

³² Alfred Stockwell, 4064, 29/10/1877.

³³ Elizabeth Cook, third admission, 28/2/1870.

After a week of observation at the HCA an asylum medical officer would make a formal diagnosis. This would then be entered into the admissions register and casebook. He would take into account all the information previously offered to him in the reception order and from the patient's companion, along with his own observations, and then assign the condition a name, usually one of four major categories discussed in the following chapter. These categories of, "mania", "melancholia", "dementia", and "idiocy" were used throughout the period 1852-99. They tended to describe the symptoms that presented themselves rather than the origin or progress of the disease. General paralysis of the insane was sometimes described as a condition in its own right and sometimes as a cause or result of mania or dementia. Similarly, epilepsy could be symptom, cause and embodiment of insanity. Doctors also attempted to distinguish symptoms of mental impairment present from birth from those arising later in life and related to accident or illness.

If, on admission, the medical superintendent could not personally verify the existence of insanity, he would then keep the patient under observation for a while before beginning the discharge procedure. For example, Emily Kate Harvey, a prostitute who had been working in Portsmouth, was transferred to Knowle from Fisherton House asylum in June 1875. In spite of a reception order which detailed her disruptive behaviour and abominable language, Dr Manley could find nothing insane about her conduct or appearance and wrote to the Commissioners in Lunacy to tell them so. When she was discharged on July 8th he entered "not insane" rather than 'recovered' in the column assigned to the type of discharge.

5.6 Role of families in discharge

Dr Manley had something to say about the involvement of friends and relations in discharge. He pointed out that often families asked for discharge when nothing much had changed. The person was as dangerous to themselves and others as ever and circumstances at home had not changed in such a way that it was likely that the patient could be better looked after than previously. In other words he warned against the asylum being used as a form of brief respite arrangement for the family. Once the family had had time to draw breath they would request the discharge and this would often lead to rapid readmission because no cure taken place.

I think.. that when a near relation shows he can and is willing to support and take care of a patient who is neither dangerous to himself and others, such a patient may be fairly discharged. But when a lunatic has been sent to an Asylum to be taken care of because he has suicidal propensities or is dangerous to others and has not improved during his residence to such an extent as to lose these propensities, or is from any other cause manifestly unfit to be at large, and where, moreover, the conditions of the friends have been unchanged since the lunatic has been an inmate of the asylum, I think a serious responsibility attaches itself to the discharge of such patient even though the request for it be urgent and persistent.³⁴

Nevertheless this is what appears to have been happening in a number of cases and in many more the discharge took place because a person appeared to have recovered, even when past experience seemed to indicate that a subsequent re-admission was likely. George Hall was discharged on each of seven occasions into the care of his family and re-admitted within a few weeks or months on six of those occasions.

In the same way that documents were carefully checked to make sure that each admission was legal, patients were not discharged without some consideration of their future conduct or accommodation, though at no time during the period could the Visitors be persuaded to extend this to the provision of a small amount of financial aid. In 1855 Joseph Glasspool was considered fit for discharge on condition that a debt that his wife had contracted could be repaid. Dr Manley suggested that an allowance equivalent to his weekly maintenance could be made to him until the debt was cleared. The committee thought not and passed the problem over to the New Winchester union. The eventual solution was not recorded but a fortnight later Joseph was discharged on trial and a month after that discharged recovered.³⁵

The fact that applications were regularly made to the Committee of Visitors after only a short while, for the release of patients by the same people who had supplied the

³⁴ Medical Superintendent's Annual report, 1874.

³⁵ Visiting Committee minutes, August 18th 1855.

evidence that put them there suggests that, for many, the asylum provided the solution to a short term crisis that was part of a longer term problem. Mark Finnane drew attention to “the variety of interests which might be involved in an asylum admission, or indeed an asylum discharge.”³⁶ Many patients were calmer and showed more self control after a few weeks and the members of the household remaining at home had had time to clear up and calm down. In Sept 1853 William Hervey’s wife requested his discharge, which was granted about ten days later. Mr Wild removed his son in November of that year in spite of the fact that “the committee strongly represented to him the responsibility that he takes upon himself in taking his son away.”³⁷ On the other hand, though they wrote to Hannah Wilkinson’s husband in August 1853 to tell him she was fit to leave, there was no reply and Hannah did not leave the asylum until October.

On at least two occasions Caroline Beaton was discharged at the request of her family though they had problems of their own to deal with. After the death of her husband, the various names of Caroline’s sons and daughters appear on her documentation and she was admitted from or discharged to their homes at different times over a number of years. In 1881 Caroline’s son, Thomas Beaton and his large family, were resident in Havant workhouse and his brother Eli was a prisoner in Winchester prison. The oldest daughter Carrie Wells had mental health problems of her own and was her mother’s companion in the asylum for several years.

Families could also influence the decision the other way. In 1875 Andrew Young’s wife heard a rumour that her violent husband was shortly to be released. She expressed her feelings clearly in a letter to the Committee of Visitors,

³⁶ Mark Finnane, “Asylums, Families and the State”, *History Workshop Journal 20*, Autumn 1985, pp134-148.

³⁷ Minutes of the Visiting Committee. August 1853.

If he returns again to me I don't know what in the world I shall do for while he was here between the time of his first discharge and of going back the second time both me and the children lived in perfect dread and misery.... And after he had been home a fortnight he was quite incapable of being left with the children while I was out at work and when I returned home in the evening I dreaded to enter the house for fear something dreadful had happened in my absence. Knowing that he carried a weapon always with him.³⁸

The letter illustrates what must have been a common dilemma in such cases. The wife must work because the husband couldn't and yet he was not fit to care for his family either. On this occasion the rumour proved unfounded and Andrew was not discharged until three years later but he eventually returned to his family and was discharged from the HCA and readmitted several times in the following twenty years.

Finally, there were also those patients for whom a peaceful end at home was the final thing a caring relative could do. George Dacre went home to his sister in Winchester in 1892 and the Clerk to the asylum wrote a letter of explanation to his local Poor Law guardians.

I am instructed to inform you that [George Dacre] was this day discharged by the committee...to the care of his sister...who wished to have him home to die.³⁹

5.7 Conclusion

George Hall's admission to the HCA in 1890, with which this chapter opened, was his fourth in three years. On this occasion, as he was still confused and had been violent he spent a few days in a padded cell. Sedatives were prescribed until he appeared to be his old self and was able to work. Two weeks later, George had had no further fits and was "agreeable, conversable and rational". When he was restored in a matter of weeks

³⁸ Andrew Young, second admission, 3587, letter dated April 4th 1875.

³⁹ Asylum letter book, 30th March 1892

to a situation where “he goes on quietly, industriously and well, gives no trouble and is in excellent bodily health [and] mentally remains perfectly rational and agreeable”, it was time to discharge him to the care of his parents. As on previous occasions he was soon able to find labouring work. Bournemouth was a hive of building activity at this time. This was the pattern of George’s life for the next decade. He returned to his family and was always able to find work on discharge but was usually incapacitated by his fits whenever they returned.

George Hall’s history extended over a number of years, was continued from one admission to the next and it can be seen in this record that his family was essential to his remaining in the community between admissions by keeping him in good health and attempting to care for him when his attacks came, even though he tended to exacerbate his condition by occasional drinking bouts. He was always discharged to his parents until 1902. His father had become an invalid by that time and his younger brother Charles lived at home with his parents. George was not readmitted to the HCA again and he disappears from view at this point.

Comments on reception orders show that families and to a certain extent, neighbours and communities, could tolerate eccentricity or just plain strangeness. It might have led to talk but not necessarily to action to remove someone from the community. Once violence to others, self-harm or publicly disruptive and embarrassing behaviour became an issue, in both chronic and acute cases it was more likely that certification would be sought. In any of these cases the burden of care upon the family was increased. It has been argued that this was not practical in a hand to mouth economy as both the sufferer and the carer were then prevented from earning a wage or caring for the family’s needs. This must certainly have been an issue, though John Walton has suggested that, in the mid-century at least, the changes to family economics resulting in the separation of home and workplace, have been exaggerated.⁴⁰ The comments on the reception orders do not spell out family difficulties in financial terms but emphasise organisational and emotional difficulties suffered within the household. In spite of the effect on the family, from the official point of view bad behaviour alone

⁴⁰ J. K. Walton, “Casting out and bringing back in Victorian England: pauper lunatics 1840-1870,” in *The Anatomy of Madness*, vol 2, p135.

was not sufficient to justify an individual's certification. Some quality defined as insanity had to be recognised and described by someone considered qualified to do so.

In this respect some practitioners were better than others at expressing the information required and at separating events noted by families from the underlying psychological condition which they were responsible for recording. They concentrated on a variety of behaviours, which could be identified as abnormal, either for the individual concerned or for the community within which they resided. Though incidents involving violence towards self and others were important and situations which defied public decency were also included, the demonstration of an insane frame of mind was the most important aspect for both groups and even sudden or shocking events which precipitated admission had to be justified in terms of altered states of mind rather than just because of the incident which had occurred. In some areas Poor Law officials, particularly relieving officers, were much more likely than doctors or lay informants to be in a position to have experience of deciding if a person was a suitable case for an asylum as they were more frequently involved in events leading up to the signature of the reception order and they often accompanied a patient to the asylum and were responsible for communicating background information.

The act of certification could, in these circumstances, be described as a social diagnosis, in which both the Poor Law doctors and family members were part of the same community involved in a decision to exclude one of its members as a last and not a first resort. By virtue of their medical qualifications doctors were called upon to mediate so that a social decision came to have a medical justification. In effect, therefore, the reception order sanctioned a removal from the community of which doctors were a part. Though they attempted to demonstrate that their patient's mind was disturbed, they only described symptoms and the business of diagnosis was left to the asylum medical superintendent. Then, as now, general practitioners trod delicately around the territory of the specialists and may have been relieved not to have to take responsibility for defining the disease.

The documents also show that the diagnosis of the mental condition remained the prerogative of the asylum medical superintendent and that he was interested not only in the medical officers' comments but in what else could be learned about the patient's

life. It is clear that the patients' lives outside the asylum were considered as important in the diagnosis as were the actual symptoms of insanity, though the emphasis was on their material rather than their moral problems. In that information the doctor could seek to discover both the cause and the underlying circumstances on which the acute condition was based. In the same information we can begin to see the desperate circumstances that some individuals and families found themselves in. Though every person had their own story to tell, it becomes increasingly clear that in most cases the sufferers themselves and the people they lived with coped for a considerable time at home and with very difficult situations before considering asking for outside help. The following chapters examine this in greater detail.

Chapter 6

Outside the asylum

The historiographical emphasis on asylums and asylum treatment is hardly surprising when asylums have generated the most readily available archival material. The prevailing philosophy stressed the utmost importance of early discovery and immediate treatment for insanity and the age assessed itself in terms of its great institutions. All this might lead to the development of a view that the asylum was the first rather than the last resort for all concerned, family, patient, and medical practitioner. However, it has been suggested that, “care outside the walls of the asylum remained the primary response of industrial societies to the problem of the mentally disordered from 1750 to the present day.”¹ Such care is difficult to assess as it was offered on both a formal and an informal basis.

The documents associated with the admission process show that an acute situation was usually put forward as the reason for admission, even though this might come as the culmination of a series of increasingly troubled events or towards the end of a chronic and deteriorating condition. However, the HCA officials recognised that the person’s personal history and circumstances were also important in assessing his or her condition and the prognosis of the case. The patients’ records studied for this research show no examples of individuals who were leading normal lives on one day and were candidates for asylum admission the following day. There was a period during which families attempted to cope at home and considered alternative treatments and this appears to have been true in both chronic and acute cases. For families in Hampshire the alternatives were to continue to look after a person at home or to transfer the care to the workhouse. A few people were supported by the union as boarders but these appear to have been individuals who had no immediate family living nearby and the arrangement was only acceptable for as long as the boarder was well behaved.

¹ Peter Bartlett and David Wright, eds., *Outside the Walls of the Asylum*, (London and New Brunswick: Athlone, 1999), p viii.

This chapter looks at the circumstances under which families coped for varying periods of time before applying for help resulting in an asylum admission. This was not a straightforward choice between alternative treatments but was inevitably bound up with the problem of reconciling the advantages of the asylum with its stigma: the loss of an individual from the family group with the possibility of a healthy return. On a practical level there may have been something of an informal waiting list though it is difficult to know about individuals who were possible candidates for certification but who were not eventually admitted to the HCA.

Medical superintendents at the HCA continued to stress the importance of early treatment and, as far as they were concerned, the accumulation of chronic cases only served to emphasise the point. In 1862 John Manley wrote that, “insanity, to be treated correctly must be submitted to appropriate treatment early”.² A quarter of a century later Thomas Worthington was complaining that “in many [cases] valuable time has been lost in not placing them sooner under proper treatment.”³

Nevertheless both doctors claimed to believe in “the confidence the public has learned to place in the management of these institutions”,⁴ but five years after her discharge Rhoda Vollow was readmitted saying that “the women twitted her about having been in the asylum”.⁵ This is an indication that members of the community in general did not accept either mental illness or asylum residence in the same spirit as physical illness or hospital treatment. John Dixon Reid waited impatiently for years while his son and son in law made it clear that it would not be possible for him to return to Alton, where his embarrassing behaviour had led him to the HCA on two occasions. They claimed to be looking for somewhere else for him to live quietly but he remained an asylum inmate until his death in 1905.

² Medical Superintendent's annual report, 1862, p 15.

³ Medical Superintendent's annual report 1889, p 17.

⁴ Medical Superintendent's annual report 1894,

⁵ Rhoda Vollow, second admission, 3201, 30th June 1872

6.1 Duration of illness

The first part of this chapter, therefore, considers the length of time an individual lived with his or her illness before the decision to seek an asylum admission was taken. Duration of illness was recorded in the admission register and casebook but not included in the reception order. This suggests strongly that the source of such information was probably the person accompanying the patient to the asylum, who was frequently the relieving officer though family members also went along, particularly with women. The answers given were correspondingly varied and depended on the nature of the relationship between patient and attendant.

Though the proforma of the register was laid out to receive precise figures in weeks, months and years, many people replied 'some months' or 'several years'. Others felt compelled to explain their answer. Amelia Smith's melancholia had been evident for eighteen months but was 'worse the last three'. Charles Mackell suffered from epilepsy for three years but was 'worse the last month'. Such statements make the duration of illness hard to tabulate but at the same time they feel more valid than those given in precise numbers, for who can know at what moment an illness of any kind begins? Some informants may have fixed on the moment of crisis when outside help was summoned; others may have looked further into the past to find a moment when things were not as they usually were. So the 'duration of illness' refers not to an absolute measurement of an illness but to the perception of the illness by someone else. It is possible that previous attempts had been made to admit individuals but, unfortunately, the records do not help to clarify this. Duration of illness was recorded in eighty-four percent of all entries in the admissions registers and can give a general impression of the length of time an acute situation would be tolerated before certification and committal to the asylum began to seem like the most appropriate course of action.

In twenty-two percent of all recorded cases the condition which led to admission was extremely acute, having existed for ten days or less. Men within this group were more likely to be admitted in the first seven days whereas women were more likely to be admitted in the last four days of this short period. This is true of all admissions, whatever their age or marital status. It implies that women were likely to be allowed an extra few days grace at home or in the workhouse, either because they were physically

easier to control and therefore less of a danger or because families were willing to try harder to look after their female members. There may also have been a greater possibility of extended family or neighbourly support for a sick woman as part of reciprocal help or because it was possible for one woman to take over part of another woman's work. A man suffering from an acute mania was not only more likely to be dangerous, but it was not easy to compensate for his lost income at a level of society where few individuals could earn enough for a whole family's needs. This might have been a reason for delaying consulting a doctor until the point where someone was considered in acute need of asylum treatment but if he remained at home beyond this point he presented a double burden whereby his income and that of his carer might be lost. In the fifty-five to sixty-four year age group, seventy-four percent of males and only twenty-six percent of females were reported as having been ill for a few days only.

Half of all those for whom duration of illness was recorded had been admitted within a month of the perceived onset of their condition. Seventeen percent had suffered for over a year but this group included those with a lifelong condition.

Children and those labelled as idiots had usually been cared for outside the asylum for many years but young adults were more likely to have been admitted quickly than were the elderly. Twenty-seven percent of all fifteen to twenty-four year olds whose duration of illness was recorded had been considered ill for fewer than ten days whereas only thirteen percent of the over sixty-fives found themselves in the same situation. This was probably due to the different character of mental illness in these age groups. Young people were much more likely to experience acute conditions, which caused unexpected disruption in the household. The older group was more likely to be suffering from dementia and to have received care and supervision over a long period of deterioration. Fifty-seven percent of this age group suffered dementia in one of its forms. Amongst both married and single people the duration of illness before admission was roughly equivalent for men and women. Widowed women were ill for longer than widowed men before admission, again reflecting a willingness in families to continue to look after female family members for longer than male family members and suggesting a sustained relationship with families over many years, which was rewarded by prolonged care in old age.

6.2 Delaying or avoiding admission: care in the community

Though family relationships were important, the length of time that a person could be looked after in the home and community depended, to a certain extent, on the nature of their condition. Many conditions were chronic and their sufferers were considered to be harmless. In such cases the extra care they needed was provided in various ways for some considerable time. Other conditions were alarming and sudden, but because of the nature of the cause could often be expected to be temporary. These different conditions cast different needs on the families and community and may have elicited different responses and levels of tolerance.

Families where a member suffered from a mental handicap or a chronic dementia struggled on at home for the longest times. Since these tended to be either the young or the elderly, it meant that family members responsible for both groups were usually aged between thirty and fifty, a prime age for asylum admission in their own right.

Individuals who were deemed to be mentally handicapped or brain damaged were classed as idiots or imbeciles. Though, in many cases, the condition had existed from birth very few children were admitted to the HCA each year and all parties tried to move them elsewhere as soon as possible. They were always recognised as a group for whom separate provision ought to be made and this was the only group for which this was achieved at the HCA during the nineteenth century. The desire to improve and educate these children can be seen as an aspect of the idea of the therapeutic asylum. The feeling was that such children could “under proper supervision and teaching... be immensely improved in many ways.”⁶ A separate block was eventually built for the benefit of the children and the Commissioners in Lunacy were “much pleased with their neat appearance and bright, happy faces”. However, they also acknowledged that “by their residence here, the mothers are able to attend to their home duties, which if the idiot children were left at home, they would be unable efficiently to perform.”⁷

⁶ Medical Superintendent’s annual report, 1892.

⁷ Appendix to the 53rd Report of the Commissioners in Lunacy to the Lord Chancellor 1899, p289.

Certainly the admission of children was very much related to the situation at home. A family's ability to cope depended on the accommodation it occupied, the position of the child in the family and the number of other siblings. Charles Burton's mother had eight children older than Charles, whose father had drowned in the week of his birth. One of his sisters was described as 'simple' though she was not recorded as an imbecile in the 1881 census. Only the presence of older siblings must have made caring for such a family possible. Charles had regular epileptic fits from the age of three months, was violent and incontinent. His family managed to look after him at home for seven years but he was in the workhouse for only a few hours before it was decided that he could not be kept there.

Edward Atkins's family had been made homeless by his behaviour. Edward had been sent to the HCA by the workhouse authorities at the age of six, because he was hard to handle, but had been discharged from there at the order of the visiting committee, advised by the medical superintendent, because "the asylum was not intended for such cases."⁸ However, the family was unable to find anywhere to live because of the boy's behaviour. They had spent the summer living in barns and in the winter the mother and son went into the workhouse. In 1873, when Edward was eleven years old, he was returned to the HCA at the end of what must have been a difficult winter in the Petersfield workhouse. Edward had frequent fits, was unable to speak and could only scream and shout. The workhouse master stated the obvious, that "this is particularly difficult in the workhouse especially to the inmates of the sick wards near which he is necessarily confined." Both parents and the workhouse master felt that they had done their best but "he is less manageable as he grows older." He remained hard to control in the asylum and died there six months later.⁹

Edward's earlier discharge was not unusual as the asylum doctors continued to seek to make alternative arrangements for young children. Annie Troke had also been admitted from the workhouse, aged three. Having been partially paralysed and coming from a family where the parents were described as 'rather simple' and her brothers as 'imbeciles', Annie had few alternatives though the medical superintendent continued to look for them. In the early 1890s she was sent to board with Mrs Anscombe who

⁸ Visiting Committee minutes, 28th November 1868.

⁹ Edward Atkins, second admission, 3303, 12th March 1873.

had formerly been head nurse and was married to the head male attendant. When Mrs Anscombe became housekeeper Annie returned to the wards and died there in 1923, aged forty-five. There are other examples of children, particularly girls, who were placed in the homes of asylum attendants, so technically they remained on the asylum's books but lived in a family.¹⁰

Some children lived at home for many years until the moment, usually in adolescence, when due to a developmental change in the child or a change in domestic circumstances, the family could cope no longer. Mentally impaired children were hard to handle at any time, especially in small houses with open fires and overcrowded rooms. Constant supervision was almost impossible to achieve either in the house or outside in the common space of the street, especially when the child was the eldest in the family. When the child was the youngest the parents were often approaching their own old age because of the prolonged nature of childbearing in families at this time.

Leonard Knight lived at home until his teens. The third of thirteen children born over twenty-five years, he lived with his family until 1894 when he was fourteen. This was the year in which Louisa and Richard Knight's tenth child was born. Leonard appears to have been one of the many cases of epilepsy that caused such problems of organisation and supervision in the asylum. He suffered from fits for most of his life and they led to violent outbursts and mental deterioration. Though he had been supervised by the doctor in the local Petersfield workhouse for eight months before his admission the frequency of his twice-daily fits and their after effects made him increasingly difficult for infirmary staff to handle. His fits increased in number and severity until his death seven years later in 1901, the year in which his parents' last child was born. One can assume that Louisa would not have given Leonard up lightly, unless the situation had become impossible. The family was close and remained so over many years. In 1925, having brought up her own large family, Louisa Knight started again by taking in the children of her daughter Helen, who had died from peritonitis.¹¹

¹⁰ Appendix to the 43rd report of the Commissioners in Lunacy, 1889, p209.

¹¹ Additional information contributed by Pauline Daniels, Leonard's great niece.

In some cases care at home had continued into adulthood and in these cases the problem was that the parents were ageing, while siblings were not in a position to take over full time care of a difficult adult. Michael Mylward, at nineteen, was approaching adulthood; the doctor noted his sprouting beard and moustache. Brain damaged since birth his “expression pleasant but unintelligent”, Michael was the youngest of eight children born as his parents moved around London, Essex and Hampshire. Michael’s parents were in their sixties when he was admitted to the HCA in 1890. His behaviour had recently changed for the worse and he had used his crutches to hit his mother. But they too may have been ill. Michael died of phthisis the following year and both his parents also died in that year.¹²

Margaret Tocock was looked after by her widowed mother at home until she was twenty-six, even though the family seems to have been mobile, and their circumstances became more difficult over the years. While temporarily in Aldershot in 1885 Margaret’s mother Harriet placed her in the Farnham Union workhouse and went to live with another daughter. Margaret was deaf and had a limp caused by one leg being a couple of inches shorter than the other. She caused such disruption during her seven or eight weeks in the workhouse that it was decided to move her to the HCA. She “[got] out of bed at night, dancing, swearing destructive”. Her response when challenged appears to have been to lift her skirts and expose herself. Her mother’s distress on hearing of her daughter’s move is expressed in her letter to the head nurse at the HCA.

I was compelled through the greatest distress to place her in Farnham Union and that I fear has taken this great effect on her, ... from birth she has suffered with water on the brain She has always been an invalid. ...She had never been from me a day before I put her there and I am sure it has been too much for her. If she is at all conscious would you tell her that I am coming to her? ...I am only waiting for the means to come and see her as I am distressed about her. She is such a good docile Christian girl when well and nothing but the deepest trouble compelled me to part from her...¹³

¹² Additional information contributed by Margaret Switzer, Michael’s great great niece.

¹³ Margaret Tocock, 5554, 29th May 1885.

At the other end of the age-range another irreversible and sometimes long-term condition had a different type of impact on the household. Unlike the acute conditions dementia represented a breakdown in the mental faculties rather than a perversion of the normal way of seeing the world. So it could include memory loss and an inability to perform normal daily activities. Senile dementia caused the same sort of care problems as idiocy, without necessarily generating the affection or sympathy that can support the families of children. Careful supervision and personal care over a long period of time were often necessary and this was not possible if there were no additional household members to share the care. Admission to the HCA occurred when the level of personal care required had gone beyond the family's ability to supply it, but there could also be acute precipitating events.

In 1857, James Frost, aged seventy-four, appeared to have been deteriorating over the course of three years. His wife and daughter had coped until recently when he began to suffer fits and threatened to throw himself on the fire. He had "an imperfect state of memory and knowledge of the common daily habits and assumptions of his family", said his doctor, and his relatives were finding it difficult to cope with his wandering.¹⁴ In a similar case, in 1880, Isaac Wilcox was living with his wife, Ann, in Bitterne. In the previous three years he had deteriorated to the extent that he was incontinent and incoherent and did not know his own name. He attacked his wife and the final straw was when, "on Friday last he got out into the street screaming and shouting and was only brought back with difficulty". He died within three months of his asylum admission.¹⁵ Sarah Monk's husband, William was said to be "an old man, upwards of seventy and very fond of his wife".¹⁶ He died before she was discharged five years later and she was probably cared for by a daughter until she was readmitted a few months before her death in 1873.¹⁷

Cases where dementia was related to epilepsy or general paralysis were similar though they tended to appear in younger people and thus have a different effect on the household in that they were more likely to affect someone who could otherwise

¹⁴ James Frost, 882, 4th November 1857.

¹⁵ Isaac Wilcox, 4579, 2nd April 1880.

¹⁶ Sarah Monk, first admission, 881, 2nd November 1857.

¹⁷ Additional information about Sarah Monk was contributed by her descendant, Richard Monk.

contribute to the household income. Fifty-seven percent of all those admitted suffering from dementia were male, possibly because of the prevalence of GPI. Around seventy-eight percent of recognised general paralysis cases within the HCA database were also male.

Those people with acute conditions were likely to have spent less time at home before admission. Mania and melancholia, often thought of as two sides of the same coin, could develop suddenly in previously healthy people and reach crisis point in quite a short time. They were also subject to remission and individuals who were re-admitted on more than one occasion were usually suffering from one of these two conditions.

Mania was by far the largest area of diagnosis accounting for almost half of all cases. It was the condition most feared by the public and most symbolic of classical madness as understood in literature and tradition. It was associated with violence, delusions, and disruption. A manic person could surely be identified as different and as a risk to self and others. And, as these conditions tended to be acute in that they arose suddenly and often subsided just as suddenly, there was, from an institutional viewpoint, a possibility of cure. With mania the diagnosis was on firmer ground than in other categories. The evidence of an unsound mind was proven by the antisocial activities ranging from the raving dangerous to the tiresomely unsettled. This was true to such an extent that even in cases where the underlying diagnosis was otherwise, any symptoms of excitability were readily included to make the point. Therefore, though Joseph Glasspool supposedly suffered from melancholia, the fact that he was excited and threatened his wife was cited as one of the main reasons for admission. Similarly, in cases of dementia the potential for violence and agitation was often emphasised. As with all the other categories there could be a variety of underlying factors. Agitated and violent behaviour could be associated with fits, with drunkenness, with psychotic delusional conditions.

In some cases it appeared humorous. Caroline Beaton must have been quite a sight in Havant in the 1880s, capering through the streets in bizarre dress, followed by a crowd of children “generally conducting herself in such a strange manner as to attract the observation of neighbours and others to induce boys...to follow her about with jeers and laughter.” Meanwhile, at home she left a trail of destruction, “disputing with her

husband and threatening to destroy the whole of their belongings and this without cause or provocation.”¹⁸

Some individuals were violent and frightening at home. In 1877, Stephen Butler’s wife Thirza had every reason to be living in continuous fear for her own safety and that of her children. Her husband, a hard drinker, who was inclined to hear voices, had been imprisoned for assaulting her on a previous occasion. Having drunk away the £40 he inherited from his father he found himself in the workhouse, where he repeatedly requested a knife to cut his own throat, and the attentions of three or four other inmates were required to keep him from doing harm. This way of life continued for the family for the next ten years with Stephen being discharged to his wife’s care on five occasions between 1870 and 1886 as his GPI became more pronounced. Judging by his physical condition on his last discharge Stephen probably died shortly after this and by 1901 Thirza was living in her native county of Dorset.

Finally, Helen Townsend was simply wearing out all the people she lived with by her strange behaviour and continuous rambling conversation.

She stood with one foot on the sofa and one foot on the chair and drank soda water...she talks incessantly day and night without sleeping and requires constant watching.¹⁹

In all these cases the person involved was probably difficult to live with most of the time and the instability of their mental condition and behaviour was recognised. But in every case a breaking point had been reached where it seems reasonable to conclude that removal was a necessity not just for his or her own sake but for the sake of the rest of the household.

In cases of Melancholia a similar breaking point could be reached but in these cases it was more likely to be caused by fear about whether the patient might come to harm if left unsupervised. In such broad mental illness categories there is bound to be an overlap where symptoms can indicate more than one type of diagnosis. Melancholia is

¹⁸ Caroline Beaton, sixth admission, 6254, 20th May 1889.

¹⁹ Helen Townsend, seventh admission, 7429, 27th November 1894.

the most difficult in this respect. It can represent the reverse side of mania and therefore be associated with a psychosis, or it can be associated with clinical depression. In its extreme form it was sometimes mistaken for dementia, which might go some way towards explaining some rather surprising recoveries in the latter category. A diagnosis of melancholia was assigned to a relatively small group of patients. About eighteen percent of all patients were diagnosed as melancholic. The diagnosis was more common among women than among men as twenty-one percent of all female cases and fifteen percent of all male cases were melancholic. This is true in every age group and for every type of marital status.

Cases of melancholia could continue to be tolerated at home and in the workhouse for some time before a crisis, such as an attempted suicide, precipitated some sort of response. James Fullick had been

in a desponding state of mind for several weeks past and ...his relations have been obliged to watch him in consequence... this morning they found him hanging by a cord attached to his neck.²⁰

When cut down he rushed into the fire, scattering it about the room, a danger to himself and to the rest of the family. Elizabeth Cook was admitted in March 1877 because she had reached a non-responsive state where she would not talk to anyone, move, dress or eat. The more she refused to eat the more unwell she became. In a similar situation, in 1880, she refused food and declined to undress. She remained speechless all day and sat picking at her clothes.

Elizabeth Cook and James Fullick were a danger mostly to themselves but Julia Groom's actions also endangered her children. In 1881, on a trip to London she tried to jump into the Thames, with her baby in her arms. And when her husband, a ship's purser, was at sea she failed to spend any of the money he left her on food or on looking after the children. The doctor who was eventually called reported,

²⁰ James Fullick, 4711, 31st January 1881.

I notice her very distressed and vacant look, also her restless manner...she tells me she cannot carry out any of her domestic duties or attend to her children at all and states that she has utterly failed in everything connected with her home or children.²¹

These families lived hard lives and it is unsurprising that a degree of depression was common and passed unremarked. The situation could continue for a long time before the breakdown became apparent in the chaotic lives of the rest of the family, or in an uncharacteristic act of self harm or of violence to others.

Families and doctors of those with both acute and chronic conditions attempted to give care at home. Some of the more fortunate individuals were sent away for a change of scene. Helen Townsend spent time at the seaside at Southsea and also with relatives at Waterlooville. In the spring of 1863 Ernest Higgs was “observed to be morose and melancholy and was then sent for a change of air. He came back well”.²² Caroline Sparham’s family thought highly of “cheerful society and a little change” to lift the spirits and, though Caroline had more than once been in a “weak, low and disponding [sic] condition”, her mother wrote that “we gave her a change and she soon came right again.”²³ Unfortunately, in all three cases the beneficial effect was only temporary.

For others, in spite of the problem of reconciling the need for medical assistance with the Poor Law principle of less-eligibility, there was a rudimentary support structure for some of those who remained in the community. There was still the possibility of out-relief either to the individual or to someone else on their behalf so that boarding arrangements could be made. The out-relief received in the form of medical extras by Louisa Painter weighed heavily on her mind in 1879. Martha Tyrell, described in the 1881 census as “in receipt of parish relief”, lived as a lodger with Mary Kinchett and her son, in Hambledon, before her admission to the HCA later that year, while in East Woodhay Arthur Comyns, an imbecile, was lodging with Caroline Bond. Jane Port was supported in an almshouse for twelve years, with six shillings a week of extras but

²¹ Julia Groom, 4897, 29th December 1891.

²² Ernest Higgs, first admission, 1809, 23rd January 1864.

²³ Caroline Sparham, 3778, 13th March 1876.

she was sent to the HCA when she refused to leave the house or eat the food sent in to her.

Individuals like those mentioned above were in a vulnerable situation and their eventual inability to take care of themselves might be sufficient to warrant their removal first to the workhouse and later to the asylum. Louisa was one of many children born to Jervis and Mary Anne Painter and although she lived with her mother for many years after her father's death in the HCA in 1855, by the late 1870s she was living alone.²⁴

However, there were also acute cases, where relatives and friends tried to alleviate the situation at home before deciding on an asylum admission. Rachel Avery "began to be ill three weeks ago and had some medicine", while Emma Carter "refused to take a sedative drug... offered her." Others were restrained or watched in the hope that they would soon calm down. Ellen Wells had been "very violent and [had] been obliged to be confined by a straight waistcoat." Thomas Marriott "had two men sitting up with him for a week".²⁵ Both these examples reinforce the idea that neighbours played an important part in coping with these very difficult situations.

In other cases casual remarks by Poor Law doctors make it clear that they knew the patient well and had been visiting for some time. Elizabeth Cook had been "under Dr Lyford at Winchester for some time past", when she was admitted in 1858.²⁶ George Hall's doctor visited him several times before each admission and Olive Priest's doctor noted that she had "been under my observation for upwards of a year during which time she has had three attacks of great excitement." None of these led to an asylum admission but they were taken into account when she tried to cut her throat with a pair of scissors in 1869.²⁷ George Scorey's doctor suggested asylum treatment in 1876 because "his ideas are absurd [and] knowing him personally I can see that he is not in

²⁴ Additional information about the Painter family was contributed by the great great grandson of Jervis Painter.

²⁵ Rachel Avery, first admission, 3973, 10th May 1877. Emma Carter, second admission, 4329, 22nd January 1879. Ellen Wells, second admission 1103, 20th June 1859. Thomas Marriott, fourth admission, 3106, 3rd October 1871.

²⁶ Elizabeth Cook first admission, 1698, 31st July 1858.

²⁷ Olive Priest, first admission, 2744, 2nd September 1869.

his usual frame of mind".²⁸ Albert Orchard's doctor had been visiting for five months, during which time "he has been in the same dejected state...and unable to follow his employment."²⁹

In all these examples the families tried hard, with the help of relatives, neighbours and doctors, to provide care and treatment and to keep the sufferer and the rest of the family safe. They coped with strange conversations, eating habits, modes of dress and even a degree of violence in an attempt to keep the household on an even keel. Eventually they admitted defeat because all the individuals mentioned above became asylum patients, but it is clear that on previous occasions some had managed to recover without going to the HCA. Ellen Wiseman was admitted for the first time in 1859 but was said to have been "rather queer six years ago."³⁰ Ann Rickman had been treated as an outpatient at Bart's hospital in London. Caroline Beaton's notes record that she "had an attack about three years ago, for which she was treated at home."³¹ It is reasonable to assume that there would have been others whose treatment was successful and for whom an asylum admission was never necessary.

6.3 Delaying or avoiding admission: the workhouse

Many families made enormous efforts to cope with very difficult situations at home before seeking outside help. Their first resort was likely to be to call on the resources of the Poor Law doctor and the treatments available were restricted to recommending a more nourishing diet, which might be supplied as a form of out-relief, or prescribing a limited range of medicines, primarily sedatives. Simple though the alternatives were, they nevertheless represented a form of tension between medical treatment and financial prudence, as the union would have to pay for 'medical extras' while most Poor Law medical officers had to supply medicines at their own expense.³²

When none of this worked there was still the option of removal to the workhouse infirmary. Mary Ann Barton had been treated in Southampton Workhouse ten years

²⁸ George Scorey, sixth admission, 3802, 6th May 1876.

²⁹ Albert Orchard, first admission, 4300, 14th October 1878.

³⁰ Ellen Wiseman, first admission, 1107, 9th July 1859.

³¹ Caroline Beaton, first admission, 2951, 13th December 1870.

³² Anne Digby, *Making a Medical Living*, (Cambridge: Cambridge University Press, 1994), pp245-246.

before her first asylum admission. Leonard Knight, mentally handicapped and epileptic “has been under my care for eight months in the infirmary.”³³ In 1870, Harriett Battman spent two nights in the workhouse having placed herself “in a position of great danger on the railway line.”³⁴ In 1879 Emily Brown showed her opinion of being taken from home to the workhouse by breaking twelve panes of glass the following morning.

Commissioners in Lunacy had mixed feelings about the use of the workhouse, veering over time between dislike of it as “a mistaken and ill-judged economy [which] has the tendency to render chronic and permanent such as might have yielded to an early cure”³⁵ and a guarded approval for its use in certain circumstances, “Many of them provide a really excellent accommodation.... and in almost all of them there are signs of continued progress.”³⁶

Both commissioners and asylum doctors recognised that, because the different types of institution advocated in the lunacy legislation had never come about, the “well-regulated” workhouse was a necessary part of the system insofar as the mentally handicapped or elderly demented were concerned but they never accepted that acute cases could be successfully treated there. In spite of this the large workhouses in Southampton and Portsea Island and some of the smaller ones, such as Alverstoke, constructed both infirmary and lunatic wards with their own attendants.³⁷

Few of the smaller workhouses of rural Hampshire had adequate facilities to care for lunatics, though they all occasionally hosted a difficult character who could no longer be cared for at home and who might be en route to the asylum. The dangers of doing this for more than a short while were demonstrated by the case of James Port, suffering from GPI, who was admitted to the HCA after four months in the Alton workhouse “having numerous bruises on the back, arm and legs, evidently showing

³³ Leonard Knight, 7358, 26th July 1894.

³⁴ Harriett Battman, first admission, 2850, 16th April 1870. Harriett was the wife of Joseph Battman and the mother of George Battman.

³⁵ 11th Annual Report of the Commissioners in Lunacy, 1857, p16.

³⁶ 48th Annual Report of the Commissioners in Lunacy, 1894

³⁷ Portsea Island was the Poor Law union covering most of Portsmouth. Alverstoke union covered Gosport.

that he had recently been severely beaten with a strap.”³⁸ The workhouse authorities had done what was usual in such cases and put two other pauper inmates in charge of him. When he became violent they had no means of dealing with him and “ the two paupers admitted having beaten him with a strap and a piece of rope.”

In this case the commissioners,

addressed a communication to the Alton guardians as to the impropriety of having detained a person so long in the workhouse, and urging the appointment of a paid attendant for the insane. A caution was also given to the medical officer as to the necessity for a more careful discharge of his duties in the future.³⁹

The comment seems to have had little effect on the Alton guardians. Eight years later, in 1881, only one nurse was listed in the census, though the population of the workhouse contained fifteen individuals described as lunatic or imbecile as well as the usual quota of the infirm.

The census records of April 1881 show that Hampshire’s workhouses tended to be home to those described as ‘idiots’ or ‘imbeciles’ rather than ‘lunatics’. On census night 1881 the HCA contained 817 individuals. A further one hundred and sixty-nine ‘lunatics’, for whom the unions were responsible, were housed in Hampshire’s union workhouses (excluding Southampton and Portsmouth). Over three-quarters of the latter group was classed as ‘idiot’ or ‘imbecile’ and all but five of these were adult, the oldest being seventy-three. The term ‘imbecile’ in this context probably covered those who were suffering from dementia while the ‘idiots’ were those who had been mentally impaired since birth. Thirty-five of the workhouse cases had asylum experience at some point before or after April 3rd 1881 and their workhouse residence can be seen as part of a pattern of respite care. The remaining cases were not sent to the HCA during this period. The workhouse appears to have been the beginning and end of their institutional care.

³⁸ 27th Annual Report of the Commissioners in Lunacy, 1873, p73.

³⁹ 27th Annual Report of the Commissioners in Lunacy, 1873, p74.

Workhouses continued to accommodate such cases throughout the century in spite of the confusion in everyone's minds about their suitability, mainly because the alternatives for the care of the mentally impaired and the elderly demented just did not exist. The problem was that the ethos of the late nineteenth-century workhouse as a place less desirable than almost anywhere else did not sit comfortably with the idea that those who were ill or afflicted with insanity needed rest, exercise and a better diet. Nor was the inability of the workhouse to detain individuals against their will very reassuring for the staff or the community. The minutes of the House Committee of the HCA record the case of George Cutler, who in 1855, was discharged from the HCA to the Fareham workhouse for a month on trial,

from which place he obtained his discharge by giving the Master of the Union the three hours usual notice and having left the Union he wandered away to the neighbourhood of Lymington without any visible means of supporting himself and was brought back to the Asylum.⁴⁰

However, the proportion of cases retained in the workhouse fell as the century progressed. The lunacy commissioners reviewed annual returns from Poor Law unions about the location of individual lunatics, for whose upkeep they were responsible, not only in county asylums and licensed houses but also in workhouses and in the community. Table 6.1 shows how the emphasis shifted in Hampshire during this period, from 57.2% resident in county asylums and 42.8% percent which was divided between workhouses and the community, to 80% in the asylum and the rest divided between the other two alternatives. So the preference for the asylum was growing and the emphasis on workhouse or home as an alternative depended on the opinions of the current Poor Law guardians.

So, a significant number was formally dealt with by the authorities, away from the asylum but by the end of the century over three-quarters of all cases sponsored by local authorities found themselves in the HCA. It is not possible to count those who never came into contact with the Poor Law authorities and simply continued to cope at home over long periods or who successfully recovered from an acute attack.

⁴⁰ Minutes of the Visiting Committee of the HCA July 7th 1855, p155.

	Total *	County Asylum	Licensed Houses	Workhouses	Outside
1864	1013	57.2%	0%	21.7%	21.1%
1884	919	75.1%	0.3%	16.1%	8.3%
1899	1193	80.5%	0.2%	9.3%	9.8%

Table 6.1: Lunatics supported by poor relief in Hampshire. Source: Reports of the Commissioners in Lunacy.

(* Excluding Southampton, Portsmouth and the Isle of Wight).

Alton workhouse provides a brief case study. The Lunacy Commissioners' figures for 1864 recorded that the Alton Union was supporting thirteen individuals in the County Asylum and fourteen in the workhouse. In 1884 sixteen were housed in the workhouse, less than half of the thirty-six who were in the HCA. In 1899 there were ten in the workhouse and forty-five in the asylum. So the relative proportions in asylum and workhouses dropped by two thirds over the period.⁴¹

	HCA	Workhouse	Total
1864	14	13	27
1884	16	36	52
1899	10	45	55

Table 6.2. Lunatics supported by the Alton Poor Law Union
Source: Reports of the Commissioners in Lunacy 1864, 1884, 1899.

As a proportion of the workhouse population the numbers also dropped. The 1881 census shows eighty-two inmates of the Alton union workhouse of whom fifteen were described as 'lunatics' or 'idiots'. In the 1891 census seventeen of one hundred and forty-three were so described. Four of the 1891 group were also listed in 1881 and were probably resident in the interim. Only four of the 1881 group and two of the 1891 groups also experienced the HCA in the period covered by this study.

⁴¹ In some areas out relief was an alternative but this does not seem to have been frequently used in Alton.

Looked at from the asylum's point of view admissions directly from workhouses occurred in sixteen percent of all cases in which a previous abode was noted.

Reception orders seem to show that when the workhouse stay was transitory it was not given as place of abode so I have assumed that, where the workhouse has been noted, a longer stay there had previously taken place.

The proportion of workhouse admissions was higher amongst males. 17.1 % of males were admitted from workhouses and 14.9% of women. The proportions of those admitted from workhouses increased as the century progressed, 10.5% in the 1850s and 21.7% in the 1890s, which may be partly due to a drive to use the workhouse rather than other forms of relief and partly due to a reduced tolerance in such places for those who might disrupt daily routine. In the 1890s over 25% of all men admitted came from the workhouse while the figure for women was 18%.

Those at the younger and older extremes of the age range were most likely to have lived in the workhouse before admission. Almost twenty-seven percent of the children and nearly forty-two percent of those who were over seventy-five had lived in the workhouse prior to admission. A connection with marital status can also be seen in table 6.3. The largest group admitted from the workhouse was the single (never married). The proportions of the widowed admitted from the workhouse were higher than among admissions generally.

	General Admissions		Workhouse Admissions	
	Male	Female	Male	Female
Married	45%	44%	28%	22%
Single	42%	40%	54%	51%
Widowed	9%	15%	14%	26%
Unknown	4%	1%	4%	1%

Table 6.3. Marital status of those admitted from workhouses 1854-1899, compared with marital status of whole group.

Source: HCA database

All these figures seem to indicate that the community saw the workhouse as an appropriate place for ineducable children and the demented elderly. Its regimentation might have been seen as a solution to unmanageable behaviour, but the workhouse itself because of its disciplined nature, was only able to include them when they presented no problems of control, cleanliness and nursing. Though some of the children and young adults had been cared for at home for years they were tolerated only a short time in the workhouse before being transferred to the HCA. And the behaviour that made the senile elderly a danger in the home also made them a liability in the workhouse. Wandering, incontinent and noisy inmates could not be contained for long and by the 1890s, in the smaller workhouses there appeared to be no question of admitting the insane for more than a day or two.

6.4 Managing admission: readmission as a strategy

The evidence of patients' records shows that families managed at home for varying amounts of time and that in some cases, individuals were removed to the workhouse, on either a temporary or permanent basis. Families were able to reclaim their members from the workhouse with comparative ease. It was harder to claim a relative back from the HCA because of the legal status of certification and the bureaucracy involved in the discharge process. Nevertheless, on the giving of undertakings by the family, and the asylum medical superintendent's assurance that the individual was not a danger to self or others, he or she could be removed. It is possible that in this way some families were able to use the HCA as a form of respite care.

This appears to have been particularly true in cases where the cause of insanity was linked to the patient's life outside the asylum. In 1868, Dr. Manley pointed out that,

the great causes of relapse are hereditary pre-disposition, intemperance and domestic trouble to which must be added, in the case of women, the condition of pregnancy and the puerperal state.⁴²

⁴² Medical Superintendent's Annual Report, 1868.

Of the thirty-one cases of multiple readmission studied, one or more of these factors was mentioned in every case but one. With the exception of hereditary predisposition, all serve to link a diagnosis of insanity to circumstances of life, as much as to a mental illness, and intermittent asylum admissions could be a way of dealing with a difficult set of circumstances.

George Scorey, from Minstead, for example, was admitted seven times between 1864 and 1880. On four occasions out of the seven, drink was offered as the cause of his recurrent mania because the events that led to his certification had been preceded by a drinking bout. However, drunkenness alone was insufficient cause for an asylum admission as the police were there to deal with such cases. The drinking had to be seen to be connected with the symptoms of insanity and in particular violence and extreme incoherence. The difficulty of this was readily acknowledged,

I may mention the difficulty of distinguishing cause and effect, but my impression is, that a very small percentage of the admissions can be absolutely attributed to drink but rather that insanity has led to intemperance, the patient having resorted to it after the insanity set in.⁴³

Dr Manley was prepared to accept that drunkenness was more likely to be the result of insanity rather than its cause, but there were others who thought the reverse and during the nineteenth century experts wrestled with the dilemma of designating alcohol addiction as an inherited or an acquired condition.⁴⁴ They were becoming more receptive to the idea of alcohol addiction as a disease, while continuing to attribute all social ills, such as poverty, crime, and insanity, to the influence of drink.⁴⁵ In the HCA alcoholic drink was specifically indicated as a contributory cause of insanity in 342 cases, though it was also implied in others. But it should also be remembered that alcohol was a part of everyday life in this period, in the asylum as much as in the community, and beer was served throughout the day to both staff and patients, only being withdrawn from the dietary schedule in 1888.⁴⁶

⁴³ Medical Superintendent's Annual Report, 1872, p18.

⁴⁴ W. Bynum, "Alcoholism and Degeneration in nineteenth-century European Medicine and Psychiatry". *British Journal of Addiction* 79 (1984), 59-70, (p60).

⁴⁵ Peter McCandless, " 'Curses of Civilisation': Insanity and Drunkenness in Victorian Britain." *British Journal of Addiction* 79 (1984), 49-58, (p53).

⁴⁶ Annual Report of the Visiting Committee, 1889, p6.

Therefore, if, as McCandless suggests, the perception of drunkenness in the community at large “was rooted in the social conditions and prejudices of the time,” and how people viewed alcohol “affected the kind of information they supplied or selected as significant,”⁴⁷ then bad behaviour fuelled by intemperance would have to exceed some communally recognised limit of violence or disruption before it would be considered a case for the asylum. The decision would be based on the behaviour itself, rather than its perceived alcohol-related cause.

George Scorey is a good example. He appears to have been a person of limited intelligence who was prone to be excitable and whose moods were exacerbated by occasional drinking bouts rather than regular heavy drinking. The fact that his excited condition continued long after the effects of alcohol had worn off made him a candidate for asylum admission. In 1870 a drinking bout led to an unpleasant episode when “he walked into a neighbour’s house and tried to strike a man’s gouty toes”.⁴⁸ Five years later he had “been drinking hard up to yesterday” when “he grossly insulted the innkeeper’s wife and daughter in a way not usual with a sane man”. In 1876 he climbed “to the top of an apple tree and jump [ed] off eight or ten times running”.⁴⁹

Stephen Butler, who was known to be “of an irritable disposition and hasty temper” used drink to deal with life’s disappointments. He drank to excess when his first child was stillborn, quarrelled and fought with his friends, threatened and used obscene language to his employers. Once admitted to the asylum he usually recovered fairly quickly. Discharged as recovered on five occasions, the length of his stay increased on each occasion as the medical staff became more cautious in making the decision to release him, but he was never resident for longer than eighteen months. In between times his family led a wretched life. He was frequently unable to work, sometimes sent to the lunatic ward of the workhouse and spent time in prison for assaulting his wife. By his final admission in 1888, his wife, Thirza, had had enough. Her whereabouts were unknown and Stephen was brought from the workhouse.

⁴⁷ McCandless, “‘Curses of Civilisation’: Insanity and Drunkenness in Victorian Britain”, pp49-50.

⁴⁸ George Scorey, fourth admission, 2955, 24th December 1870.

⁴⁹ George Scorey, sixth admission, 3802, 6th May 1876.

Edward Horne's problem was definitely alcohol. His drinking bouts were so extreme that they resulted in his doing terrible damage to himself and terrifying others. His shocking attempt to cut his throat resulted in his first admission. Later he was suffering from delirium tremens and his mother could not look after him. Much to everyone's surprise he eventually married and the admission after that was his last.

Forty-five percent of these cases were discharged as recovered, over three-quarters of them after a stay of less than twelve months. Problems caused by excessive drinking, to the extent that the sufferer could appear mad, could be dealt with fairly swiftly by the asylum, where a supervised withdrawal period could assist both patient and family. It looked good for the HCA's recovery figures and it might help a family to deal with a difficult problem, either once and for all or at least until the next time, so the HCA was not opposed to receiving such cases.

Another major cause of both admission and readmission was specific to women and involved the events leading up to and associated with childbirth and its aftermath. The link between the events surrounding childbirth and the onset of insanity is culturally both strong and continuous, though the aetiological framework within which it is understood has shifted.⁵⁰ Hilary Marland suggests that, as the responsibility for such cases shifted from the world of obstetrics and the individual practitioner to the sphere of the psychiatrists, so the number of cases treated in asylums increased and the nature of the treatment became harsher.⁵¹ Furthermore, its absorption into the category of moral insanity redefined puerperal insanity "not as loss of reason, but as deviance from socially accepted behaviour."⁵²

A very close reading of all the documents relating to puerperal insanity over the whole period would be necessary to confirm whether this was true at the HCA but the HCA data supports Marland's view that, in spite of this, women were still only admitted when they became 'dangerous, suicidal, reckless or excessively troublesome.'⁵³ The

⁵⁰ Joan, Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder*, (London: Macmillan, 1996), pp159-160.

⁵¹ Hilary Marland, 'Destined to a perfect recovery', the confinement of puerperal insanity in the nineteenth century, in *Insanity, Institutions and Society, 1800-1914*, ed. by Joseph Melling and Bill Forsythe, (London and New York: Routledge, 1999), 137-156, (p152).

⁵² Marland, 'Destined to a perfect recovery', p143.

⁵³ Marland, 'Destined to a perfect recovery', p 146.

well-known temporary nature of the condition meant that treatment at home was still the treatment of choice. It was believed that women could be beneficially separated from the strains of being at home but not necessarily by being incarcerated in an asylum.⁵⁴ However, in poor families such advice is more easily given than taken. For many families this all too regular occurrence could cause a crisis, particularly if it was associated with a poor physical or mental recovery by the child's mother. Sometimes it must have made sense to separate mother and child, allowing the mother to be treated in the asylum and the child to be nursed at home.

Parturition or lactation was mentioned as a specific cause in 210 cases in the database, and, as with intemperance, there were many other instances of it being mentioned in connection with the circumstances of admission. As with cases related to intoxication these women recovered fairly quickly and were discharged. Three quarters of all the cases mentioned above were discharged as recovered and eighty-three percent of those in under a year.

However, while this is a relatively short stay in asylum terms, it is a long time in the life of a child and the situation at home must have been very difficult for both the returning mother and her family. Sarah Phillips gave birth to a child shortly after her admission to the HCA in 1884. She was sent home at her family's request but was returned to the asylum at the end of the trial period. The following July she went home again, once again at her family's request but was brought back a month later because

she sleeps well at night and takes her food but could not look after the house and children, is not safe to be left alone with the children, she intended to do for the baby which she says is not her own.⁵⁵

Sarah's family missed her but she was unable to fulfil the practical duties of wife and mother and presumably the children in their turn had some difficulty in recognising her as their mother after so many months of separation. However, she had been home long enough to become pregnant again and another son was born the following April.

⁵⁴ Marland, 'Destined to a perfect recovery', p 145.

⁵⁵ Sarah Phillips, 5267, 5th February, 1884.

His father removed him a month after his birth and Sarah was never at home with any of her six sons again before her death in 1900.

Other women were admitted and discharged several times, returning to their children before the birth of another baby disrupted the family again. Emma Carter, for example was admitted five times between 1877 and 1895 and four of these admissions related to her mental condition at childbirth. On the fourth occasion she was admitted during labour and a stillborn child was delivered two hours later. Her admissions were authorised not only because her behaviour was odd but also because she was considered a danger to her children. Her doctor reported that “she suckled her baby while I was present but in a manner which rendered it violently unsafe for her to have the charge of it”. Her past history involved a previous period of mental ill health around the time of the birth of her first child when she suffered puerperal mania and convulsions. On that occasion she recovered at home but shortly afterwards the baby was discovered dead in bed. An inquest returned the non-committal verdict of ‘found dead’ but when Emma gave birth to her next child the doctor issued “strict orders to the friends not to leave the baby and mother alone together.”⁵⁶ There were other such cases where one or more confinements had been attended by such difficulties but where recovery took place at home. Often it was only when the puerperal problems took place when there were other children to look after that the mother had to be admitted to the HCA.

In Ellen Wiseman’s case three of her six admissions were specifically linked to childbirth by her doctors and a close examination of her notes shows that the other three occurred during pregnancy or shortly after parturition. Eliza Bedford was admitted once while she still had a breast-feeding infant and once during a pregnancy resulting in a stillbirth. A third admission involved her mistaken belief that she was pregnant. When a woman was admitted in these circumstances she was separated from her children, including any who were still being nursed. The relative distress that would be caused by the mother either going or staying must have been hard to assess. So it is not unreasonable to believe that only the most difficult situation would have caused a family to consider this course of action because of its effects on mother, infant and those remaining in the family home. When Ellen Wiseman was separated

⁵⁶ Emma Carter, first admission, 3942, 3rd March, 1872.

from her three-month-old baby, Walter, in 1865, "she...made up a bundle of rags, she has taken on her lap and put to her breast thinking it to be her child".⁵⁷ A child born after admission was removed at the earliest opportunity, which could be days or months later, depending on the condition of both mother and infant.

The asylum doctors showed that they recognised that, as with intemperance, the situation was never straightforward. Though pregnancy and puerperal factors were mentioned in a number of multi-admissions, on closer examination is it clear that many of the cases were physical rather than mental consequences of childbirth, that childbirth was often mentioned even when the link was fairly tenuous and in many cases a multitude of other factors, physical, mental, environmental played an important part. Medical staff at the asylum recognised this and frequently mentioned their patients' circumstances at work and at home as contributory factors. Nevertheless families perceived childbirth as a dangerous time for a woman's mental health and some were ready to accept a short asylum stay as a possible alternative to a disrupted family.

The fact that in this age we are very aware of psychological problems linked directly to the menstrual cycle and the post-partum state makes it necessary to tread carefully around this subject. Unlike most modern western women, many of the women in this sample were pregnant for most of the first half of their adult life and therefore likely to be pregnant or in a post-partum condition when admitted, whether or not this was related to their mental condition. Though post-natal psychoses have always been described and treated sympathetically, many women who were admitted in the post-natal period were suffering for other reasons, particularly in cases where admission took place a considerable time after the birth of the child. Ellen Wiseman's admissions may have been linked to childbirth on six occasions but she actually gave birth to thirteen children of whom twelve survived infancy. That this stage of a woman's life could have deleterious effects on her mental health was undoubtedly well-known but childbirth is a social stage in a family's life cycle as well as a physical event for a woman and it was necessary to consider the situation as it was experienced by all members of the family.

⁵⁷ Ellen Wiseman, third admission, 2081, 31st August, 1865.

Furthermore the other circumstances of a woman's life were known to have a bearing on her condition even when the strongest link was still perceived to be childbirth.

Eliza Bedford was admitted six times between 1860 and 1878. She appeared to be very ill and living a hard life. Among the hardships could be counted the perils of continuous childbearing, which was presented as a factor in her first two admissions. On her first admission she was still breastfeeding, on her second she was pregnant and suffered a stillbirth while still in the asylum. On this occasion she had only spent a month at home so she must have become pregnant immediately on her discharge. The third admission involved her belief that she was pregnant although she was not. However she also delivered several children without having to be admitted. In addition she suffered from epilepsy and after severe attacks her mood and behaviour were affected. But she had also led an unhappy and physically hard life. While she was in the HCA in 1860 her husband, "a bad character", lived with another woman. Finding out about this on her discharge was supposed to have precipitated her relapse. On subsequent occasions local circumstances and family troubles were mentioned. A son died shortly after one discharge. Her husband was only a farm labourer and Eliza herself "has not sufficient food owing to the circumstances of her husband [and] was overcome by the heat while working in the field".⁵⁸ Eliza's admission appears to have been part of a series of measures to look after her and keep the family together. By the time of her final admission her daughter had been living at home for the previous six months to look after her parents and her youngest sister. In the 1881 census her daughter and grandchild were also members of her household. This combination of family care and occasional asylum admission meant that Eliza was still living with her family in 1901.

Intemperance and childbirth were specific causes of family crises, which might require outside assistance if the family was not to collapse. But asylum doctors recognised that often the underlying situation involving personal or domestic distress might be just as important though the beginning of the crisis was not so easy to determine. In the 1870s Dr Manley was particularly aware of the difficult circumstances many of his patients had experienced.

⁵⁸ Eliza Bedford, fourth admission, 3824, 10th January 1876.

[H]ave we not of late years, had an upward tendency in the process of all the necessaries of life? Have the poor man's earnings increased in equal ratio? In short has there not been harder struggle of life than heretofore? Have not the great majority of patients admitted been reported as in feeble health and has not an improvement in bodily health been the precursor of improvement in mental condition?⁵⁹

In many cases it certainly appeared that a rest and good food were an essential part of a full recovery. Patients were weighed on admission, fed on 'strengthening' foods such as eggs and beef tea and usually left a few pounds heavier than they had been on arrival. It certainly seemed as if the general debility of many patients was a major contributory factor in their mental condition. Dr Manley's notes continued,

in the great majority of cases brought to the asylum the symptoms of insanity have been preceded by debility, the result of anxiety and insufficient nourishment and in many cases, of the two combined.⁶⁰

Resorting to the workhouse in such circumstances was unlikely to produce the desired result and in many such cases the few weeks of rest procured by an asylum admission resulted in the patient being discharged as recovered. This may also help to account for the greater likelihood of women to be admitted and discharged recovered a short time later. Women frequently deprived themselves of food and medicines in order to provide for the rest of the family. Dr Edward Smith's appendix to his report on the nutritional state of the working people of the country concluded that women often allowed themselves to suffer nutritionally to ensure that first the male of the family and then the children had enough to eat.⁶¹

Domestic problems included both practical and emotional difficulties though, fortunately, not everyone suffered the traumatic life of Richard Fullick. His father and uncle were sentenced to transportation for stealing potatoes and barley when he was a child, and his mother left Richard and his brother in the workhouse when she went off

⁵⁹ Medical Superintendent's Annual Report 1872, p17.

⁶⁰ Medical Superintendent's Annual Report 1872, p 18.

⁶¹ 6th Report of the Medical Officer of the Privy Council, 1863, Appendix 6, p262.

with another man. When Richard was a young man, his niece, the daughter of the brother with whom he lived was brutally murdered by her employer's father. When Richard started to hear voices ordering him to hang himself there was no doubt in the doctor's mind that his troubled past was a contributory factor even though he was thought to be a steady type.⁶²

On the whole though, young people in particular were often said to have been 'disappointed in love', or the victims of 'overstudy'. Older people found 'losses in business' too much to bear or were grief-stricken at the loss of a child, spouse, or sibling. Henry Orchard was said to be distressed at the death of his father-in-law with whom he had worked. The notes do not usually record which came first, the illness or the problem, but it seems likely that they were often equally important in precipitating an asylum admission. Removal from the cause of the problem must have seemed worth a try, when all else had failed.

Finally, the asylum paperwork throughout the period always included a question about other cases of insanity within the family, particularly in the last two decades of the century. The records in six casebooks of the 1880s record 964 admissions of which 195 (20.2%) include a reference to another family member. Some of the references are specific, mentioning the admission numbers of particular individuals. Others are gossipy and uncorroborated by evidence from this asylum, at least. A discussion of hereditary insanity and its implications is beyond the scope of this research, but the high incidence of references to other relatives in this sample suggests the possibility that once one member of a family had been a patient at the HCA, it may have been less of a problem for other family members to consider it as a solution. Certainly Walter Higgs sent his son Albert to the HCA in 1875 because he had experienced the recovery of his son, Ernest, there a few years previously,

You sent him home quite cured and I shall ever feel thankfull [sic] to you for what you did for him. He is now in business at Sandown and doing well.⁶³

⁶² Additional information about Richard Fullick was contributed by Andrea Hay.

⁶³ Letter included in notes of Albert Higgs, first admission, 3692, 17th August, 1875.

In some cases admission and a brief stay, followed by recovery formed a pattern over a few crucial years or over a lifetime. Tracing individuals after discharge is quite difficult but where there have been several admissions it is possible to see that a short stay at Knowle at a difficult time punctuated some people's lives and may have made it possible for them to continue to live as part of the family for the rest of the time. This is explored further in the next chapter.

Helen Townsend and Ellen Adams were both examples of individuals who periodically behaved strangely. Helen tended to be embarrassing rather than dangerous and Ellen could be agitated and sometimes violent. Helen never married and was the responsibility of her parents and later her sister, though she does appear to have lived alone as well. There is also evidence that she was sent away to the seaside at Southsea and later to relatives at Waterlooville, for the sake of her health. Her asylum residences were never longer than a few months and were often separated by several years. For the rest of the time she lived in the area in which she had grown up with people she had always known. Her father was a farmer and as a child and young woman she lived with her family in quite a large farming establishment at Swanmore. After her father's death she lived with her mother in the village of Upham where her sister had a house and took in boarders. Later Helen lived with her sister. Her longest asylum admission took place between 1905 and 1907 but then six years passed before her next admission and death in 1912.

Ellen Adams also experienced brief admissions over a period of thirty years, none lasting longer than a few months.⁶⁴ In the intervening years she worked as a nurse and married twice though she never had children. She too lived in the same small community all her life. Each of these two women experienced eleven admissions but it is important to remember that taken together they do not amount to a large proportion of their lives. Helen's admissions totalled no more than nine years out of a life sixty years long and Ellen's only six years out of sixty-five. Several other women had similar admission patterns.⁶⁵ Only one man seemed to be admitted in a similar pattern. Joseph Glasspool was admitted for the first time in 1855 aged twenty-seven

⁶⁴ Ellen Adams was her final married name. She had also been admitted as Ellen Clark, her maiden name and Ellen Wells her first married name.

⁶⁵ Ellen Wiseman, Emily Brown, Elizabeth Cooke, Ann Cox, Amelia Knowles, Elizabeth Messum, Eliza Moon,

and discharged for the last time in 1880, having been admitted on six occasions. After living with his sister for a while he remarried and was never admitted again. However, he was destined to end his life in an institution. In 1901 at the age of seventy, he and his wife were pauper residents of the New Winchester union workhouse at Weeke. Joseph's six residences at Knowle added up to about thirty-six months of his life.

In other cases short and repeated stays worked for a while but a time came when the person was admitted and subsequently died or became a long-term inmate. Mary Ann Morgan was admitted on four brief occasions in the 1860s and 1870s but her final admission in 1879 led to a stay of sixteen years before she was transferred unimproved to another asylum. This pattern particularly applies to men. Edward Hayter was admitted for a few weeks at a time in 1883, 1886 and 1888, for five years between 1888 and 1893 and finally in 1896 when he remained a patient until his death in 1914. Ernest Higgs was admitted briefly on four occasions and then for three lengthy periods in quick succession. In 1896 he and his brother Albert were transferred together to the new Isle of Wight asylum.

Finally, the saddest cases were those who were optimistically sent home when their condition appeared to improve but who could not adjust to family life or whose family could not cope with them. They tended to spend longer in the asylum than out of it until eventually they were no longer discharged. Susan Mitchell for example was admitted on five occasions between November 1887 and October 1892 but once she was ill she was never really better and on each occasion she was readmitted within a year. While her husband remained in the family home bringing up their two children, she spent the last ten years of her life in the asylum, dying of tuberculosis at the age of forty-five, in 1902.

Caroline Beaton's career combines at least two of these situations. Her first two admissions took place in 1870 and 1872. She was at liberty from 1874 until 1882 and was then admitted four times in the next seven years. Another quiet time from 1890 to 1895 was followed by an almost continuous period of eighteen years in the asylum before she died there in 1912 although in this time she had been admitted and discharged three times. Caroline's career was exceptional because she lived to be so old. She was already fifty at the time of her first admission and over ninety when she

died. She was clearly a very difficult and unpredictable person and members of her family had troubles of their own, which have already been mentioned. However on at least two occasions she is known to have been discharged at the request of her family and she lived with several of them in turn. It is likely that her later admissions had a different cause from her earlier ones but nevertheless they reflect the willingness of the family to use the asylum and to dispense with it when it was not wanted.

6.5 Conclusion

Though an admission was very often preceded by an acute situation of one kind or another it usually came at the end of a period of time when the patient had been increasingly unwell and more and more demanding of care. During this time families and Poor Law officials tried various formal and informal ways of treating the person outside the asylum. Medicines were administered, changes in diet advised and though they are not mentioned in official records it seems reasonable to assume that this happened alongside a body of well-meaning advice from family and friends. At certain critical moments those friends and neighbours were called in to sit up all night with the sufferer or to help restrain him or her as in the case of Thomas Marriott. When all else failed they contributed their evidence and opinions to the doctor's enquiries.

When care at home became difficult the workhouse was offered as an option. Finally an asylum admission might be suggested but this does not appear to have been the first option in any of the cases studied. The number of recovered patients who were never re-admitted suggests that for some people it provided sufficient relief to those both in and out of the HCA, to enable the household to continue. In other cases, where a person was admitted and re-admitted on several occasions it may have become part of a family strategy that enabled everyone concerned to struggle on. The HCA can therefore be seen as one stage on a continuum of care rather than as a complete response or an end in itself.

Chapter 7

Households, and family responses to asylum admission

Whilst some households may have managed to survive because of the timely removal of one member to the HCA, others found that either the mental illness of one of the members or the fact of their asylum admission resulted in the break-up or relocation of the family. This chapter considers the nature of the household from which asylum patients were removed and to which they returned, and the responses of family members to the situation.

7.1 Social status of HCA patients and families

The study of occupations of HCA patients in chapter four suggested that, while the majority of inmates of the HCA were not representative of an underclass, neither were they drawn from the prosperous middle class or upper class. Even though, at various times, legal provision was made to allow the admission of private patients, almost without exception, applications for admission to the HCA were processed through the machinery of the Poor Law. Only a few dozen private admissions took place in the course of fifty years and these were not continuous throughout the period. In the first two decades of the HCA's history only thirty-eight private patients were admitted and when the asylum was almost full, as it was in 1856, many private patients were removed, while others were transferred to the pauper list. Yet they did not always conform to a strict definition of pauper and later in the period the issue was made more complicated by the financial involvement of the government in paying the unions a grant towards the upkeep of pauper lunatics in asylums and by the growing tendency to require relatives to make a contribution

The necessity for Poor Law involvement in the admission process has already been discussed and the issue of this emphasis on the pauper nature of the lunatic asylum population nationally is important in any discussion of the increasing degree of state involvement in the lives of ordinary people. However, the issue of pauperisation is

difficult to resolve; comparing the admissions and population of the HCA to the pauper population of the county gives no clear answers, as it is evident that the process of becoming a lunatic and that of becoming a pauper were closely associated. In the County of Southampton in 1861 of a population of 467,353 there were 31,715 paupers in receipt of relief, of whom 1,237 were defined as insane. Only half of these (634) were in the county asylum however. Of the remaining half the majority (399) were in workhouses but a substantial minority (175) were residing with relatives, and some were in other institutions.¹ Those who were already receiving poor relief were the most visible to the relieving officer when things started to go wrong and might find themselves more readily certified and admitted to an asylum. But there were also those in whom the process of mental deterioration led to increasing contact with the relieving officer where none had previously been necessary.

In 1862 Dr Manley drew attention to the plight of those who were not paupers but who would certainly be pauperised if expected to make long-term contributions to the cost of institutional care.

but there is one class of insane patients to be pitied more than the insane pauper: I mean those with limited means, just above pauperism, people whose daily struggle with life enables them to support themselves and families with some degree of comfort whilst health attends them, who perhaps have even put by a small store, but who become paupers (unrecognised ones, however, till their little pittance is all gone) directly insanity attacks some member of the family.²

Eventually therefore these patients and their families would become a charge upon the union thus cancelling out any financial benefit that might have been gained initially, by refusing to help with asylum costs. Henry Tilbury of Chilbolton was maintained as a private patient at Fisherton House Asylum, near Salisbury, in the mid 1870s, while his wife continued to try to keep up his grocery business. He was transferred to the HCA as a pauper patient when she went bankrupt. However, the authorities at Fisherton continued to maintain him, without payment, while his transfer was agreed.

¹ Comparative returns of insane paupers January 1871.

² Visiting Committee annual report, 1862.

Subsequently, the guardians of the Andover Poor Law union agreed to take up the cost of his maintenance at Knowle, even though they usually preferred to maintain their pauper lunatics in their own infirmary ward.³

Though few financial accounts for the HCA have survived and survival of Poor Law unions' accounts is patchy, there is evidence that families in Hampshire, who could make a contribution to the weekly maintenance charge, did so. The paperwork was still that of a pauper admission, requiring the signature of only one physician. In 1875, when Albert Higgs, aged sixteen, was admitted from the Isle of Wight he was accompanied by a letter from the clerk to the local magistrates stating that "although the boy is unable to maintain himself yet his father is capable of doing so."⁴ The returns to the Commissioners in Lunacy in 1877 record that Walter Higgs was paying the full weekly county pauper rate towards his son's upkeep. However, his older son, twenty-seven year old Ernest, who was also resident in the asylum at the time, was entirely maintained by the Isle of Wight union. Ernest had also been admitted as a teenager in the 1860s but there is no record of whether his father had contributed towards his upkeep at that time. Albert was one of fifty-six inmates in the 1878 return, whose families were making a contribution towards their upkeep, of amounts ranging from one shilling weekly to almost the full amount, which at that time was nine shillings and eleven pence. Some unions were more conscientious about demanding this than others. Relatives from the Isle of Wight were making contributions on behalf of twenty-four inmates, representing nearly twenty percent of all inmates sent by that union and about fifty percent of all those whose relatives were contributing to their upkeep.⁵

The fifty-six inmates whose families were contributing in 1877 represent 8.6% of the 696 patients present in the asylum at that time so most were still supported by the poor rate and could technically be described as paupers. However, of these 696 persons only around twenty percent had been admitted directly from the workhouse.⁶

³ Additional information about Henry Tilbury contributed by John and Ann Taylor.

⁴ Albert Higgs, first admission, 3692, 17th August 1875.

⁵ Returns relating to paupers in lunatic asylums and Licensed Houses in England and Wales on 29 September 1877.

⁶ 18% (125) are known to have been admitted from workhouses. Another 25 have no address entered but the most likely previous address in these cases is also the workhouse as they were all admitted during the first few months of the asylum's existence when known lunatics were still being gathered up from union workhouses.

And many of these were taken there at the last minute because of illness rather than through destitution. Considering that many illnesses, both physical and mental, were of long duration it seems likely that families worked hard even in such difficult circumstances to keep out of the workhouse, though this might mean receiving no poor relief assistance at all apart from the HCA admission.

7.2 Households

Although the patients of the HCA were mainly drawn from the working poor, they came from a variety of different types of household and the nature of those households may have influenced the course of action taken in individual cases. Though the use of the workhouse was a complex and important part of the asylum process only a minority of those admitted had spent more than a short time resident there prior to admission to the HCA. The majority was admitted from private addresses, illustrating many types of household and circumstance. In order to look at this in more detail the households of a number of individuals in the HCA database were located within the 1881 census.

The 1881 census was selected because of its accessibility. It was available on CD-ROM, with a national index and was conveniently located mid-period.⁷ Three sample groups were selected from the database. In order to look at the types of household from which individuals in that period were admitted the first group consisted of all people admitted to the HCA in the nine months between census day, April 3rd 1881, and December 31st of that year.⁸ The second group consisted of all people discharged from the HCA in the twelve months preceding the census, in order to consider to what extent individuals had returned to their household of origin. Finally there was a group of families of people who had been admitted in the previous twelve months and were still resident in the asylum on census night. This was to try to gain an impression of what was happening to their families, particularly in the absence of a key member such as a parent.

⁷ Since October 2002 it has also been available on line on the Family Search page of the Latter Day Saints website.

⁸ Further back than 9 months 'hits' were much less frequent.. Families involved in agricultural labour were often very mobile in this period and without a corroborative address it is difficult to make a firm identification.

7.2.1 Admissions in 1881

There were sixty-nine males and eighty-three females in the admissions sample. Of these about two thirds could be located in the 1881 census with a reasonable degree of certainty.⁹ Those admitted from workhouses were hard to locate in the census.

Twenty individuals in the database sample were recorded as having been admitted to the HCA directly from a workhouse but only half could be located in the census. This could be for a variety of reasons, the most common being that they were single and living away from their place of settlement to which they would later be removed when necessary. Of the ten who could be located, half were living in a workhouse at the time of the census and the other five were at private addresses and so had probably been removed to the workhouse before resorting to the asylum. The use of a workhouse as an interim measure is clear in the histories of several patients. On the night of May 1st 1879, Emily Brown “was taken to the union last night and broke some panes of glass this morning.”¹⁰ In the case of Caroline Beaton, who was examined at the Havant workhouse on February 26th 1876, Mrs Weekes, the matron, gave evidence that she was “out of bed during the greater part of the night, tearing up her clothes, dirty in her habits, breaking windows”.¹¹

Of the five admitted from a workhouse but living at private addresses at census time, only one was living in her own home in a nuclear family. Ruth Hutchinson, a cook, was living in Surrey with her husband and two sons. The others at private addresses were a servant, a lodger, a niece and a stepson. The lodger, Martha Tyrell, who at the age of eighty-three was a labourer’s widow with dementia, was in receipt of parish relief and lodging with a widowed charwoman and her son in Hambleton. Meanwhile Elizabeth Bull, a pregnant teenager, was working with her aunt and cousins as a laundress, in a household that appeared to generate most of its income from this activity. The others were living in fairly large households of six to eight people, none of whom was closely related to any other member. Richard Colwell was a workhouse inhabitant at census time but was working as a farm labourer at Buriton at the time of

⁹ There were 100 individuals in this sample. When the reference could not be cross-checked with other information from the database it was rejected. It would be possible to identify a greater number of individuals by referring to reception orders and case notes.

¹⁰ Emily Brown, fourth admission, 4382, 1st May 1879.

¹¹ Harriett Battman, third admission, 3771, 26th February 1876.

his admission. None of the remaining five, who were resident at census time in the workhouse from which they were eventually admitted to the asylum, was there with other members of their family. They were single or widowed as well as handicapped or ill. So in this small sample those who were sent to the workhouse because of their condition came from households whose members had fewer and more distant ties of obligation towards one another.

The majority of those traced in the census were living at private addresses. Of the one hundred and thirty-two members of the group admitted in 1881 who lived at private addresses, ninety were traced in the census. Of these, fifteen were living at a different address on admission than at the census. William Hearn, for example, was boarding at Hartley Wintney in the spring but was eventually admitted to the HCA from an address in Winchester.

The enumerated households varied in size and type from single person households to large lodging houses. However, the nuclear family was the most usual kind of household. Forty-three families consisted of two parents, with any number from one to nine children, and half of these families included additional persons residing at the same address in the role of guests, servants or relatives. They may have been brought in to assist with young children or to help because of the illness of an adult important to the family. Ellen Hayden was staying with Alexander Matthews and his daughter, Emily, in Ryde on census night, two day's before Emily's admission to the HCA. Emily was certified for the first time the day after the census but her condition was said to have existed for a number of years. Additional non-family members were less likely to be found in large family groups where there might be teenage or adult children able to assist in running the household and caring for the person who was ill.

The three patients who had been living alone were all aged sixty or over and all died in the HCA within a short time. Two were women and one was a seventy-seven year old widow. Single occupancy appears to have been an issue affecting the elderly more than any other group. This sample is too small to consider any but individual cases but Richard Wall has shown that while single occupancy was relatively unlikely among the elderly before the nineteenth century it became more common as the century

progressed, especially for elderly women.¹² Single elderly occupants of households have usually been seen as particularly vulnerable and susceptible to institutional care, though it could also be true that stronger individuals were more able to live alone. In any case the benefits of co-residence should not be over emphasised as family members could help each other without having to live in the same house.¹³

When lodging houses and workhouses were excluded the average household size was 4.3 persons and a quarter of those living at a private address lived in a household of only three people. None of the multigenerational families, of which there were ten, included anyone other than family members and their ability to survive the removal of one member probably owed something to the presence of more than one generation of adults. In one three-generation household Mary Ann Riddick aged fifty lived with her mother, seventy-three-year-old Jane Newman and her fifteen-year-old daughter Amy Riddick. While Mary Ann spent twelve weeks at Knowle recovering from depression the other two may have been able to support each other. Mary Ann recovered, was discharged in July and was not re-admitted. Tabitha Love, a single woman, had been looking after her elderly widowed father and her young nephew. She spent two years in the HCA and it is possible that these two may have been supported by some of the many families of Loves, who populated this small area of the Isle of Wight at this time.

In the larger households the average age of the members was lower than in small households because large households were more likely to include several young children. Small households were more likely to consist of elderly couples whose children had left home. The average age in the two person households was sixty, while in six person households it was twenty-six, with ages ranging from seven to forty-one.

7.2.2 Discharges in 1881

In the sample of patients discharged in the twelve months before the 1881 census there were thirty males and fifty-nine females. Of these, only thirteen males and

¹² Richard Wall, "The residence patterns of elderly English women in comparative perspective" in *Women and Ageing in British Society since 1500*, ed. by Lynn Botelho and Pat Thane, (Harlow: Longman, 2001), 139-165, (p145).

¹³ Michael Anderson, *Family structure in nineteenth-century Lancashire*, (Cambridge: Cambridge University Press, 1971), p56.

thirty-two females, about half the sample, could be found in the census for Hampshire. It was more difficult to find individuals in the community after discharge than to find them before admission. This is partly an administrative problem, because addresses to which individuals were discharged were not recorded in this period, making it difficult to confirm identity without examining all case documents.

However, it could also be because many of those discharged were single adults who disappeared into other areas or whose identity cannot be confirmed. Many names did not appear in the Hampshire census at all. Some of these families may also have been unable to continue in the same place when the head of the family was no longer there.

In 1875 Andrew Young's wife, Elizabeth wrote,

I appeal to you to inform him that my house is broken up and I am going to live with my mother for what with hard work and worry I am quite unfit to support our home and six children.¹⁴

Eleven people who were discharged to their families were to be found at a different address from that given on admission. However, these addresses were usually not far from the previous abodes, indicating that the reasons for moving were more likely to be practical and associated with family and work than with asylum stigma. None of those, who had been discharged, was residing in a workhouse at census time and the only member of the sample who had been admitted from a workhouse did not return there on discharge.

Half of the households to which individuals returned were nuclear families, some of which also had additional persons. All the returning wives except one went back to families with six or more members. After a six-month stay Lydia Bulpet aged thirty-six, returned to her husband Emanuel and six children ranging in age from fifteen to one. Emanuel was a farm labourer who had been very mobile in the previous few years. Their children were born in four Hampshire villages and while the father and teenage children could probably cope with the younger ones, surely a neighbour or relative must have had to cope with the baby Lydia was still nursing when her severe depression resulted in her admission.

¹⁴ Andrew Young, second admission, 3587, 4th January 1875.

Eleven individuals returned to two generation families but none of them returned as head of the family. Most were daughters or sons. Martha Upton, aged twenty-two, returned to live on poor relief with her widowed mother in the same village but not at the same address. As with the admissions group the multigenerational families did not contain non-family members. Harriett Warner, aged sixty-nine, and “always of humble life”, was discharged to live with her son, his wife and their four young children, having been widowed during her five year asylum stay. Mary Shawyer lived with her son and daughter in the village of Soberton after her discharge. Her daughter, also named Mary was recorded by the census taker as both head of the household and “attendant on her mother”. The other seven families named Shawyer in the immediate neighbourhood were probably also related to her and able to offer some support. Nearby lived Lucy Shawyer and her four children. Lucy was head of the household because her husband James was also a patient at the HCA.

Finally, there are several examples of family groupings consisting of siblings, cousins or in-laws. Joseph Glasspool, for example, moved in with his widowed sister and her family in Winchester after he was discharged. Individuals and families were also to be found living as lodgers. Elizabeth Smith returned to her three-year-old daughter and her husband Thomas, who lived at the mill where he worked. After ten months in the HCA Mary Raddon, from Whitchurch, became Eliza Williams's lodger in Romsey and was not re-admitted.

Of the first sample, of those admitted in 1881, seventy-one were members of a nuclear family of parents and children. Only eight were related to the head of the household in any other capacity. The remaining twenty-one were living in workhouses, prisons, as lodgers or borders in someone else's household, or as a servant. Of the forty-five individuals who were traced after their discharge, thirty-five returned to a two generation nuclear family, five returned to families in some other relationship, four were taken on as servants and one as a lodger.

It seems clear from this, that just as those admitted came directly from ordinary families, the majority of those returned to the community went back to such families. However, the difficulty of tracing some of those who were discharged suggests that

the events leading up to an asylum admission and the admission itself may have had a catastrophic effect on some families.

7.2.3 Households in 1881

When tracing families in the 1881 census the third and most elusive group was that of families of people who were recorded as inmates at the time of the census. This was a group of people admitted in the twelve months before April 3rd 1881 and discharged after that date.¹⁵ The group consisted of fifty-nine male and sixty-four female patients. Of this group forty-one percent was located within the census with a reasonable degree of certainty, identity being confirmed by address or occupation or name of spouse. Fifty-four families were found in this way and the numbers of men and women were equal. It was almost impossible to trace the families of single people who were in service or who were very young. It was also difficult to find families of people who had originally been admitted from the workhouse.

The number of single occupants of households was higher than in the other two groups though the sample was small. Of the five examples two were elderly parents in their late seventies whose sons became long-term asylum inhabitants. They would have been prime candidates for parish relief or the workhouse. Two were husbands and one was a middle-aged daughter.

The two-parent nuclear family was less prominent in this group. The large number of people admitted in middle age meant that often the missing person from a family was a spouse and parent. Young people from such families may have been living away from home when they became ill, so their family connections were harder to verify. Broken nuclear families were understandably more usual, therefore, in view of the fact that the majority of asylum admissions came from the age group most likely to head

¹⁵ A group was also selected which was admitted in 1875 and discharged after the census. Their families were very difficult to find in the census. Of the forty persons who came into this category the families of only 7 could be located with any degree of certainty. This could probably be improved with reference to other documentation but is very time-consuming.

I then looked up every one admitted between 1876 and 1879 and discharged between 1882 and 1890. It was not very helpful, slightly more so towards 1879 and in the case of married people but the problem was the one identified when I initially did this work, that single people were likely to be longer residents and were therefore over represented in the sample and harder to find. This could be done more efficiently but not directly from the database as it is necessary to know something about other members of the family in order to find them.

such family units. There were twenty-four such families of which fifteen were headed by a woman. Half of these were to remain broken and half eventually received back the missing person. Fanny Dall, a forty-year-old mother of six children was presumably used to coping with change. Her four eldest children were born in three different and distant places, Jersey, Bombay and Aden, during her husband's army career. When John Dall became a school attendance officer in Freshwater Isle of Wight, where his wife had been born, life must have seemed more settled. However, Fanny was destined to continue to cope as John remained in the asylum until his death in 1889. It seems likely, though, that Fanny had relatives in the area.

Nine of these 'broken' nuclear families contained four or more children. Depending on their age children could be the reason for the complete disintegration of the family or the means of keeping it together. In the cases where a man headed a large motherless family there was also a teenage daughter in residence. Charles Holdaway, a baker of Easton, was presumably still at the stage of coping with his six children day by day when the census was taken, as his wife had been admitted to the HCA only four weeks earlier. His fourteen and eleven-year-old daughters must have had a great deal of responsibility until their mother's return in October. Their youngest brother was only one year old. Other Holdaways were eight miles away in Charles's birthplace at Woodmancott but without transport this was too far away for more than an occasional visit. Fortunately for the family Jane Holdaway was discharged in the autumn though she was to spend another three months in the HCA in 1885.

In 1881 Selina Heymer and six of her children were living in the Hursley area and her husband William had been a patient at the HCA since the previous summer. Two adult offspring were still living at home and only two of her children were still at school so Selina probably had moral and financial support until William Heymer was discharged recovered, a month after the census. He was not readmitted in this period.

In other cases there were extra persons from other generations or branches of the family. Elizabeth Hutchins, aged twenty-eight, and with two very young sons aged two and one, took on the task of maintaining her husband's business as a trader. Her brother-in-law was living with the family, as was Elizabeth's sister, Mary Ann Prout, who was presumably able to help with the children. In nearby Kingsclere there were at

least twenty Prout families so it is likely that Elizabeth could call on strong family support. Henry had recovered by November and was not readmitted during the period.

The absence of Emily Lambourne's husband still left her with her eighty-year-old infirm mother to care for, but two young adult children were working and bringing in a wage. Her husband, William was never discharged. William Baldwin's daughter Mary was discharged recovered in October 1881 after seven months at Knowle and was not re-admitted in this period. William meanwhile also looked after his eighty-year-old mother but he too had two adult children to help. This stage was usually one of the most prosperous in the family life cycle. Later when his children married and started their own families William might find he had problems.

Some families could not cope with the situation and their members found themselves distributed amongst relatives or living as lodgers. None of this group, however, appears to have ended up in the workhouse. In at least four households four children were being looked after by grandparents. At least two of these children were illegitimate. Emily Watch was a patient for eighteen months from 1880 to 1882. In the 1881 census her husband Thomas, a former seaman aged twenty-five, was living at their home in Alverstoke. However, their two-year-old daughter Emily was to be found, not with her father but at the home of her grandparents William and Jane Hawkins, also in Alverstoke. Jane Rothery was admitted in May 1880 at the age of thirty-five and died at Knowle twenty years later. A year after her admission her older children aged seven and six were living with their grandparents, Thomas and Ruth Smith. Their baby brother aged ten months was nearby at the home of George and Thirza Smith.

The complete split of the Sparham family was partly brought about by animosity between Caroline Sparham's parents and her husband. Though they admitted that Caroline had always been prone to depression her parents also blamed her husband for the situation that resulted in her being admitted to Knowle in 1876, immediately after the birth of a baby. He later blocked their attempts to have her discharged to their care. Five years later in 1881 one of her daughters was living with her maternal grandparents in Norfolk while the other lived with her father in Basingstoke. They

both grew up without any contact with their mother, and both apparently suffering from the same thyroid problem as she had. When one was admitted to a London asylum in 1914 her doctor wrote to Dr Abbot at the HCA, for information about Caroline. Apparently, though both were aware that she had been admitted to the HCA, neither daughter had known that their seventy-year-old mother was still alive and living at Knowle.

Like Caroline's family, John Maber's family life seems to have been disintegrating before his admission. He was admitted from his parents' home near Fareham in August 1875. In February 1876 a letter from his wife in Dorset, on a scrap of paper torn from a sheet of brown wrapping paper, asked

Will you kindly inform me how my husband is and whether you think
there is any change in him or not by so doing you will gratefully [sic]
oblige.¹⁶

John returned to his parents' home on his discharge in 1880, where the 1881 census described him as an 'unoccupied miller'. The same census shows his wife living with her brother's family at West Stafford, Dorset and their son with his maternal grandparents on the other side of the Ridgeway at Preston.

7.3 Family responses

The household data shows that individuals were admitted from a family situation, usually returned to that family and that in many cases the families they had left stayed together and continued to function in their absence. However, this data does not show how families felt about their afflicted relations.

One way of judging their responses to the situation might be to look at how often relatives visited or whether they visited at all. Though removal from home circumstances was often considered to be beneficial, visiting was both permitted and encouraged at certain times and under certain conditions, with the permission of the

¹⁶ John Maber, 3691, 16th August 1875.

medical superintendent. It did not take place on the wards but a room was provided for the purpose. This appears to have been well used. In 1862 Dr Manley reported that,

the Receiving Room is far too close and incommodious for the largely increased number of visitors, who so constantly present themselves at the Asylum to see their friends and relatives.¹⁷

A book was kept in which visits were recorded, of which a fragment survives in the case notes of John Rhind from the Isle of Wight.¹⁸ In his first year he was visited at approximately monthly intervals by his wife and other members of her family, the visits dropping to one or two a year as time passed. His mother-in-law, his brother-in-law and a friend also visited him between 1874 and 1879.

Though the extract refers only to visits to John Rhind the page numbers of the original entries have been included. If the pages of the visiting book were of the same size as those of the surviving asylum ledgers, then there were forty-five lines per page, which would mean that over four-hundred visitors could have signed in between Mary Ann Rhind's visits on July 26th and November 1st 1875, about a hundred per month. This would have meant that weekends in the receiving room must indeed have been busy but considering that, in the 1870s, there were around seven hundred inmates at any one time, many must have been without visitors for months at a time, if they had any at all. As Knowle is at the extreme south of the county and three miles from the nearest railway station at Fareham this is perhaps not surprising. Considering that Mary Ann Rhind had three very young children and that her journey involved a journey by land and sea to Portsmouth followed by a road and rail journey to Fareham and on to Knowle it is surprising that she was able to come at all. It is unlikely that John ever saw his children again after his admission, until he was transferred to the new Isle of Wight asylum in 1896, by which time they were adults. Though most people did not have a boat journey to contend with, other families had to travel from the borders of Berkshire, Surrey, Wiltshire and Dorset in order to visit. George

¹⁷ Medical Superintendent's annual report, 1862, p 15.

¹⁸ John Rhind, 3546, 7th October 1874.

Battman's wife, Amelia, who lived in Worthing, Sussex, and was comfortably off, was able to visit twelve times in nine months.

On occasions when patients did not receive regular visits Dr Manley tried writing to their relatives. Charlotte Mott's letter of October 1876 may have been a response to such a request.

I received your letter respecting my son for which I am very much obliged to you. I think Sir if he do not say anything about us it would be better not to come and see him as I am afraid it would upset him.¹⁹

Notwithstanding the difficulties faced by some, friends were encouraged to attend social events and in 1884 the number of friends and visitors at the Harvest Service was a source of gratification to the ageing chaplain, George Mason.²⁰

The same problems of distance resulted in many individuals being buried in the asylum cemetery. Though, doubtless, some died forgotten by their families, others were returned to their families in death, like Charles Crouch who was buried with other members of his family at Beaulieu. Relatives who did not have the wherewithal to attempt such a journey could attend a funeral service and burial at the asylum chapel. In 1857 the chaplain recorded that "thirty-four patients have been buried in the asylum cemetery and in many instances the Friends have followed the bodies to the grave."²¹

When patients were very ill or on the point of death their families were summoned and case notes show that they visited to say goodbye or even stayed with the patient until death. Mary Ann Flanders wrote to express her appreciation of her husband's treatment shortly after his death in March 1876.

¹⁹ George Mott, 3302, 12th March 1876.

²⁰ Chaplain's annual report 1884, p 10.

²¹ Medical Superintendent's annual report, 1858, p17.

Kind Sir, I hope you will excuse me taking the liberty of righting [sic] these few lines to you kind sir for as I did not see you when I left my poor husband to thank you for your kindness and sympathy to me in my grief I felt duty bound to do so and to return you so many thanks Sir and likewise for your kindness to my husband for he were so comfortable that I was bound to right [sic] and thank you. Sir if I have done wrong I do beg your pardon sir.

From your most humble servant

M A Flanders²²

This letter is representative of the small but precious correspondence which has been preserved between the asylum and the families of patients. This has survived somewhat haphazardly, probably according to office practices of the staff at the time rather than because of the content. The asylum side of this correspondence has been lost but these letters currently present the only opportunity for relatives of patients to speak in their own voices. All the letters tend to be deferential to the authority of the medical superintendent though often containing instructions about the treatment of their relative and expressing their own ideas about what should happen eventually.

In 1897 Amelia Battman wrote about to Doctor Worthington about her husband George. Amelia was a decade older than her husband and was formerly a schoolteacher. She wrote about him in a motherly way and her letter was articulate and astute. George's family came from the Havant area and the couple had been living at Waterlooville at the time of his admission, which is why he found himself in the HCA. At the time Amelia wrote this letter she had relocated to Worthing in West Sussex and was paying the out of county rate for George's maintenance. She may have felt that her financial involvement gave her the right to have an opinion about what should happen to George and she may have wished to avoid repeating the experience the family had undergone with his parents. Both George's parents had been regular

²² James Flanders, 3775, 4th March 1876.

patients at the HCA. His father was buried there in 1880 and his mother was still a patient at the time of this correspondence in 1897.

Amelia Battman's letter of August 1897 was informed and business like. She had investigated the rules, "I find that owing to Poor Law regulations he will not be allowed to remain there after the expiration of twelve months." She had visited regularly, "I have been to see him, I think, about twelve times since he has been in your charge." She had kept a close eye on his progress, "I am quite sure from close observation that he has made the most marked progress towards recovery...he refers to real events in our home life and makes enquiries about our personal affairs which he has not done for many months previous." She had researched his condition, "Two doctors who know him well who are acknowledged authorities in mental diseases led me to hope for and even expect such a change in my husband as would enable him to live with me again..."²³

Her letter set out her plan, which was for her husband to remain in the HCA until such time as he could be returned to her. She attributed George's improvement to Doctor Worthington, "I am most thankful that such a great change should have taken place in my dear husband's condition under your treatment." Her hope was that George would stay in the HCA for three more months or a little longer if necessary, at which point he could be discharged as 'relieved' into the care of herself and her sister, for whom "the charge of him would be in no sense a new experience." Unfortunately George's improvement does not seem to have been significant enough to permit his discharge to her care and though he was indeed discharged from the HCA at the end of October he was marked 'not improved' and he was sent to the Chichester Asylum. In 1901, while Amelia and her sister continued to live in the house in Worthing, George was still resident in Chichester.

The letters of parents tend to be more sympathetic to the patient than those of spouses, and often express personal anxiety or sorrow on their behalf and a willingness to remove them from asylum care whether or not they were recovered. In some cases this might result in a conflict of opinion between the spouse and his or her in-laws. The letters that exist tend to show the spouse taking a firmer line than the parents

²³ George Battman, 7889, 1st November 1896.

when it came to decisions about the patient's future. Decision-making rested with the spouse as next of kin but parents often wished to be involved and might offer care at home, whereas the spouse might wish only to welcome back a perfectly cured partner. This could be seen as reflecting the tendency of some parents to love their offspring unconditionally, even or perhaps especially when disapproving of the choice of partner. A spouse, on the other hand, quite apart from having suffered the embarrassment and anxiety resulting from the behaviour that resulted in the admission, might see it as reflecting on themselves in some way. And of course they would also have the practical difficulties of childcare in many cases.

Frederick Groom wrote to request a visit and to enquire after his "dear wife", Julia Groom, before sailing as ship's purser to the West Indies in 1882. He enclosed a letter for her and an envelope for the doctor's reply. Later he went to the asylum to discuss the case with Dr Manley because his wife's family had been agitating for her release. His own family supported him in feeling

confident that under your skilful care and treatment she will eventually recover. I have made known to her family that they themselves are preventing her speedy recovery by their absurd conduct and I particularly ask you to withhold from my wife any letters that come (except mine) and to refuse admittance to any of the female portion of the family as I can only keep thinking, on your advice, that quiet and rest are the main requisites for her ultimate recovery.²⁴

As Amelia Battman's letter confirms, his was not the only attempt to dictate a course of action to the medical superintendent. There is no evidence of Doctor Manley's compliance but the retention of the letter in the notes may have been to remind him of the husband's request. The fact that Frederick Groom and Amelia Battman felt entitled to write to the medical superintendents in this way suggests that they saw themselves as service users rather than as the beneficiaries of charity or poor relief and as such entitled to consider their own best interests as well as those of their relatives.

²⁴ Julia Groom, 4897, 29th December 1881.

Some husbands took a different course of action. Rather than trying to control what happened to a wife in the asylum they simply left her to the asylum's care. Susan McCutcheon's husband appears to have lived as a widower in London, changed the family's name and cut them off from all their mother's relatives. Susan's daughter, Annie Reay, found out about her mother in 1882 and wrote to Dr Manley 'because I am quite alone in the world [and] I did not know where she was until a short time ago'. Susan had died only a few months before this letter was written but Dr Manley was able to give Annie the name and address of her mother's sister in Ireland.²⁵ Harry Rickman from Lymington does not appear to have been quite so organised. When brought before Petty Sessions for deserting his wife and, perhaps more importantly in the eyes of the law, for not paying his contribution towards her keep at Knowle his defence was that someone had told him she was dead. This indicates that he had not kept in touch with her progress personally. As evidence of good faith he pointed out that he had not changed his name. Ann Rickman died long before Harry finished paying off a debt of £135 at seven shillings per week.

Ann Grantham, however, was admitted in 1865 and died at Knowle seventeen years later but her husband and family did not forget her. Her daughter wrote from London in the autumn of 1881,

Having promised my Father at his death if possible to see the last of my mother, I shall be thankful if you will kindly send me a line as to her present state of health.²⁶

When the end came the following spring the family was summoned and spent five days sitting with her before she died on March 17th.

Some families visited when they could and wrote when they could not. Rachel Avery's mother thanked Dr Manley for writing, in May 1877, "I thank you kindly for your letter to my sister...and the encouraging news it contained." Rachel's mother thought that overwork was the cause of her daughter's completely uncharacteristic behaviour, "She is my only daughter and such a good girl that this affliction is really more than we

²⁵ Susan McCutcheon, 3391, 1st October 1873.

²⁶ Ann Grantham, 1996, 27th March 1865.

can bear.”²⁷ She continued to hope for a ‘little letter’ from Rachel and for her improvement and was rewarded by her recovery in the following year. Apart from another short stay in 1884 Rachel continued to work as a taillorress until 1899 when she was admitted for the third time and remained until her death in 1922. It seems likely that she was another person who was able to live at home as long as her family could support her but was unable to look after her own interests in the world once her parents could no longer do so.

Those who had neither parent nor spouse to look after their interests sometimes found things rather frustrating. Members of William Pearson’s family appeared to be much more concerned with the trouble he had caused for them than with his comfort or well being. His brother, Samuel, wanted information that would enable him to receive a share of his brother’s insurance policy “for by his acts I have lost a small fortune.” William’s niece in Wakefield did not feel obliged to organise his removal to his home county of Yorkshire and did not wish to be reminded of him. “ I hope you will not allow him to write until in a proper state of mind as it would quite upset some members of the family and none will remove him.”²⁸

The son and son-in-law of John Dixon Reid from Alton were likewise not in a hurry to advocate his return to the family. After years with little contact his son, also called John, found him an embarrassing problem. His letter of January 1897 is one of a few written between family and inmate rather than from family to asylum.

It is no use continually writing to me. I have done at present all I can. You must be patient. I am glad to hear you feel well. I didn’t know your birthday. I don’t think I ever heard of it. For the past twenty years you know, I have not seen or heard much of you.²⁹

A number of other letters deal with the possibility of his living somewhere other than Alton, where his daughter and son-in-law had been witnesses to some highly embarrassing behaviour, but these never came to anything. John D Reid was one of

²⁷ Rachel Avery, first admission, 3973, 10th May 1877.

²⁸ William Pearson, 3539, 17th September 1874.

²⁹ John Dixon Reid, second admission, 7530, 2nd May 1895.

very few patients in the sample to have been admitted with a private certificate and one of the few examples I have found where the relatives seemed to be using the asylum to remove a very embarrassing relative from the scene. They succeeded, as he remained at Knowle until his death in 1905, ten years altogether.

However, non-family members could show concern as well. Thomas Candy's employer knew all about him, thought he was a good worker and was anxious to help. He was employed as a foreman by Bournemouth's local board of works. The Bournemouth surveyor wrote,

he is a very good workman and I should be much obliged if you would let me know if you think he will get well in a short time. If so I will keep his berth open for him as I do not want him to lose it if possible. I take this liberty in writing to you as I feel very anxious for his welfare...³⁰

These individual records show a variety of situations and individual responses to them. Sometimes the asylum admission became inevitable but, though they might be exhausted and exasperated, many families did not stop caring.

7.4 Conclusion

In view of the individual nature of the material used in this chapter a summary conclusion seemed inappropriate. I have therefore used the history of two women who were admitted to the HCA on many occasions to draw together some of the local and individual aspects of this research.

Ellen and Emily Lawford were sisters, born in Ringwood around 1836 and 1837. They were the daughters of William Lawford an agricultural labourer and his wife Rebecca who were the parents of a large family and known to be 'steady'. By 1851 both Ellen and Emily, aged fifteen and fourteen, had left home and were in service with local

³⁰ Thomas Candy, first admission, 4982, 24th June 1882.

farmers.³¹ Their parents, who were both still in their thirties, were living in Upper Kingston with five younger children. After the sisters left home more children were born to William and Rebecca, some of whom were contemporaries of Ellen and Emily's own children. All the Lawford children followed the example of their parents by marrying young and having large and healthy families of their own.

In 1855, Ellen, then aged about nineteen, gave birth to an illegitimate daughter, Jane, who was baptised in the autumn of that year. In 1857 she married George Wiseman, an agricultural labourer ten years her senior and by the time of her first admission to the HCA, in 1859, she was pregnant with her third child. She was later discharged and readmitted a total of six times over the course of the next twenty years. At the age of forty-three she died of gangrene in the Ringwood workhouse infirmary, shortly after the birth of her thirteenth child. Her death certificate records that she was also suffering from puerperal mania.

Emily was admitted to the HCA for the first time in 1856 when she was nineteen. She had recovered by the spring of 1857 and was discharged in April. Later that year she married John Brown, a gardener. Emily also had thirteen children and she was admitted to the HCA nine times over a period of thirty years. In 1891, when she was fifty-three she suffered a stroke and died at home.

Both sisters exhibited similar symptoms just before admission. They were restless and excited in their behaviour, liable to throw things, pacing around the house, particularly at night and muttering incoherently. Ellen, in particular experienced delusions but Emily's conversation was also sometimes directed towards imaginary people and voices. In both cases several months of increasingly strange behaviour culminated in situations that could no longer be contained within the home. Children were ignored or attacked and both sisters, at one time or another, attempted to set out from home wearing very few clothes. However, neither appears to have attempted suicide though Emily's husband once discovered her looking speculatively down a well. Most violent episodes were directed towards property or in reaction to some course of action they objected to such as the doctor's examination or removal to workhouse or asylum.

³¹ The details of Ellen and Emily's lives were drawn from asylum records, the censuses of 1851-1901, Ringwood Parish Records, Records of Ringwood Poor Law Union. There was no genealogical contact in their case.

When their behaviour was irritating or distracting it could be accommodated though it must have made an already hard life even more difficult to cope with. But when supervision was required on a twenty-four hour basis, it restricted the husband's sleep, created care problems for the children and threatened the continuation of the family unit.

Once the problem was acknowledged only a week or two passed before asylum accommodation was sought. On one occasion Ellen is said to have been 'going radically wrong' for months though the symptoms which led to her admission had only been present for a fortnight. Before Emily's first admission her symptoms had been evident for up to three months but on subsequent admissions it seems that the period was much shorter. Evidence about their behaviour and state of mind was usually offered by husbands, parents and children and neighbours, suggesting that all had been involved in trying to cope with the situation. Once the symptoms became more familiar to this group it seems that admission to the HCA was more readily sought. On Ellen's second admission the doctor remarked that "she is not now very bad but was so on a former occasion commencing as this has done. I think the sooner she is under proper treatment the sooner she will be well."³²

The doctor would have known both families well. He was involved with them and their many relations throughout the period and employed a Wiseman cousin in his household in 1881. On all but two occasions the same doctor signed the medical certificate, and the case notes indicate that he had also visited them and tried treatment at home over varying periods of time. It was he who suggested that Ellen's early admission would be advantageous and as far as he and her family were concerned this appeared to be true. Ellen was never resident at Knowle for longer than four months and her average length of stay was 97 days, short by asylum standards.

Though the symptoms were very similar, the records frequently linked Emily's attacks to a sudden fright and Ellen's to childbirth. However, on several occasions it was also noted that Emily had recently given birth. This may have been little more than an association of ideas as mentioned in chapter five. Ellen's confinements had often been more than six months before her asylum admission and both women were confined in

³² Ellen Wiseman, second admission, 1198, 10th April 1860.

childbirth more often than they were confined in the asylum. Ellen had thirteen babies of whom ten children survived infancy. She spent most of her adult life pregnant or lactating and left both grown up children and a newborn son when she died in 1879. Emily had a similar experience. Of her thirteen children eleven survived infancy and though she lived a few years beyond normal childbearing age her youngest child was only twelve when she died in her fifties.

Like other practitioners of his time Dr Manley was confident in linking other factors to insanity in connection with childbirth and the problems of growing families. In his report to Quarter Sessions in 1872 he called attention to the difficult circumstances of the lives of many rural workers and in Ellen's notes he mentioned her domestic problems. In 1865, when she was admitted for the third time he noted her growing family and the serious illness of her husband, information that had been passed to him by Ellen's mother. In 1873, when Ellen was admitted for the fifth time she, her husband and her family of seven children were living on twelve shillings a week plus a few shillings earned by the two older boys. Her diet consisted of tea, bread, a little butter and sugar and no milk. This is a story familiar to historians of urban families who show us clearly that women fed their husbands first, then their children and themselves last³³. Dr Edward Smith's report on the food of the poorer labouring classes came to the conclusion that in rural areas, while the male agricultural labourer might be said to be adequately fed, this was at the expense of the women and children in the family, whose diet was deficient,

The important practical fact is...that the labourer eats meat or bacon almost every day while his wife and children may eat it but once a week, and that both himself and his household believe that course to be necessary, to enable him to perform his labour.³⁴

On every one of Ellen's admissions she calmed very soon after admission, and showed few symptoms thereafter. Her diet in the HCA would have been regular and her

³³Maud Pember Reeves, *Round about a pound a week*, (London, Virago 1979). Elizabeth, Roberts, *A woman's place*, (Oxford, Blackwell, 1984).

³⁴ 6th Report of the Medical Officer of the Privy Council, 1863. Appendix 6, Report by Dr Edward Smith FRS on the Food of the Poorer Labouring Classes of England, p249. His overall conclusion was that though it was usually the case that labouring men were adequately fed, their wives and children had a deficient diet. p259.

responsibilities few for some weeks, whereupon she was able to return to her family and continue her old life for several years before succumbing again.

It seems that these households were continually running 'on the edge'. As long as everyone fulfilled their allotted role a large family with a small house and not very much money could continue to function but as soon as a key member was incapacitated he or she became a burden and jeopardised the integrity of the household. Removing Ellen or Emily until recovered may have been the only way of ensuring that the household did not break down. The first admission was put off for as long as possible but the experience of a speedy recovery and return was sufficient to encourage these families to see the asylum as a way of dealing with a family crisis. The father could continue to work and leave responsibility for the younger children to an older daughter. And both the Brown and Wiseman households remained remarkably stable. They occasionally moved dwelling in the way of agricultural families but never over a great distance and successive censuses show the family and children living in the same place. This continued after the deaths of both women. Ten years after Ellen's death in 1881 the 1891 census shows her widower George and several of his sons keeping house together at the same address. Emily's son John was admitted to the HCA in 1895 from the same address as his mother several years before and in 1901 John Brown and his second wife were still living there.

Finally, what sort of community response and support was there for this family? Both families lived in the same very small communities all their lives, moving from hamlet to hamlet but finding members of their immediate or extended families wherever they went. Even a quick glance at the census in any decade reveals hordes of Lawfords and Wisemans.³⁵ It is certainly inconceivable that Ellen and Emily's problems should not have been known about and discussed. In the circumstances the fact that neither family appears to have been in the workhouse at any time indicates that some sort of support in the form of out relief or from the extended family may have been available when times were really hard.

³⁵ The successive censuses seem to indicate that there were two main Wiseman branches in the Ringwood area, and William and Rebecca Lawford's family is traceable across several decades. The Browns are more difficult to pin down for obvious reasons but it seems likely that they were well represented in the area as well.

The Lawfords and the Wisemans appear to have gone in for early marriages and large families. By 1881 each of Emily's and Ellen's twenty surviving children had at least forty first cousins living within a few miles. Certainly this generation had not left the country for the town though they had left the land to work on the railway. Almost all of their Lawford uncles had jobs with the railway by 1881. Though these several uncles all had large families of their own there is some evidence that they helped out their elder sisters' families when they could. In 1881 Charlotte Wiseman was living with her Uncle William and helping to look after his six children. Fanny Brown appears to have been doing a similar job in service in Berkshire and her two older brothers were living near their parents, as lodgers with Ann Barnes, the widow of a keeper. George Lawford and his wife Emma had started their family in their teens and by their early twenties had four children. Their lodger, Mrs Charity Purton, had helped nurse her neighbour Ellen Wiseman during one of her more difficult post-puerperal times. Rebecca Lawford, their mother, is frequently mentioned in her daughters' notes so she was presumably involved and concerned with her daughters' health. They were neighbours for much of the time, but she had her own young family to care for still.

Finally it is important to note that in spite of the vicissitudes of their lives the Lawfords were not passive victims of circumstances. Emily appears to have been a fairly robust character in the early years. After her first discharge 1857, she lodged a complaint against the assistant medical officer, for behaving improperly towards her. She stuck to her story in spite of having to testify to the Ringwood guardians and the visiting committee of the HCA. The result was that the doctor in question resigned and the medical superintendent was told that it was unwise to have allowed such a young girl to be housemaid to the doctor in question. Within a year or so of this complaint the Ringwood guardians also dealt with a complaint that the local Medical Officer had not visited James Lawford's feverish son, within a day of being given the order to do so. The doctor explained what had happened to the satisfaction of the board but nevertheless he too resigned. Though admission to the asylum and the receipt of medical care involved application to the Poor Law authorities it seems that the Lawfords were not going to be messed around.

After Emily's first admission thirteen years passed before she was readmitted

and most of her problems appeared as she approached middle age, but meanwhile Ellen's experience of the HCA must have meant that it was not a totally unfamiliar place. By the time their children, John Brown and Charlotte Wiseman were candidates for admission it must have seemed an obvious course of action in such circumstances. It seems clear that there is far more to their admission to the HCA than the disposal of two inconvenient and sometimes not very nice women. They lived a hard life in a rural environment on the far side of the New Forest so the decision to send them to the HCA was a difficult one for all concerned, especially in the early days. It was expensive for the Poor Law authorities, which had to arrange civil and medical approval of the decision, pay for treatment and arrange and pay for transport. In view of the large size of the families involved though, this may have seemed preferable to providing workhouse accommodation. For the family the distance meant the time and cost would prevent regular visiting and on several occasions the responsibilities relinquished included the care of a small baby. On one occasion it was noted that Emily was worrying about her children and the fact that she had not had a letter from her husband. Even after the railway was available there was the question of travelling the three miles from the station at Fareham to the asylum at Knowle.

In some ways Ellen and Emily's asylum experience was exceptional. Though many families sent more than one member to the HCA at various times in this period none had two members who, between them, were admitted so many times. And, as individuals, both women were among only 0.4% of those who were admitted to the HCA on five or more occasions. Taking their admissions individually, however, it is difficult to see that there were any different circumstances from those under which others were certified and it may be that this family simply developed a strategy for dealing with a very precarious situation. One can only feel sorry for Emily and Ellen who were pregnant or nursing almost continuously for twenty years and who did not live long enough to benefit in old age from the ministrations of their children. They struggled to cope with little money, endless children and mental illness, and asylum admission appears to have been part of the family's strategy rather than another obstacle to be overcome. Their asylum admissions may be seen as punctuating rather than dominating their lives and they may have made it possible for that life to have continued along relatively normal lines for other household members.

Chapter 8

Fit Objects for an Asylum

Much of the literature of insanity and asylums has presented the nineteenth-century county asylum in a symbolic light. The Victorians may have seen it as a symbol of the enlightened attitudes of the age towards the sick or helpless. Their successors have been inclined to see the symbolism in terms of patriarchy and repression, a metaphor for suppressed instincts and emotions within the psyche of an confident and expanding society, where self-help was the watchword of a flourishing and increasingly respectable working class.

The network of county asylums that had developed in England by the third quarter of the nineteenth century did not develop organically or accidentally but as the result of a concerted campaign on the part of reformers and legislators. Expressed in its simplest form, the combination of the social reforming zeal of some Evangelicals such as the seventh Earl of Shaftesbury and the utilitarian projects of the Benthamites were manifest in many types of institution. Asylums were important among them because if lunacy was the final disintegration of a person then uncontrolled lunacy might be the means of initiating the final breakdown of society. At the same time, the growing interest in medicine and a move towards a scientific approach to diseases of the body was being assimilated by those who concerned themselves with diseases of the mind and it is not difficult to see how medical science could be seen as a means of regulating social behaviour.

Whether those who initiated and sustained the asylum movement would or could have acknowledged such motives is less clear and much existing research has shown that whatever the underlying motivation of the founders of the asylum movement, the outcome in the form of the county asylum was a complicated institution at the centre of a network of relationships, which included the patients and their families. Perhaps the social and economic effects of industrialisation and urbanisation meant that the

modern industrial family not only found it difficult to continue to support non-productive members but was beginning to expect the state to take over this role.

However, once it was built and open for business, the HCA was a local institution and part of the local landscape. As with many other county asylums the institution's name and its location eventually became synonymous, though Knowle did not become part of its official title until the twentieth century, when it also became known as a hospital and not an asylum. As such, the people who were involved with it in any capacity had a personal relationship with the HCA and as well as a symbolic or theoretical relationship with the asylum system. The purpose of this research was to explore that relationship and the different definitions of what constituted a 'fit object' for asylum treatment.

The focus of this thesis has been on what happened outside the HCA rather than on what happened within it. The circumstances of individual cases became important because it became clear that, although I was focusing on social situations, it was difficult to ignore the fact that very many of those who were admitted were suffering from serious psychotic, neurological and degenerative conditions, for which there was no cure and very little successful treatment. These were not people who just failed to conform socially and although retrospective diagnosis will always be inconclusive, I realised that it was necessary to be aware of the overwhelming difficulty of the home situation in many cases. In any asylum admission the actual events in an individual household were as important as the underlying social factors. For the individuals who were admitted and readmitted the remembrance of the HCA and the knowledge that its services might one day again be necessary, became part of the family story.

8.1 The nature of the institution

Quite apart from any symbolic or metaphorical interpretations of the county asylum, the institution itself, the contradictory nature of the HCA in its local setting appears in these records. It was not technically a Poor Law institution but was associated with the operation of the Poor Law at every level. Some members of its management committee were also Poor Law guardians in their own areas. The official decision about who could or could not be sent as a patient, who was, in fact, "a fit object for an

asylum" rested with Poor Law officials. Once the decision was made the patient and sometimes members of his or her family were supported by the local Poor Law union. The guardians of that union also had the right to inspect the conditions under which their paupers were being kept.

The HCA preferred to see itself as a medical institution, like a hospital, and medical superintendents and the management committee continued to stress this throughout the period. Their problem was to provide both care and cure for very different cases within the same establishment and practical and therapeutic considerations found themselves continuously in a very precarious balance. The asylum's wish to present itself as a place where cure took place was part of its desire to be accepted as a legitimate part of a hospital service that was increasingly focusing on science and the cure of acute illness, rather than the nursing and alleviation of chronic conditions. It could be argued that this became more necessary as the century passed, in order to attract a high calibre of staff, yet progress in the alleviation or cure of acute mental illness remained elusive. Meanwhile patients admitted to the HCA, of whatever type, were all cared for, some with more sympathy than others, until they recovered and were discharged or until they died and it was in this capacity that local families sought to use its services.

The HCA itself, therefore, had to cope with an identity crisis in the mixed messages it was both sending and receiving. Committed to the idea of cure it found itself organised around principles of care and safe confinement, its patients arriving late in the course of their illness, often when other treatments had been tried and found wanting. The fact that so many persons were admitted when their condition had reached a crisis of violence and destruction implies that, within the community, the asylum was seen as a last resort, a place of containment while nature took its course.

As such it tended to be a late rather than an early decision. For the Poor Law guardians the county asylum was an expensive choice. Whereas it only cost two or three shillings to support an individual in the workhouse for a week, it could cost between eight and eleven shillings weekly to maintain him or her in the HCA. The union also had to bear the cost of transporting and escorting a patient to the asylum and retained responsibility for his or her well being without actually being able to

influence the treatment. So, for the local guardians, in the first half of this period at least the HCA was a choice based on a balance of need, expense and availability. The need had to be great in order to justify the expense before a journey to the asylum was authorised. In the last half of the period some of the cost to the guardians was defrayed by a government grant and the feeling of the asylum managers was that this would exacerbate the problem of chronic patients rather than encourage early and successful intervention. However, the absence of acute cases in Hampshire's workhouses later in the period indicates that it may have had the desired effect in some areas.

The family decision came before the official decision and though the cost here might be measured in lost wages and local stigma the calculation would also include family safety. In the final moments the decision was likely to be based on a complicated mixture of emotions and calculations as to whether the household would cope better with or without the afflicted person.

The asylum's assessment of itself as a medical institution was genuine but the possibility that others might perceive it this way was made more complicated by its association with the Poor Law. It continued to promulgate its ideas of cure but its real strength lay in its ability to contain and care for an embarrassing and difficult sector of society, who were also both ill and distressed. They were genuinely able to seek asylum at Knowle and their relations found respite. The examples of Edward Horne and Ellen Adams are a reminder that patients asked to be readmitted when they began to recognise that their symptoms were returning.

There is evidence also of a desire to ensure that each admission carried a medical passport in the form of a clinical rather than a social description of the individual's condition. With some consistency doctors tried to apply a medical approach to their patients' condition and to a degree the acceptance of the reception orders at the asylum depended on this. Doctors often found it difficult, for a variety of reasons. The recognition of madness still tended to be instinctive rather than based on the structured identification of clinical signs, though doctors often asked the same questions as nowadays to test how well a prospective patient understood the world around him or her. These involved questions about time and currency as well as

current events and well-known people. However difficult they found it doctors tried to limit their comments to the clinical area. To a lesser extent the friends also tried to show their awareness of the need to focus on the concept of illness rather than on unacceptable behaviour.

None of this means that all concerned joyfully embraced the idea of asylum care but it increasingly came to be accepted as an alternative by those who were associated with its services. However, the evidence of these records is that alternatives at home and in the workhouse were tried for sustained periods before an asylum admission was suggested, even in cases where admission had previously been found necessary. This suggests that the asylum was not the treatment of choice either when there was acute mental illness or when chronic mental conditions persisted. It was not necessarily, therefore, perceived as a place where there was a better chance of cure than there was anywhere else. In fact the evidence seems to point to a belief in the transitory nature of much mental illness and a hope that time would prove the only treatment necessary. It is possible, however, that the HCA's credentials in the field of care were more readily accepted by the public as a form of medical care. In cases where the patient needed constant supervision there must have been relief that he or she was going to a place where their activities could be contained and also where the imminent possibility of embarrassment or, in the worst case, danger to the family, would be reduced. These are human reactions and are perfectly compatible with a desire to provide a place of safety and a good level of care.

8.2 The nature of the asylum population: gender and other variables

Having considered the nature of the asylum and what it had to offer, the next steps were to ask who became its patients and how this came about. The HCA database was designed to approach the first of these questions in detail and to provide a gateway to the second. The number of variables involved made this a complex task and the resulting analysis is only the beginning of a project that could be developed further.

The comparison of the HCA population with the population of Hampshire was undertaken in the light of Walton's findings in Lancashire and those of subsequent asylum studies, which showed that those admitted to asylums in other areas were not

usually outcast or destitute members of society. Analysis of occupations of HCA residents showed, not surprisingly that most people admitted to the HCA were connected with agriculture to some extent. They either worked as agricultural labourers or in a more specialised area such as gardening, dairy or transport, or they were members of the families of such workers. A daughter might be in domestic service but she almost certainly came from a family where the main breadwinners were employed in the precarious and poorly paid world of agricultural labour. The other important group comprised tradesmen and artisans who served the populations of these rural communities in the local towns or villages. In terms of social status most of this second group might have thought of themselves as superior to the labourers and most had only occasional contact with the system of poor relief until asylum care was needed.

Analysis of residential origins shows that the majority of those admitted were members of families and the majority of those discharged returned to their families. Of those admitted from elsewhere some were resident at their place of employment and some in a workhouse, but of those in the workhouse many had been admitted because of their illness and very few were residing there simply because of prior destitution. So although the population of the HCA reflects the poorer section of wider society this research supports that of Walton in rejecting the idea of an asylum population consisting of society's failures or undesirables.

The asylum population was drawn from a group that found daily life hard, but nevertheless maintained family life, usually within a conjugal relationship. The existence of that relationship and the probability that its offspring would be in a position to help may have contributed to the fact that the proportion of married people among the admissions was lower than the proportion in the population of Hampshire. It was certainly relevant to the future prospects of patients. The lack of family support for the adult single male and to a lesser extent for the single female on discharge must have contributed to the fact that two thirds of the male population and just over half the female population of the HCA in April 1891 was single. Because it was difficult to make suitable discharge arrangements for these patients they tended to stay longer in the HCA. This group was affected, therefore, not so much by the social prejudices of a superior section of society, but by the needs and preferences of the

social group from which it was drawn, where the conjugal household was the basic unit and its exclusivity made it difficult to support anyone who was not an integral part of it.

The analysis in Chapter Four showed that occupation, place of residence, health, age and marital status were all interrelated and relevant to the admission, asylum experience and outcome for all HCA patients. Inextricably woven into this analysis and that of subsequent chapters was an awareness of gender. That more women than men were admitted in absolute terms is certainly true, though as the proportions of those admitted the two sexes tend to reflect the proportions of each in the county's population. Admissions of one sex were not affected by admissions of the other because the two sides of the asylum were separate so numbers of males admitted could only rarely be affected by the admission of more or fewer females.

In the two separate wings the population rose steadily throughout the period, the population of women outstripping the population of men from an early date. Nevertheless, in the last half of the period particularly, the proportions of men and women admitted to the HCA reflected closely the proportions of men and women in the population of Hampshire. However, it was clear from the database that in some respects men and women were admitted to the HCA for different reasons and could expect a different outcome of the experience. Gender was almost certainly a factor when it came to describing the illnesses of both men and women. GPI was a real condition and one associated primarily with men. When cures started to work the number of men in asylums dropped. Childbirth on the other hand is something that only happens to women and it has always been known that it can cause serious mental problems for a variety of physical, psychological and social reasons. In addition the poor physical health of many men on admission meant that though men and women had a roughly equal chance of their length of stay lasting only a few months, men were more likely to die in that period while women were more likely to recover. The Victorians were perhaps correct therefore in thinking that the growth of the number of women in the resident asylum population was as much to do with the longevity of women and the different nature of their illness as with anything else though the nature of that growth in terms of numbers of women admitted has been exaggerated.

However, there were also conditions more clearly associated with cultural understanding of gender than with physical factors. Intemperance was high on the list of perceived causes of insanity among both sexes but mostly among men. Both men and women could show signs of mania but women were considered more likely to be melancholic. Further research would be necessary in order to explore the extent to which the differences were there in a patriarchal society because they were perceived and interpreted as such by the medical and legal profession who had the power of certification and how much they were related to gender influences on the way these people actually led their lives.

At this stage, however, the theoretical work on women and madness, such as Showalter's, originating in cultural criticism, should be applied with great caution to these women. They may have been the victims of a degree of stereotypical expectation but their lives were just too busy and too difficult for them to have time to agonise over the restrictive nature of their role as women. The situation of women in this section of society meant that they were often ill or disabled by child bearing, malnutrition and hard physical labour. A short asylum stay may have provided the physical rest necessary for recovery. Some of the asylum work in the laundry and needle room was hard too but the food was adequate and regular and there were no other responsibilities.

The issue of gender cannot be left out of any analysis of asylum admissions but it is also important to include other variables such as age, marital status and occupation as they operated in a relationship with gender, to produce a nuanced picture of the circumstances surrounding both male and female admissions. It is, for example, certainly true that the lives of the working class women who were admitted to the HCA were circumscribed by poverty, hard work and childbearing. For many there is little doubt that their female biology lay at the root of their physical and mental health problems. However, it is likely that they were too busy recovering from the last confinement and stretching the income to feed all the family to have time to worry about their role in society. Such a pre-occupation was a middle-class luxury and therefore probably not an issue for most of the women in this sample. The same might be said of the men in the study, who also dealt with hunger, physical hardship and ever-growing families.

That is not to say, however, that the doctors and officials who came into contact with these patients and their families were not influenced by contemporary cultural constructions of gender regarding both sexes, which it is not within the scope of this thesis to explore in depth. Doctors, Justices and Poor Law guardians, who were all members of the middle class, may have had an understanding of women based on their psychology, femininity and perceived weakness or capacity to corrupt men and of men based on ideals of physical power, responsibility and sobriety, but their families and friends judged them more on their ability to fulfil a role which was demanding and crucial to the success of the family unit. If women were sent to the asylum it was more likely to be because the family itself would suffer in practical ways if the current situation continued, rather than because of any sort of psychological theory about women and this applied differently but no less importantly to men. Doctors, especially those who had worked in these communities for some time, probably absorbed these attitudes and were influenced as much by them in making their diagnosis as by the cultural expectations of their own class. The reasons given for certification were usually based on a mixture of personal and family circumstances as well as on stereotypical gender judgements.

8.3 Families, households and personal choices

The database therefore shows that gender, marital status and age are all important factors but they cannot be viewed separately from the mental and physical condition of the patient and their social background. As it is impossible to know if every patient was truly mad one has to accept the witnesses' own assessment of what constituted a suitable asylum case and compare the situations as reported in order to assess the circumstances which resulted in an individual's being removed to the HCA.

With this in mind the reception orders and case notes of selected patients were reviewed in order to ask what circumstances outside the HCA finally led to an admission. One thing became increasingly clear. In theory the county asylum might represent the best hope of cure for those afflicted with insanity, but in practice, doctors and friends alike sought to carry out treatment within the sufferer's home or in the local workhouse. However, occasionally individuals such as Edward Horne

headed back to the HCA of their own accord because “he now says he has not control over himself and that he comes back to the asylum to place himself under care and treatment.”¹ And it seems likely that when people were admitted on more than one occasion a previous recovery might encourage the family to hope that the same thing might happen again. Walter Higgs certainly hoped that his son Ernest’s recovery might be repeated in the case of his younger son, Albert. The large number of individuals who appear to have been related to another asylum patient suggests that the admission of one family member, particularly one who had recovered, might make it less difficult to make the decision to send another and might make a diagnosis of insanity more likely.

In the majority of cases, however, a period of treatment at home could last a long time, ending only when the patient’s behaviour became dangerous or unmanageable. And, for the most part, the sign that a recovery had been effected was when their behaviour had returned to a generally accepted level of normality. Though the decision to certify was often taken in an emergency and was probably not based on conscious reasoning it was a fine judgement that the crisis point should be recognised in time to prevent the disintegration of the family. It was important that there should be a family to return to later.

There is not much evidence in these records of families being put under pressure to send relatives to the HCA. Doctors appear to have been called in late in the illness except where there was a sudden crisis. Treatments and care were attempted at home and the asylum was offered when other things had failed. On the whole people were sent because the family had reached crisis point. This was true in both acute situations and when the case was long-standing such as with mental handicap or dementia. Mental illness can be the result of and the cause of crisis. The effect on families varied depending on the type of family, its stage in the family life cycle and the patient’s gender, age, and marital status. Families where the mother was admitted could, on the whole, continue as long as an older daughter stayed at home or an additional adult joined the household. Families that lost fathers could have a harder time unless the older children were able to contribute a wage to the household. Such families could

¹ Edward Horne, second admission, 3328, 15th May 1873.

also experience more problems before admission as men's illnesses often led to unemployment and violence.

No one appears to have been admitted in the expectation of a long stay. Many of the long-stay patients were admitted for the first time for only a short period at the end of which they were optimistically thought to have recovered. Later they would be readmitted. Several of those who experienced repeated admissions went in and out over a number of years before remaining in residence. Families tended not to head for the asylum as a first resort though those admitted previously may not have waited so long as on the first occasion. This is probably true of all illness as experience makes the warning signs evident earlier. Willingness to readmit someone may show a remembrance of a successful cure on a previous occasion and a hope for the same again. But it may also be based on a new understanding of how a stay in the asylum for one member could enable the rest of the family to go on coping for longer than it otherwise could.

8.4 Methodological Issues

This research aimed to place the HCA, not into a theoretical, legislative or medical context but into the personal context of the lives of the people associated with it as patients, and the research method reflected this, moving from theoretical issues to an overview based on figures derived from a database, and finally to the experiences of individuals as reflected in personal records. And yet, as the historiographical reflections in Chapter Two indicated, the possibility of engaging with the lived experiences of the inmates of the HCA is bound to be compromised by the expectations and experiences of the researcher and the perspectives of the time.

This difficulty, however, is present in any situation requiring empathy but it is important to understand how people live with the consequences of social policies. Notwithstanding the limitations of interpretation imposed by a present perspective and the influences of both present and past culture this research has shown that the records of the HCA in conjunction with the imaginative interpretation of the historian can offer a valuable contribution to the creation of a profile of the HCA population on every level from the aggregate to the individual.

However, it also became clear in the course of the research that this type of project presents organisational difficulties related to the large amounts of documentary material involved. While it certainly would be possible to work on a microhistory in this way it was also clear that this project could explore only a few aspects of the material. The construction of the HCA database has repaid the time and effort involved by providing a systematic approach to the more detailed case notes and reception orders that could not have been achieved in any other way. It could be expanded as more records become available and it has created a new source for researchers in which the information is now available in a searchable form, though the records themselves remain the definitive source for any research. Its potential remains to be developed further and there is scope for developing a means of handling, in a meaningful way, the large quantities of text generated by close study of reception orders, case notes and administrative records. It could also contribute towards possible large-scale comparisons between areas.

One of the original aims of the project was also to make use of other records of the type held by county record offices, such as census, poor law, court and parish records as suggested by David Wright.² In view of the extensive data collection already undertaken in the creation of the database this proved too time-consuming to pursue in more than a few cases. However, census records helped to build a picture of some families and households, especially in the cases of some individuals such as Ellen and Emily Lawford, Caroline Beaton and the Battman family. The family historians who shared the results of their researches have often used these sources and this extended the scope of the study. Wright was setting historians a complex and labour intensive task but, with the aid of modern information technology that enables information to be exchanged via e-mail and the Internet, not an impossible one. The rewards of this methodology, which could lead to a form of community reconstitution in a future project, are evident, even in the small number of cases explored in that way here.

It also became clear that the scope of this project could not extend to all the possible aspects of the subject because of the time it would involve. This study looks at only

² David Wright, "Getting out of the asylum: Understanding the Confinement of the Insane in the Nineteenth Century." *Social History of Medicine* 10, (1997), 137-155.

one aspect of individual's lives around the time of their asylum admissions and discharges. The potential is there to exploit these records to consider their asylum careers and to investigate the daily running of the asylum and the lives of its inmates, both patients and staff and particularly the medical superintendents. Dr and Mrs Manley spent the whole of their married life in the big house at the centre of the asylum. Their two daughters were born and grew up there and Mrs Manley died there. It would have been impossible for them to have lived there without being fully immersed in the daily events of the asylum. Mrs Manley organised music in church and for entertainment, often lending her own instruments. She also played a big part in obtaining an organ for the new chapel shortly before her death. According to the Commissioners in Lunacy Dr Manley knew all his patients and to what extent the Manleys' kindness and interest permeated the atmosphere of the asylum and made it a more tolerable place than it might have been is an important question. When Dr Worthington was appointed it seems as if some of the 'family' atmosphere disappeared. He was not a married man and the sister he brought with him as housekeeper died of typhoid shortly after her arrival at Knowle. Numerous staff left or were dismissed in the year after his arrival and within a few years he had moved out of the central house to one which was detached and at a slight distance from the asylum. This is an area in which further research might consider whether such changes, along with a more bureaucratic and less personal approach to record-keeping could be seen as reflecting a movement from optimism to pessimism in the treatment of psychiatry in asylums in the last quarter of the nineteenth century.

The HCA stood geographically and socially at a distance from the local community that serviced it and the wider community of Hampshire, which it served. But it would be a mistake to portray it as isolated because in every respect and at every level it was linked in complex relationships with those communities. The links were legal, medical, commercial and moral and this thesis has referred to all these aspects of its interaction with the wider world. Those who advocated, built and sustained the HCA may have done so out of a mixture of philanthropy and social anxiety, and promoted it with the language of medicine and the hope of a cure, but it does not necessarily follow that those who used it did so in the same spirit.

The records show that, in many cases, families cared for one troubled individual for as long as possible before calling on the resources of the HCA. However, the fact that the asylum was a last resort and that it could often do little more than contain a problem person, does not mean that it did not provide a valuable service of caring that was unavailable elsewhere, even though the asylum authorities tried to play down this role. The debate about whether such services should be funded from the same budget as acute medical services, or provided in the same institutions is alive and well in the twenty-first century and the difficulty of balancing the targets of service providers with the expectations of service users continue.

The focus of this thesis, on the experiences of patients and their families, shows that for many, the HCA was offered in one spirit, where the 'fit objects' were suffering from a condition which could be treated and cured. Yet it was often accepted in quite another spirit, on behalf of those who were in need of a place of safety or care, as part of a wider and continuing strategy that enabled troubled families to continue to function. Underlying factors such as those described by Scull, relating to the household's ability to survive in economic terms had the potential to affect responses and strategies towards its weaker members. However, very many households in Hampshire and throughout the country were in a similarly precarious economic state and yet continued to be self-sufficient in the face of enormous difficulties. The instinctive reaction of families when a member was thought to have been afflicted by insanity was to protect and care for them. Relatively few families gave up members to asylum treatment and when they did so it was in the face of enormous crisis, when the strain on the household had caused it to reach breaking point. These records show that this strain was usually caused by exhaustion, fear, financial disaster or a combination of all three. Furthermore the work of both Anne Digby and Charlotte Mackenzie showed that regardless of income or social status middle-class families had these reasons in common with their poorer neighbours for turning to asylum care. Scull was right to look at the social and economic structure of the world they inhabited but it is also important to think about the daily lives and personal situations of individuals and families who eventually became involved with the HCA. It is evident that households tried to maintain the status quo for as long as possible before

resorting to the HCA and the principal influence on the eventual decision was the balance of household disruption against personal sentiment.

With this in mind the challenge continues to be to seek out individuals and their families within the community as well as within the asylum. The lack of detail in case progress notes is a problem that could be addressed through the study of repeated admissions and record linkage. A carefully structured and searchable database and the application of text mark-up software would make it possible to address many of the issues noted here, such as the importance of age, marital status and gender in the context of individual experience, in a systematic and ultimately illuminating way.

Only by looking at places like the HCA in this sort of detail can we say anything about what they meant to the people who used them and who lived and died there. The HCA itself existed not only in the world of parliament, philanthropy and social welfare but in the human experience and suffering of individuals and this should not be forgotten in either academic or popular history in this area.

Appendices

Appendix 1

Conversion of approximate measures of length of stay into exact measurement.

Approx measure	Exact measure (days)
<30 days	1-30
1-6 months	31-180
7-12 months	181- 365
1-3 years	366- 1000
3-10 years	1001- 3700
10-20 years	3701 – 7500
>20 years	7501 days +

Poor Law Unions of Hampshire



Appendix 2: Map showing Poor Law unions of Hampshire and location of HCA.
Based, with permission, on a map produced by the HRO.

Appendix 3: Reception Order of Amelia Cooper admitted 12th October 1892.
 Reproduced by permission of the Hampshire County Record Office.

STATEMENT OF PARTICULARS.

STATEMENT OF PARTICULARS referred to in the above or annexed Order.

If any particulars are not known, the fact is to be so stated.

[Where the patient is in the order described as an idiot, omit the particulars marked*.]

The following is a Statement of Particulars relating to the said Amelia Cooper
 Name of patient, with Christian name at length Amelia Cooper
 Sex and age Female 60 years
 *Married, single, or widowed Married
 *Rank, profession, or previous occupation (if any) Labourer's Wife
 *Religious persuasion Church of England
 Residence at or immediately previous to the date hereof Mortimer West End
 *Whether first attack Yes
 Age on first attack 60 years
 When and where previously under care and treatment
 as a lunatic, idiot, or person of unsound mind Nowhere
 *Duration of existing attack 3 months
 Supposed cause Unknown
 Whether subject to epilepsy No
 Whether suicidal No
 Whether dangerous to others, and in what way Yes Threatened to cut her husband's head off
 Whether any near relative has been afflicted with
 insanity Yes Father
 Union to which lunatic is chargeable Basingstoke
 Names, Christian names, and full postal addresses of
 one or more relatives of the patient John Cooper, Husband,
 Mortimer West End. Mortimer
 RSO
 Name of the person to whom notice of death to be
 sent, and full postal address, if not already given John Cooper
 as above

[o] To be signed by the
 relieving officer.

(Signed) []

*Joseph Jibb
 Relieving Officer of the Union.
 of Basingstoke
 Dated the 12th day of October 1892.*

CERTIFICATE OF MEDICAL PRACTITIONER.

In the matter of ^[1] *Amelia Cooper* [1] Name of patient.
 of ^[2] *Mortimer West* [2] Insert residence of patient.
 in the County of Hants ^[3] *married - age 60 yrs.* [3] Insert profession or occupation, if any.

I, the undersigned ^[4] *Walter John Roalfe Cox* [4] Name of Medical Practitioner,
 do hereby certify as follows:—

1. I am a person registered under the Medical Act, 1858, and I am in the actual practice of the Medical profession.

2. On the 12 day of October 1892
 at ^[5] *Mortimer West* ^[5] *Age of 60 yrs.* [5] Insert the place of examination, giving the name of the street, with number or name of house, or should there be no number, the Christian and surname of occupier.

in the County of Hants, I personally examined the said ^[6] *Amelia Cooper* [6] and came to the conclusion that she is a ^[7] *person of unsound mind* [7] A lunatic, an idiot, or and a proper person to be taken charge of and detained under care and treatment. [8] Insert name of patient.

3. I formed this conclusion on the following grounds, viz.:—

(a.) Facts indicating insanity observed by myself at the time of examination, viz.:—

Patient - has a vacant expression & other signs appear as though thinking doubly - wanders aimlessly about the house muttering to herself - "Oh dear oh dear" says they have lost all their property - that people are running away with it - rats - i children - thinks there are children buried under the floor - & take no notice when spoken to.

(b.) Facts communicated by others:—

by Mary Ann Wiggins - Patient, has frequently said that she has no wife - that a threatening mob has been threatening her - that people are running away with her money & children - that children are buried under the floor. Dr. Oct: 7: was found sitting, upon floor in cottage - to what the house is, children - has been strange in manner for 3 months - and agrees to answer what has not done so for 6 weeks at a time.

4. The said ^[11] *Amelia Cooper* ^[11] appeared to me to be in a fit condition of bodily health to be removed to an Asylum. [11] Insert name of patient.

5. I give this certificate having first read the section of the Act of Parliament printed below.

(Signed) *Walter John Roalfe Cox* [10] Insert full postal address.
 of ^[10] *The Laurel, Mortimer, Bexley*

Dated this 12 day of October 1892

Extract from section 317 of the Lunacy Act, 1890.
 Any person who makes a wilful misstatement of any material fact in any medical or other certificate or in any statement or report of bodily or mental condition under this Act, shall be guilty of a misdemeanor.

Appendix 4: Index of individual patients

Names marked with an asterix are those for whom genealogical research was available.

Adams, Ellen

Admission no	From	To	Outcome
(Clark, private)8	13/1/55	20/9/55	Recovered
(Wells)1103	20/6/59	26/12/59	Recovered
(Wells)1332	15/3/61	5/9/61	Recovered
(Wells)1637	25/11/62	2/5/63	Recovered
(Wells)1801	31/12/63	1/8/64	Recovered
2636	12/1/69	16/6/69	Recovered
2881	11/6/70	28/11/70	Recovered
3230	13/9/72	19/4/73	Recovered
3761	24/1/76	26/9/76	Recovered
4457	25/10/79	8/6/80	Recovered
5472	12/1/85	22/8/85	Recovered

Ellen's adult life was punctuated by periods of residence in the HCA. As Ellen Clark she spent time in the private Laverstock Asylum and was admitted as a private patient to the HCA. On this occasion her employers, the Lords of the Admiralty paid for her maintenance. On her discharge she continued to work as a nurse at the Naval hospital in Gosport. Later she was admitted as Ellen Wells. Each attack appears to have consisted of a period of deep depression during which time she was cared for at home, followed by a violent outburst at which time she was admitted to the asylum. She is described as educated and of good character and does not appear to have had any children. She continued to live with her husband for several years after her final recovery and they both died in 1895 by which time Ellen was about 70.

Atkins, Edward

Admission no	From	To	Outcome
2610	2/11/68	12/1/69	Not improved
3303	12/3/73	14/9/73	Died

When Edward Atkins was a few months old he fell into the fire and his head was severely burned. From the age of two he suffered from fits and, once mobile, was uncontrollable. He ran around making a high pitched scream and at night he had to be tied to his bed. When he was six years old he was admitted to the HCA but on Dr Manley's recommendation was returned to the workhouse as an unsuitable case for an asylum. In 1873 he still bore the scars of the old burn and the master of the Petersfield workhouse found it impossible to look after him in the infirmary there. His family could not look after him at home because his behaviour meant that they could not find anywhere to live.

Avery, Rachel

Admission no	From	To	Outcome
3973	10/5/77	8/6/78	Recovered
5305	18/4/84	18/9/84	Recovered
8555	15/5/99	4/11/1922	Died

Rachel was in her twenties, lived with her parents and worked as a sewing machine operator. At the time of her first admission she was thought to have been working too hard. She had been treated at home but had continued to threaten violence to herself and offer abuse and violence to those around her. After six months in the HCA with little change in her behaviour things started to improve and six months later she was considered to have recovered. An aunt had been an inmate of the HCA and all members of her immediate family were described as eccentric.

Baldwin, Mary

Admission no	From	To	Outcome
4726	5/3/81	24/10/81	Recovered

An excess of religion was blamed for 24 year old Mary Baldwin's attack of mania.

Barton, Mary Ann

Admission no	From	To	Outcome
6775	2/1/92	29/1/92	Died

Mary Ann Barton was acutely depressed on admission. She had been treated for something similar in the Southampton workhouse ten years previously and had never seemed well since then. She had been living apart from her husband ever since as 'he was afraid of her' but he had continued to support her. Shortly after admission she caught influenza and died of complications a week later.

Battman, George

Admission no	From	To	Outcome
7889	1/11/96	21/10/97	Died

George was the son of **Joseph and Harriet Battman** and so was no stranger to the HCA when he was admitted. He had also been a patient in other asylums. His condition was noisy and excited and he rushed about. Although his wife, Amelia, expressed a wish to have him at home he was never considered well enough to be discharged and was eventually transferred to the asylum at Chichester, which was nearer his wife's home.

Battman, Harriett

Admission no	From	To	Outcome
2850	16/4/70	4/2/71	Recovered
3413	10/11/73	28/4/75	Recovered
3771	26/2/76	28/7/77	Recovered
4207	1/7/78	5/3/79	Recovered
4453	9/9/79	12/6/1907	Died

Harriet was born in about 1830, in Horndean. She married **Joseph Battman** in the late 1850s and their married life was spent in the Havant area. She and Joseph were both patients at the HCA during the 1870s and their family was scattered by 1881, though the youngest daughter remained at home, presumably to look after them. The usual circumstances leading to Harriet's admission were a mixture of depression and excitement but by the time of her final admission she had lapsed into a state of dementia, which lasted until her death 27 years later. She was buried at Knowle in 1907.

Battman, Joseph

Admission no	From	To	Outcome
1423	18/9/61	11/6/62	Recovered
3317	17/4/73	2/9/73	Recovered
3483	27/4/74	3/2/77	Relieved
4157	3/5/78	5/3/79	Recovered
4353	10/3/79	27/6/80	Died

Joseph Battman was one of a number of sons born to a farming family on the borders of Hampshire and Sussex in the 1830s. He married and remained in the area all his life. Episodes of excitement exacerbated by drink characterise his admissions and on more than one occasion his outrageous behaviour in public precipitated his certification. His inability to work and his wife's insanity contributed to the break up of the family. He was buried at Knowle in 1880. His wife, **Harriet Battman** and son **George Battman** were also patients at the HCA.

Beaton, Caroline

Admission no	From	To	Outcome
2951	13/12/70	3/10/71	Recovered
3147	7/2/72	26/8/74	Recovered
4992	18/7/82	22/1/83	Recovered
5748	5/7/86	16/9/86	Recovered
5861	19/2/87	2/1/88	Recovered
6254	20/5/89	27/11/89	Recovered
7429	27/11/94	5/2/95	Recovered
7528	27/4/95	25/4/98	Relieved
8442	8/12/98	27/4/99	Not improved
8695	12/12/99	27/12/1912	Died

Caroline was over 50 on her first admission, married to a labourer and working as a charwoman. Her children were all grown up and over many years took it in turns to be responsible for her. She lived in her own home, in their homes and in the workhouse at various times and was often removed from the asylum by them. Her embarrassing public behaviour, defined as 'mania', was at the root of her early admissions but as time went by her dementia was the main cause. Her final stay lasted 13 years and she was over 90 when she died. During this time one of the daughters who had looked after her was also admitted as a patient and they kept noisy company with each other in the asylum infirmary.

Bedford, Eliza

Admission no	From	To	Outcome
1290	3/11/60	14/12/60	Recovered
1307	10/1/61	5/7/61	Recovered
1431	8/10/61	2/12/64	Recovered
3756	10/1/76	1/5/76	Recovered
3824	30/6/76	25/7/77	Recovered
4103	17/1/78	22/4/79	Recovered

Eliza Bedford was born in London but she married William Bedford whose family had always lived in Cove, and that was where they stayed. They had a hard life with little money and Eliza was usually in poor physical condition when she was admitted. William was a 'bad character' who took the opportunity of her first asylum admission to live with another woman but every time Eliza was discharged she soon became pregnant and her pregnancies combined with the necessity for her to undertake fieldwork to earn money took their toll. Her epileptic fits were often followed by a state of mind characterised as mania. However, William and Eliza were still together in 1881 and living with their two daughters and grandson.

Blevins, Louisa

Admission no	From	To	Outcome
499	1/11/55	23/2/56	Not improved
533	14/3/56	19/9/57	Recovered
5640	2/11/85	2/2/86	Died

Louisa was married to William Blevins, who worked as a mender of umbrellas and china from premises in the Market Square in Romsey. She was suffering from melancholia when brought to the HCA in November 1855 and was under supervision on the ward because she was considered to be suicidal. Several days after her admission she blinded herself in the right eye. William took her home briefly in February 1856 but returned her to the asylum within a month. She gradually recovered over the course of the next year and she returned to her family. After her husband's death she lived as a lodger in Romsey and the 1881 census noted that she was now completely blind. Her readmission in 1885 was once again put down to depression though this time the cause was thought to be senility as she was now 70. She died only three months after this final admission.

Brown, Emily

Admission no	From	To	Outcome
(Lawford) 572	15/5/56	1/4/57	Recovered
2867	10/5/70	2/8/70	Recovered
3977	15/5/77	25/9/77	Recovered
4382	1/5/79	25/11/79	Recovered
4952	15/4/82	19/4/83	Recovered
5140	5/5/83	19/4/84	Recovered
5453	22/11/84	20/6/85	Recovered
6150	28/9/88	31/12/88	Recovered
6422	5/5/90	27/9/90	Recovered

Emily's story is told in detail in chapter seven.

Bull, Elizabeth

Admission no	From	To	Outcome
4790	16/6/81	2/1/82	Recovered

In April 1881 17 year old Elizabeth Bull was living with her uncle and his family on the Isle of Wight and working as a laundress, as were her aunt and three cousins. Elizabeth must have been heavily pregnant at the time because shortly afterwards she was admitted to the workhouse, either to give birth or because of complications from the birth. She was admitted to the HCA from there suffering from puerperal mania in June but early in 1882 was discharged recovered and not readmitted during the research period.

Bulpet, Lydia

Admission no	From	To	Outcome
4581	24/4/80	23/10/80	Recovered

Lydia and her farm labourer husband, Emmanuel moved from village to village as he found work and six children were born on their travels. After the birth of the sixth Lydia was very depressed and was admitted to Knowle where she recovered over the course of the summer of 1880.

Burton, Charles

Admission no	From	To	Outcome
3699	7/9/75	16/3/87	Died

Charles Burton was seven years old when admitted. He was the youngest of eight children and his father had died within the week of his birth. His mother had been coping ever since but one of her other children was said to be 'simple' and Charles was incapable of doing anything for himself. His bodily health was poor and he had frequent fits. This situation continued until his death from phthisis at the age of 19.

Butler, Stephen

Admission no	From	To	Outcome
2695	2/6/69	1/1/70	Recovered
3240	4/10/72	20/8/73	Recovered
3921	23/1/77	25/10/77	Recovered
4622	9/7/80	24/10/81	Recovered
5385	31/7/84	4/1/86	Recovered
6171	13/11/88	15/5/1902	Not improved

Family misfortune and strong drink combined to cause or exacerbate Stephen's condition on several occasions. The first child of his marriage to Thirza was stillborn but at least two others were born subsequently. Thirza looked after the family and dodged Stephen's blows for many years between his admissions and some inmates of the HCA found themselves dodging them when he was an inmate there.

Candy, Thomas

Admission no	From	To	Outcome
4982	24/6/82	21/9/82	Recovered
5632	9/11/85	8/3/86	Died

Thomas Candy worked as a foreman of labourers in Holdenhurst and was well regarded by his employer. However, his behaviour became increasingly excitable and unpredictable and he appeared to be labouring under a number of delusions about his wife, which resulted in their separation. He appeared to recover and having left the asylum went back to work in Bournemouth, but it became clear that he was, in fact, suffering from GPI. His delusions became marked and he threatened both his mother and his housekeeper. His deterioration was rapid; he was admitted because it took three men to restrain him and he had to be put in strong dress and given sedatives after his admission. His family was called to his bedside in January and he died a few weeks later.

Carter, Emma

Admission no	From	To	Outcome
3842	3/3/77	26/11/77	Recovered
4329	21/1/79	2/8/79	Recovered
4863	22/10/81	22/5/82	Recovered
5654	1/1/86	17/4/86	Recovered
7450	22/12/94	2/3/95	Recovered

Emma Wise was a domestic servant before her marriage to William Carter. Her problems began with the birth of her children and continued until her childbearing days were over. Her first baby died in bed and it was not thought safe to leave her with the second. All her admissions except the last were associated with childbirth but she also had a goitre. She was not admitted again after 1895 when she was about 46 and she was still living in Fyfield with her family in 1901.

Clark, Hester

Admission no	From	To	Outcome
489	20/9/55	19/2/56	Recovered

This was Hester Clark's only admission. She was 40 years old and had been suffering from melancholia for about a month but was described as in fair health. She recovered within a few months and returned to her family at Chiddesden, near Basingstoke. The 1881 census shows her still living at Chiddesden with her husband, Thomas and her sister, Elizabeth.

Clark, Ellen

(see Adams)

Admission no	From	To	Outcome

Coles, Eliza Ann

Admission no	From	To	Outcome
760	24/3/57	17/12/57	Recovered
898	8/1/58	12/8/58	Recovered
1292	9/11/60	4/9/61	Recovered
1661	10/1/63	29/1/67	Recovered
2324	7/2/67	14/4/70	Relieved

Eliza Coles was an unmarried schoolteacher in her forties. She had been an inmate of several private asylums before being admitted to the HCA suffering from delusions. Between admissions she lived with her sister but her length of stay increased on each admission. Her final discharge after seven years at Knowle saw her being transferred to Fisherton House asylum near Salisbury, where she probably remained.

Colwell, Richard

Admission no	From	To	Outcome
4845	13/9/81	2/7/84	Died

Richard Colwell was a 48-year-old single man, considered to be imbecilic but working as a farm labourer. He had also recently been a workhouse inhabitant.

Comyns, Arthur

Admission no	From	To	Outcome
4899	30/12/81	3/9/85	Died

Arthur Comyns, aged 48, was described as having been an idiot since birth. In April 1881 he was lodging with Caroline Bond in East Woodhay, where there were several other Comyns families.

Cook, Elizabeth

Admission no	From	To	Outcome
1698	27/4/63	30/11/63	Recovered
2611	7/11/68	30/8/69	Relieved
2832	28/2/70	1/2/72	Recovered
3335	2/6/73	15/12/74	Recovered
3952	29/3/77	22/10/77	Recovered
4648	2/9/80	10/9/81	Recovered

Elizabeth was brought up and lived all her life in Stockbridge, until after her husband's death. She was admitted to the HCA in her mid forties, suffering from delusions. Periodic bouts of serious depression resulting in physical deterioration led to several admissions to the asylum. After her husband's death, and with no children to support her, she appears to have wandered away from Hampshire. On her final admission in 1880 she had been transferred from a Kent asylum and was said also to have been living in Buckinghamshire.

Cox, Ann

Admission no	From	To	Outcome
986	31/7/58	23/9/58	Recovered
1413	17/8/61	14/12/61	Recovered
3105	3/10/71	31/1/72	Recovered
3333	29/5/73	3/9/73	Recovered
4037	22/8/77	24/10/77	Recovered

Ann Cox was admitted to the HCA for five very short periods between 1858 and 1877. Though her attacks were of short duration, she became violent and dangerous to herself and others. She was born around 1825 and worked as a domestic servant and had at least one child before her marriage to Thomas Cox. By the time of her first admission she had had four children, and she had suffered a similar attack before the asylum opened, from which she appears to have recovered at home. After her discharge in 1877 she was not re-admitted and in 1881 was living in Andover with her husband and daughter.

Crouch, Charles*

Admission no	From	To	Outcome
4125	7/3/78	17/7/99	Died

Charles was mentally handicapped and lived with his family until his mother's death when he was fifteen. He was taken to the workhouse to be cared for but they could not control him and soon afterwards he was admitted to the HCA.

Crump, Ellen

Admission no	From	To	Outcome
5449	17/11/84	5/9/90	Died

Ellen Crump was a 35-year-old spinster who painted and taught music at her parents' house. Her health had not been good for some years and she had always had some strange habits such as kissing the bedposts every night, but the violence and attempts at self harm which led to her admission had only started about nine months previously. While in the HCA her behaviour deteriorated rather than improved and she died of phthisis a few years later.

Cutler, George

Admission no	From	To	Outcome
445	3/4/55	1/7/56	Recovered
1046	22/1/59	6/3/86	Died

George Cutler had apparently been an imbecile from birth. In 1855 he was 39 and in good health. A year after his admission he was discharged for a month's trial in the workhouse but he left and wandered off to the New Forest from where he was returned to Knowle. The following year he escaped and because he was considered not to be dangerous he was allowed to remain at liberty, continuing to live in the Fareham area for a couple of years. He was readmitted in 1859 and subsequent escape attempts were foiled so George remained a resident for the rest of his life.

Dacre, George

Admission no	From	To	Outcome
6739	20/10/91	30/3/92	Not improved

George Dacre was a 40-year old schoolmaster from Winchester whose epilepsy had resulted in advancing dementia. He was discharged because he was considered close to death and his sister wished him to die at home.

Dall, John

Admission no	From	To	Outcome
4694	17/12/80	13/10/89	Died

John Dall married his wife, Fanny, when he was in the army, and their children were born at various army stations around the world. When he was pensioned they returned to Fanny's home town of Freshwater on the Isle of Wight. However John's attack of mania in 1880 resulted in his admission to the HCA where he died nine years later.

Douse, Eunice

Admission no	From	To	Outcome
595	29/6/56	27/11/56	Recovered
886	21/11/57	8/5/58	Relieved
1008	25/9/58	3/11/58	Not improved
1498	29/3/62	14/6/62	Recovered
1677	7/3/63	16/9/63	Recovered
1773	1/10/63	29/4/64	Died

Eunice Douse was 38 years old and working as a charwoman when she was first admitted to the HCA. She was married but had separated from her husband 15 years previously. Between her first admission and her death in 1864 she lived at various addresses including the workhouse but usually stayed near one of her sisters or brothers. Her periods in the asylum were usually brief and associated with either mania or depression but she also had undiagnosed cancer of the uterus from which she eventually died very suddenly, aged 46.

Duncan, Jane

Admission no	From	To	Outcome
482	31/8/55	14/2/56	Recovered

Jane Duncan was a 32-year-old bonnet maker from Basingstoke, admitted suffering from Mania. She was in reasonable health and was a patient for only a few months before she was considered to have recovered sufficiently to return to her family. She was never re-admitted.

Flanders, James

Admission no	From	To	Outcome
3775	4/3/76	22/3/76	Died

James Flanders had marked symptoms of General Paralysis. He had been 'strange' for over a year but was only admitted to the HCA in time to die.

Frost, James

Admission no	From	To	Outcome
882	4/11/57	18/11/57	Died

James Frost was a 71-year-old shoemaker from Shedfield who was living with his wife, Elizabeth. He had recently had several fits and had started to wander from home. His memory had also gone. He was in poor health and died within days of admission, a classic example of a case that Dr Manley thought should have been cared for in the workhouse.

Fullick, James*

Admission no	From	To	Outcome
4711	13/1/81	24/9/90	Recovered

James Fullick was very depressed when he was admitted after attempting to hang himself. His cousin **Richard Fullick** was a patient at the same time. He remained 'quiet and dull' for years but when, in 1890 he showed signs of brightening up, he was discharged.

Fullick, Richard*

Admission no	From	To	Outcome
4481	17/10/79	10/6/80	Relieved
4830	15/8/81	23/9/1909	Died

Richard Fullick was born in 1827, the fourth of seven children and destined to have a difficult life. When he was a child his father was transported to Australia and by 1841 Richard and his brother were living in the workhouse. An uncle and a cousin were also transported and Richard's niece was murdered while at her employer's house. In spite of being part of a notorious family Richard was known as a steady man and not a drinker. He was over thirty when he eventually married and he and his wife had seven children. He heard voices in his head for some time and it was not until they started telling him first to hang himself and then to beat his wife that he found himself at Knowle. He returned to his family in 1880 and though he continued to act strangely he held down a job for most of the following year but the hallucinations returned and he also suffered physical symptoms. Twenty-five years later he died at Knowle aged over 80.

Glasspool, Joseph

Admission no	From	To	Outcome
456	13/5/55	18/8/55	Recovered
942	4/5/58	2/2/59	Recovered
2040	1/6/65	30/11/65	Recovered
2486	24/1/68	27/10/68	Recovered
3058	14/7/71	30/11/71	Recovered
4527	22/12/79	29/7/80	Recovered

Joseph Glasspool had been suffering attacks of mania since he first drank a large quantity of whisky at the age of fourteen. In 1855 he was 27 years old and recently married but had recently become threatening towards his wife. His bouts of depression or mania occurred at intervals for the next quarter of a century but he was never resident for more than a few months and lived for over twenty years after his final discharge, remarrying in middle age.

Green, Elizabeth

Admission no	From	To	Outcome
6133	20/8/88	4/1/89	Recovered
6548	15/12/90	3/9/92	Recovered
6970	23/11/92	1/9/93	Recovered
7352	19/7/94	2/12/95	Recovered
8192	4/1/98	1925	Died

Elizabeth Moss was the daughter of a domestic coachman and a lady's maid. Her father died of GPI in the HCA in 1878, when she was 12 and by 1881 both she and her mother were in service in different households. Elizabeth married William Green, a labourer while she was still a teenager and by the time she was admitted to the HCA at the age of 22 she had given birth to at least three children. Some of her admissions were linked to pregnancy or parturition and on admission she was usually in a poor physical condition. Her mental and physical recovery seemed to be linked on the early occasions but after 1898 she remained a patient until well into the nineteen twenties.

Groom, Julia

Admission no	From	To	Outcome
4897	29/12/81	18/6/91	Died

Julia Groom's husband was frequently away from home because he was purser on a steamer to the West Indies. In 1881 he was away and Julia, heavily pregnant, was living in Southampton with her two children and a servant girl. However, she appeared to take no interest in her family and, though she did not spend the money Frederick had left on food or necessities for the children, she could not say where it had gone. She felt she had failed at everything and when in London with her husband and new baby she tried to jump into the Thames. There appears to have been some dispute between her husband and other members of her family about whether the HCA was the best place for her but her husband's view prevailed and she remained a patient until her death ten years later.

Hall, George

Admission no	From	To	Outcome
6013	27/12/87	3/3/88	Recovered
6079	4/5/88	29/8/88	Recovered
6146	19/9/88	28/6/89	Recovered
6402	31/3/90	23/7/90	Recovered
6588	18/2/91	28/2/94	Recovered
7295	20/4/94	31/8/98	Recovered
8510	22/3/99	28/3/1902	Recovered

George Hall's story is told in detail in chapter five.

Harvey, Emily

(alias Kate Macdonald)

Admission no	From	To	Outcome
3669	2/7/75	7/8/75	Not insane

Emily Harvey was a prostitute. Originally from the Isle of Wight she was working the docks in Portsmouth before she entered the workhouse in February 1875. Her behaviour there was so wild that she was removed to Fisherton House asylum in June form where an application was made for her removal to the HCA. By the time she arrived at Knowle she showed no signs of her original behaviour and Dr Manley took immediate steps to discharge her.

Hayter, Edward

Admission no	From	To	Outcome
5131	18/4/83	23/7/83	Recovered
5792	29/9/86	19/11/86	Recovered
6024	13/1/88	3/3/88	Recovered
6090	1/6/88	5/6/93	Recovered
7878	9/10/96	1/5/1914	Died

When Edward Hayter became confused and violent his wife, Eliza, was afraid to stay in the house. On several occasions two or three neighbours had to restrain him. Though he was only an inmate of the HCA for three short periods in the 1880s his notes indicate that he always acted strangely and he was in poor health and very depressed. His son, daughter and one of his sisters were also inmates of the HCA at various times.

Hearnes, William

Admission no	From	To	Outcome
4865	24/10/81	26/6/82	Died

William Hearnes was only 20 years old and worked as an assistant schoolmaster. In April 1881 he was lodging in Hartley Wintney but by October he was lodging in Winchester and studying too hard for an exam. He was in good health on admission but died the following year.

Hervey, William

Admission no	From	To	Outcome
219	7/5/53	16/9/53	Relieved

A 59-year-old brewer from Winchester, William Hervey was in good health when admitted in a manic state. His wife applied for his release at the end of the summer and though he had not completely recovered it was allowed. He was not readmitted.

Heymer, William

Admission no	From	To	Outcome
4614	21/6/80	21/5/81	Recovered

William had been suffering from mania for a week when he was admitted. His wife and six of his children remained in the family home but at least two of the children were adult and probably became responsible for the family income.

Higgs, Albert

Admission no	From	To	Outcome
3692	17/8/75	9/7/77	Recovered
4133	25/3/78	7/7/96	Not improved

Albert Higgs, younger brother of **Ernest** was born in Shanklin, Isle of Wight in about 1860, the son of an auctioneer and land agent and one of several brothers. Always a slow boy he found satisfaction working on his relatives' farm until a fever resulted in symptoms of mania which put him in the asylum. Apart from a six-month period in the winter of 1877/78 he appears to have remained institutionalised for the rest of his life, transferring to the Isle of Wight asylum with his brother in 1896. Albert's father paid a large proportion of his weekly upkeep in 1877.

Higgs, Ernest

Admission no	From	To	Outcome
1809	23/1/64	27/7/64	Recovered
2299	15/12/66	3/5/67	Recovered
4003	23/6/77	31/12/77	Recovered
4332	23/1/79	23/12/79	Recovered
5550	25/5/85	30/3/87	Recovered
6155	8/10/88	30/3/91	Recovered
6738	19/10/91	7/7/96	Not improved

Ernest Higgs was born in Shanklin, Isle of Wight in about 1850, the son of an auctioneer and land agent. As a young boy he was a drummer in the army and appears to have been musical all his life, participating in musical events in the HCA. Despite being admitted to the HCA in his teens, he completed his apprenticeship with a jeweller and later worked as a watchmaker. He is known to have moved to London for a time and to have been engaged to be married though the marriage never took place. He had his own establishment but was increasingly unable to look after himself. His admissions were precipitated by periods of excitement and wild behaviour accompanied by delusions. After several admissions and recoveries he became a long-term patient and was transferred to the new Isle of Wight asylum with his brother, **Albert**, in 1896.

Holdaway, Jane

Admission no	From	To	Outcome
4727	5/3/81	1/10/81	Recovered
5543	12/5/85	20/8/85	Recovered

Jane Holdaway had to leave six children at home when she was admitted in March 1881. Her teenage daughters must have had to cope at home, as the census shows no adult apart from their father at the family home. Fortunately Jane's stay was short, as was her second stay in 1885.

Horne, Edward

Admission no	From	To	Outcome
3237	27/9/72	23/4/73	Recovered
3328	15/5/73	5/11/74	Recovered
3792	10/4/76	23/4/79	Recovered
4565	9/3/80	20/6/85	Recovered
6514	10/10/90	28/11/90	Recovered

Drink appeared to be Edward Horne's main problem. He lived with his mother at Eversley, did not marry until he was past forty and had been an asylum inmate on four occasions. On the first occasion he had made a gruesome attempt to cut his throat. Later he returned to the HCA of his own accord because he said he felt himself getting out of control. He declared his intention of becoming a teetotaller but failed and was found wandering in a confused state of mind. Though admitted on one occasion after his marriage he was discharged after a few weeks and never readmitted.

Hutchins, Henry

Admission no	From	To	Outcome
4709	28/1/81	26/11/81	Recovered

This was Henry Hutchins's only admission. While he spent most of 1881 in the HCA his wife tried to keep his business going. Her sister and her husband's brother lived with her and she had extended family contacts in the area.

Hutchinson, Ruth

Admission no	From	To	Outcome
4767	16/5/81	16/4/1902	Died

In the Census of 1881 Ruth was living with her husband, an army pensioner, and two sons in Surrey, and working as a domestic cook. Soon afterwards her husband died and Ruth must have gone back to Gosport, where her sons had been born. She was admitted to the HCA from the Alverstoke House of Industry in indifferent health and suffering from mania supposedly brought about by the death of her husband and heavy drinking.

Jones, Mary

Admission no	From	To	Outcome
4774	1/6/81	26/1/82	Recovered
5211	4/10/83	21/7/84	Relieved

Mary Jones, the wife of a railway signalman, left three young children at home when she was admitted in very poor health in the summer of 1881. Her husband applied for her discharge in November but was told to try again at the next committee meeting. She was actually discharged about two months later. Admitted again in 1883 she was in better health this time and appeared to harbour a grudge against her husband. Again she recovered within a few months, was discharged and was not re-admitted to this asylum.

Knight, Ada

Admission no	From	To	Outcome
5466	22/12/84	13/8/88	Died

Ada was the eighth or ninth child of a fish hawker, who had since died, and a mother who was given to drink and who had deserted her children. As a baby Ada had been thrown to the ground by her mother and her mental disability was attributed to that. At the age of eight and weighing under three stone she was unable to do anything for herself and had been placed in the workhouse. Her needs were so great that the workhouse staff could not cope with her and she was transferred to the HCA where she died of pneumonia four years later.

Knight, Leonard*

Admission no	From	To	Outcome
7358	26/7/94	8/5/1901	Died

Leonard Knight had fits almost from birth. He was the third child of a very large family and lived at home with them until the birth of the tenth child, by which time Leonard was 14. At first he was sent to the workhouse infirmary but his fits became so frequent that he was unable to walk unaided and was incontinent. During his time in the asylum his fits made him increasingly infirm and he eventually died of exhaustion after several days of almost continuous fits.

Lamourne, William

Admission no	From	To	Outcome
2856	29/4/70	28/9/70	Recovered
3616	8/3/75	27/4/75	Recovered
4653	14/9/80	1/1/95	Died

William Lamourne's two brief asylum experiences in the 1870s were related to his melancholia but in 1880 he had an attack of mania which never abated. His wife continued to care for her elderly mother and two adult children seem to have provided the family income.

Lawford, Emily

(see Brown)

Admission no	From	To	Outcome

Love, Tabitha

Admission no	From	To	Outcome
4872	12/11/81	22/11/83	Recovered
5700	12/4/86	25/9/96	Not improved

Tabitha Love had been living with her elderly widowed father and her young nephew when she became ill in October 1881. She was admitted to the HCA in November. After she was discharged as recovered two years later she returned to the same address and resumed her occupation as a lodging housekeeper. Three years later she again became excited and delusional and eventually returned to Knowle, where she lived for the next decade, being transferred to the Isle of Wight asylum when it opened in 1896.

Maber, John

Admission no	From	To	Outcome
3691	16/8/75	26/5/80	Recovered

John Maber had already left his wife and child in Dorset and returned to his family near Fareham before he was admitted. His wife enquired after his health but the family was split up and after his discharge he returned to live with his parents.

Marriott, Thomas

Admission no	From	To	Outcome
2450	26/10/67	26/5/68	Recovered
2762	7/10/69	18/4/70	Recovered
2984	9/2/71	2/9/71	Recovered
3106	3/10/71	2/9/72	Recovered
3245	14/10/72	8/6/74	Died

Thomas Marriott was a gunmaker and had a shop in Botley. In his sixties he started to suffer from fits and delusions and although five admissions are recorded he was a patient at the HCA almost continuously from 1867 until his death in 1874. On each of the first four occasions his wife removed him against the advice of the medical superintendent, only to return him within weeks. The son of his first marriage, also called Thomas Marriott was a patient at the same time as his father in 1872 and died there in 1873.

Matthews, Emily

Admission no	From	To	Outcome
4746	5/4/81	22/2/91	Died

A 32-year-old spinster living with her father on the Isle of Wight, Emily had been in indifferent health for several years. A female friend was staying with them on census night 1881, perhaps as a nurse or companion for Emily.

McCutcheon, Susan

Admission no	From	To	Outcome
3391	1/10/73	9/6/81	Died

Since the death of Susan McCutcheon's baby she had been increasingly deluded and inclined to wander about the army camp where she lived. She was not considered fit to look after her children as she had pawned their clothes and rejected her husband. She died in the asylum eight years later and her children were brought up by their father in London, under a different name.

Messum, Elizabeth

Admission no	From	To	Outcome
485	10/9/55	31/1/56	Recovered
902	21/1/58	22/6/58	Recovered
1146	2/12/59	29/5/60	Recovered
1674	27/2/63	15/9/63	Recovered
1948	10/11/64	5/6/65	Recovered
2310	18/1/67	17/6/67	Recovered
2618	27/11/68	27/4/69	Recovered

Elizabeth was in her late fifties, a soldier's widow, when she was first admitted to the HCA but she had been in other institutions at least twice in the preceding decade. At intervals she became excited and delusional but usually recovered fairly quickly. She was never a patient at Knowle for longer than seven months. Her daughter Louisa looked after her when she went home but it must have been difficult as her children lived in fear of their grandmother. She died in 1873, aged 74.

Mitchell, Susan

Admission no	From	To	Outcome
5991	5/11/87	29/3/88	Recovered
6076	1/5/88	28/11/88	Recovered
6374	13/2/90	13/2/91	Not improved
6582	13/2/91	30/9/91	Recovered
6939	8/10/92	1/2/1902	Died

Susan Mitchell's history was not promising. Her mother was known to have been an asylum patient and her father had committed suicide. She was suffering from delusions involving both money and God and was inclined to wander around the countryside at night in her nightdress. She was emaciated and had scars on her arms from broken glass. In the asylum she gained weight and recovered her spirits and was discharged but within three weeks her husband had to employ someone to look after her because she was threatening suicide. When she was discovered to have swallowed a cup of paraffin oil she was readmitted. On subsequent occasions she would calm down in the asylum but become very excited again soon after her discharge. Meanwhile, her husband William brought up their two children, a daughter who went into domestic service and a son who was still a schoolboy when his mother died of tuberculosis in 1902.

Monk, Sarah*

Admission no	From	To	Outcome
881	2/11/57	28/7/62	Recovered
3414	10/11/73	14/5/74	Died

Sarah Monk became very agitated and started to believe that her husband wished to dispose of her so she took a knife to bed at night, though he was said to be an old man and 'very fond of her'. In 1854 her only surviving son had left for the USA to join the Mormons in Utah but her two daughters remained in the area and when she was discharged after five years she became their responsibility because William had died. She continued to live in her own house but had parish relief and her daughters paid her rent. She was readmitted when senile dementia meant she could no longer look after herself.

Moon, Eliza

Admission no	From	To	Outcome
1523	10/5/62	21/7/62	Recovered
3121	2/11/71	26/2/72	Recovered
3376	23/8/73	2/12/73	Recovered
3720	17/10/75	31/1/76	Recovered
4479	14/10/79	5/1/80	Recovered
4690	12/12/80	1/1/82	Relieved
5182	8/8/83	21/4/84	Recovered

Various explanations were advanced for Eliza Moon's occasional bouts of crazy behaviour. They lasted only for a few weeks and were sometimes associated with family troubles and her tendency to drink. But she sometimes had fits and in 1879 appears to have had some sort of seizure. She had had seven children but three had died in infancy. Her husband, a college servant, worked away from home during the week but two unmarried daughters lived at home with her and her son and his family were neighbours. Another daughter was married and the excitement of preparing for her wedding was given as the cause of her troubles in 1880.

Morgan, Mary Ann

Admission no	From	To	Outcome
2270	10/10/66	12/11/66	Recovered
3063	20/7/71	4/1/72	Recovered
3355	9/7/73	1/11/73	Recovered
3665	21/6/75	5/2/76	Recovered
4574	5/4/80	22/9/96	Not improved

Mary Ann Morgan left her father's farm on the Isle of Wight to go into service as a lady's maid. Her first mental problems occurred in London and she was sent first to Camberwell workhouse and later to Peckham House asylum. She was transferred to the HCA in 1866. She later worked in Southsea but when her next attack came in 1871 she had to be put in a straitjacket. After that she was probably unemployable and returned to the Isle of Wight in 1872. By 1873 her father and brother were unable to cope with her behaviour as household objects flew past their heads and she was readmitted briefly on two further occasions. In 1880 she stormed about her brother's house with a knife threatening suicide and after this she remained institutionalised, transferring to the new Isle of Wight asylum in 1896.

Mott, George

Admission no	From	To	Outcome
3302	12/3/73	1/11/76	Died

George had suffered from severe epileptic fits for years for which he had been treated at home. He was 38 years old and single and living with his parents and sister but his fits had made him violent and they could no longer cope. His first act on admission was to try to strangle two other patients in the ward and though he became quieter he remained confused and increasingly feeble.

Mylward, Michael*

Admission no	From	To	Outcome
6462	24/6/90	14/2/91	Died

Michael had been physically and mentally handicapped from birth, using crutches to get about, unable to look after himself and very slow to respond to questions. By 1890 his parents were elderly and Michael was proving difficult to look after, hitting out at his mother with his crutches and requiring constant attention. He appeared increasingly phthisical during the months following his admission and died of a combination of pulmonary disease and hydrocephalus in 1891. Both his parents also died in that year.

Neal, Hannah

Admission no	From	To	Outcome
500	1/11/55	6/12/62	Recovered

Hannah was 55 when she was admitted suffering from delusions and epilepsy. She was also suicidal. After a year or so her husband started to make strenuous efforts to secure her release but she was considered unfit because she was still suicidal. William Neal attended meetings at the asylum regularly, collecting signatures from doctors and the local clergyman to say that Hannah was fit for release but was always turned down until 1862, when she was discharged as recovered.

Neal, Sarah

Admission no	From	To	Outcome
290	30/12/53	26/9/54	Relieved
551	9/4/56	27/4/65	Died

Sarah Neal was an inmate of the Winchester workhouse when she was first admitted muttering incoherently. She was a drinker and considered dangerous to her children because she neglected them. Throughout September 1854 her husband made strenuous attempts to have her discharged and after her release the family appears to have moved to London. Sarah was next admitted from the Lambeth workhouse in 1856, by which time she was deluded, "violent and unmanageable. She was forty-five when she died.

Nicholas, Edward Josiah

Admission no	From	To	Outcome
1508	14/4/62	26/9/63	Relieved
2240	21/7/66	11/11/1908	Died

Edward Josiah Nicholas was 20 and working as a dockyard messenger, when he was admitted suffering from mania. After about a year his parents applied for his discharge. Dr Manley was against this but the parents were determined and after a month the committee agreed to discharge him. Three years later he was re-admitted, this time in poor health and he became one of the HCA's long stay patients, remaining until his death forty-two years later. Meanwhile his father, Josiah Nicholas, also died in the HCA. He was admitted in 1873 aged 57, suffering from mania and died there in 1882.

Orchard, Albert

Admission no	From	To	Outcome
4300	14/10/78	18/2/80	Recovered
6295	6/8/89	30/8/89	Died

Albert was depressed and unable to work when he was admitted in 1878. When he was readmitted in 1889 he was still depressed but with marked symptoms of premature senility. His brother **Henry Orchard** was admitted the following year.

Orchard, Henry

Admission no	From	To	Outcome
6520	27/10/90	30/3/92	Recovered

A gardener from St Helen's on the Isle of Wight, Henry Orchard was admitted after a dramatic attempt to kill his wife and then take his own life. His brother **Albert Orchard** had died in the HCA the previous year and he had become increasingly depressed after the death of his father in law, with whom he worked. This, combined with his wife's refusal to let him touch her because she didn't want any more children, was blamed for the severe beating he gave her before he tried to hang himself from a nearby tree. She did not die and Henry gradually recovered, no longer complaining of headaches, happily singing in the choir and able to work a little. The committee was dubious about discharging him in 1892 but he was released for a month's trial and was not re-admitted.

Painter, Jervis*

Admission no	From	To	Outcome
98	29/1/53	8/12/55	Died

Jervis Painter was born in about 1795, probably in the Emsworth area, where he lived out most of his life. As a boy he went to sea before marrying in 1815 and fathering 19 children of whom 11 are known to have survived. By the 1850s he was unwell, suffering from rheumatism and increasingly from depression. After he tried to hang himself he remained at home but was eventually sent to the lunatic ward of the Carisbroke workhouse and later to Camberwell asylum. Shortly after the HCA was opened he was transferred there and died of phthisis about three years later. He was brought home to be buried in the parish churchyard at Warblington, where his children had been baptised.

Painter, Louisa*

Admission no	From	To	Outcome
4374	16/4/79	22/7/80	Died

Louisa was the daughter of **Jervis Painter** and was born in 1821 with a hare lip and double cleft palate. She did not marry and by 1851 was the only child left at home. She lived with her mother until the latter's death after which she lived alone working as a laundress. A broken arm in 1878 seriously interfered with her ability to work and she became increasingly depressed. She was in poor health on admission to the HCA showing signs of phthisis. She continued to be unhappy and her health deteriorated. In mid July 1880 her relatives were summoned and Louisa died a couple of days later.

Pattenden, William

Admission no	From	To	Outcome
683	17/12/56	15/12/60	Relieved
1464	19/12/61	15/2/70	Relieved
2851	22/4/70	4/2/77	Relieved
5935	18/6/87	11/8/94	Died

William was a seaman from Emsworth, admitted on four occasions because of his attacks of mania. He soon recovered but was not discharged because no satisfactory living arrangements were forthcoming. He took matters into his own hands and escaped in 1860. On this occasion he was not recaptured but when he tried it on subsequent occasions he was brought back. His mania became chronic and he suffered from delusions about money.

Pearson, William

Admission no	From	To	Outcome
3539	17/9/74	12/3/75	Not improved

William's family did not want much to do with him. He was admitted from the Isle of Wight workhouse suffering from general paralysis and delusions of wealth but his relatives were scattered all over the country and considered themselves out of pocket because of him. Eventually he was transferred to the City of London asylum.

Phillips, Sarah

Admission no	From	To	Outcome
5267	5/2/84	13/2/1900	Died

Sarah was the wife of an army quartermaster, stationed at Aldershot. In 1883 she was about to set out to join her husband in Egypt but was put off the ship at Gravesend and sent to the Camberwell asylum. Her husband removed her before she was considered to have recovered and she did not improve over the following months. She talked continuously and incoherently and suffered from visual and aural hallucinations, which made her feel that the world was going to fall on her. She already had four children and gave birth to another shortly after her admission to the HCA. Her family removed her returning her to the asylum at the end of the month on trial each time. She returned pregnant from one of these visits, gave birth to another son and he was removed by her husband shortly afterwards.

Port, James

Admission no	From	To	Outcome
3250	26/10/72	18/1/73	Died

James Port was admitted in a very poor state from the Alton workhouse. He was 40 years old and suffering from advanced GPI. Though feeble he became violent from time to time and his workhouse companions had responded by beating him. The commissioners in lunacy took an active interest in his case.

Port, Jane

Admission no	From	To	Outcome
3894	23/11/76	10/3/77	Died

Jane Port was a single woman aged 74 who had lived in an almshouse for the previous twelve years earning part of her living as a sempstress. For some years she had appeared eccentric but in the few months before her admission she had seemed unable to care for herself. Food rotted in her house and she wandered the countryside, followed by a crowd of children. In the workhouse and then in the HCA she was noisy and quarrelsome with no memory of her past.

Priest, Olive*

Admission no	From	To	Outcome
2744	2/9/69	28/7/73	Relieved
4280	30/9/78	1/3/79	Died

Olive Priest was born in 1813, married at 16 and a widow in her early forties. She seems to have lived in Winchester until about 1850 when she moved to London with her husband, who died in the workhouse in 1856. In 1861 Olive was found wandering by police and taken to the workhouse. She had recently been living with a man and had suffered bouts of insanity over the last decade. In June 1861 she was admitted to Hanwell asylum, after a suicide attempt. She was discharged from there in 1862 and readmitted in 1863. From Hanwell she returned to the workhouse and from there appears to have been sent back to Winchester as her place of settlement. Admitted to the HCA in 1869, she was transferred to Fisherton House and later returned to the HCA, where she died. No one seemed to want Olive. By the 1860s she seems to have had no relatives remaining in London and her sons were in London but neither knew much about her or felt inclined to help her.

Raddon, Mary

Admission no	From	To	Outcome
4531	28/12/79	25/10/80	Recovered

Mary was a 73-year-old widow admitted suffering from melancholia. After a year at Knowle she recovered sufficiently to go and live as Eliza Williams's lodger, in Romsey, and was not readmitted.

Reid, John Dixon

Admission no	From	To	Outcome
7467	25/1/95	27/3/95	Recovered
7530	2/5/95	14/3/1905	Died

John Reid had an upholstering business in Alton. By the time he reached his late sixties he was suffering from delusions of persecution which he would shout out in the street, much to the embarrassment of his daughter's family. He calmed down quickly on his first admission to the HCA but reverted to his old accusation and threats shortly after his discharge and was readmitted. The fact that he was not subsequently discharged had much to do with the fact that his son and son in law were in no hurry for him to return to Alton and yet failed to provide an alternative home for him. He petitioned anyone who might be interested but with no success and died in the asylum ten years later.

Rickman, Ann

Admission no	From	To	Outcome
6621	4/4/91	29/3/97	Died

Ann Rickman had suffered from epilepsy since shortly after her third child was born and at around that time two of her sisters in law were living with the family, perhaps to provide support. She had been treated as an outpatient in London in 1887. By 1891 she was showing signs of epileptic mania and memory loss and was not considered safe to be with her children. By the time she was admitted to the HCA she was very feeble and slow. Over the next five years she had numerous fits followed by violent behaviour and died after one of these episodes. Meanwhile her husband had moved away and failed to keep up her maintenance payments. He was tracked down to a London tugboat and pursued through the courts for the arrears.

Riddick, Mary Ann

Admission no	From	To	Outcome
4749	12/4/81	22/7/81	Recovered

Mary Ann was a baker's widow aged 50 who lived at Brading on the Isle of Wight with her mother and daughter. She had apparently had attacks of depression all her life but had never previously been certified. She had been increasingly melancholic for about five months. This was her only admission to Knowle and after three months she recovered.

Rothery, Jane

Admission no	From	To	Outcome
4594	17/5/80	23/8/1900	Died

Jane was the wife of a merchant seaman. She suffered from depression after the births of all three of her children but only on the last occasion was she admitted to the HCA. In the census of 1881 her older children were living with their grandparents and her baby son from whom she had been parted after only a few weeks, was living with other relatives. There was no sign of her husband Thomas who was probably at sea.

Scorey, George

Admission no	From	To	Outcome
1427	26/9/61	19/7/62	Recovered
1857	20/5/64	12/6/65	Recovered
2434	29/7/67	12/3/68	Recovered
2955	24/12/70	5/6/71	Recovered
3595	27/1/75	26/7/75	Recovered
3802	6/5/76	23/12/79	Recovered
4562	2/3/80	1/4/1916	Died

George Scorey was a baker by profession and a drinker by inclination. His regular drinking bouts were associated with memory loss, aggression, suicidal tendencies and generally anti-social behaviour which must have been embarrassing to the rest of his family who were tradesmen in and around Minstead, in the New Forest. On at least two occasions he escaped from the asylum, but it was never long before he was recaptured or readmitted and he spent the greater part of his adult life in the HCA.

Shawyer, Mary

Admission no	From	To	Outcome
4637	12/8/80	24/1/81	Relieved

Epilepsy and dementia was Mary's diagnosis. Once she seemed settled and had not had a fit for a while she went to live with her son and daughter in law in Soberton.

Smith, Amelia

Admission no	From	To	Outcome
4510	25/11/79	21/6/81	Recovered

Amelia Smith, the 36 year old wife of a printer and stationer from West Cowes, Isle of Wight, had been getting more and more depressed for about 18 months but had been much worse for the last three, so that her general health was affected. While she was in the HCA her husband kept his home and business going. On Amelia's discharge in 1881 her husband, son and four daughters were still living in their High Street home.

Smith, Elizabeth

Admission no	From	To	Outcome
4572	31/3/80	18/9/80	Recovered

Elizabeth had been ill for five weeks before she was admitted. Six months later she was able to return to her family.

Smith, Thomas

Admission no	From	To	Outcome
1176	7/2/60	29/10/60	Relieved
1304	15/12/60	19/2/61	Died

Thomas Smith was suffering from mania associated with epilepsy and on his first admission was suffering from various physical ruptures and cuts associated with his latest attack. His wife applied for his discharge after a few months but it was refused because it was considered likely that they would have to be supported by poor relief. Thomas's brother offered to guarantee to prevent this happening and Thomas was eventually discharged. However, only a few weeks later he was readmitted from the Southampton workhouse and died a couple of months later aged only 39.

Sparham, Caroline

Admission no	From	To	Outcome
3778	13/3/76	27/11/1917	Died

Caroline Sparham's family life was falling apart before she got as far as the HCA. She was depressed and missed her family in Norfolk. Her husband did not get on with her family and refused to move to live near them. Her recurring depression came on again after the birth of her third child and she wandered about listlessly unable to eat or sleep. She also had a goitre and sensory hallucinations in which she saw glorious colours. One of Caroline's daughters remained with her grandparents in Norfolk, one stayed with her father in Hampshire. Both were subsequently treated for thyroid troubles and in London asylums. Neither knew until they reached middle age that their mother remained in the HCA for over forty years before her death.

Stephens, Dorothy*

Admission no	From	To	Outcome
5494	12/2/85	19/8/1909	Not improved

Dorothy Stephens was 26 when she joined her mother Ellen in the HCA. Ellen had been a patient for over twenty years and the two remained there for another twenty before being transferred together to the Portsmouth asylum at Milton in 1909.

Dorothy's father, Thomas claimed that she was violent towards him and she claimed that he had assaulted her, the implication being that this was a sexual assault. Dorothy was a difficult patient, working only a little, frequently excited and violent and often subject to delusions.

Stockwell, Alfred

Admission no	From	To	Outcome
4064	29/10/77	30/9/78	Recovered

Alfred was admitted only 48 hours after his wife, Lissette, who had been increasingly upset about their imagined financial and business problems. He tried to cut his throat and when that was unsuccessful he escaped from supervision and jumped down the well. However, he got stuck, was removed and certified. A year later he and his wife were discharged within a couple of days of each other. Two of their children also became temporary asylum patients, their son, Arthur, for 5 months in 1881 and their daughter Emily, who was admitted in 1892 and died of heart disease in 1897.

Tilbury, Henry*

Admission no	From	To	Outcome
3880	30/10/76	9/1/83	Died

Henry Tilbury's family had lived in the village of Chilbolton for generations and Henry followed in his father's footsteps by becoming a grocer and baker in the village. In 1872 he was admitted to Fisherton House asylum as a private patient because he had suffered from frequent bouts of excitability and depression. His wife tried to carry on with his ailing business but eventually became bankrupt. Henry became a pauper patient and was transferred to the HCA in 1876. He showed no signs of recovery and became increasingly demented as the years passed, finally dying of dysentery at the age of 70.

Tocock, Margaret

Admission no	From	To	Outcome
5554	29/5/85	25/10/86	Not improved

Margaret Tocock had lived with her widowed mother, Harriet all her life, as they moved about the country. When Margaret reached her mid-twenties Harriet could no longer cope and Margaret was received into the Farnham workhouse. She remained there for a couple of months but they could not cope with her behaviour, which was very troublesome, especially at night. In the HCA they controlled her behaviour with sedatives. Harriet was very distressed by Margaret's removal to the HCA but was unable to remove her. Eventually she was transferred to the Berkshire asylum at Moulsford.

Townsend, Helen

Admission no	From	To	Outcome
3325	3/5/73	13/12/73	Recovered
4248	19/9/78	23/12/78	Recovered
4633	10/8/80	24/12/80	Recovered
5050	3/11/82	24/11/83	Recovered
6297	19/8/89	28/5/90	Recovered

7271	12/3/94	26/12/94	Relieved
7840	27/8/96	30/12/96	Recovered
8100	20/9/97	24/12/98	Relieved

Helen was unusual among the patients studied in that she was the daughter of a fairly prosperous farmer from Swanmore. After her father's death she and her mother and sister lived in the nearby village of Upham, where her sister took in lodgers. Helen never married and though she was admitted on 11 occasions she was never a patient for long. She appears to have been well educated but she had bouts of insanity during which she became antagonistic towards her family. As they were responsible for her care, it was on these occasions that she was admitted to the HCA. Though she had several siblings, her sister Mary seems to have had the job of caring for her mother and sister. Helen was admitted to the HCA on three further occasions after 1900 and died there in 1912.

Troke, Annie

Admission no	From	To	Outcome
5823	4/12/86	3/5/1923	Died

Annie Troke was only three years old when she was admitted from the New Alresford workhouse. She apparently came from a family where the parents were simple and her brothers considered imbecile. Annie herself had seemed to be all right until about three months previously when she suffered paralysis. Afterwards she was incontinent and tended to run about screaming, though she was also uncoordinated and liable to fall. For a short while she was sent to live with Mrs Anscombe, wife of the head attendant. When she took on the job of housekeeper Annie returned to the wards where she died aged 40.

Tyrell, Martha

Admission no	From	To	Outcome
4783	18/6/81	1/3/84	Died

Martha Tyrell was an 83-year-old widow who had been living with a local woman as a lodger. She was in good health for her age but was suffering from senile dementia.

Upton, Martha

Admission no	From	To	Outcome
4226	31/7/78	22/7/80	Recovered

Martha was a 19-year-old servant girl in good health, who was admitted in a state of mania. Two years later she was thought to have recovered sufficiently to return to live with her mother in Up Nately. However, she was unable to obtain employment and both were being supported by poor relief in the spring of 1881.

Vollow, Rhoda

Admission no	From	To	Outcome
2276	1/11/66	2/5/67	Recovered
3201	30/6/72	30/12/72	Recovered
3545	1/10/74	18/3/75	Recovered
4057	15/10/77	15/4/78	Recovered
4439	10/8/79	20/9/80	Recovered
5040	10/10/82	19/10/85	Recovered
6031	24/1/88	23/6/88	Died

Rhoda Vollow was Henry Vollow's second wife, marrying him several years after the death of his first wife and two children. After twenty years of marriage Rhoda first showed signs of mental problems in the form of religious delusions and an embarrassing tendency to run naked into the garden. Discharged as recovered on six occasions she was readmitted at intervals of about two years, suffering from the same delusions and dislike of her family each time. She also had a goitre that troubled her. Between attacks she was said to be a 'steady' woman. In 1888 she was 70 and Henry, aged 78, was an invalid. Both were living with their married daughter, Martha. Rhoda's antipathy to her son in law caused many of the problems that resulted in her final asylum admission. Her sister Martha Chalfont was also admitted to the HCA in 1876 and died there in 1877.

Warner, Harriet

Admission no	From	To	Outcome
261	20/8/53	3/9/60	Recovered
3737	27/11/75	23/10/80	Recovered

Harriet was in her late forties when she was first admitted but looked much older because of her ill health. Over twenty years later she was readmitted, again in poor health and again she recovered over a period of years. By the time she was discharged recovered, her husband had died and she lived with her son and his family in Alton.

Watch, Emily

Admission no	From	To	Outcome
4628	22/7/80	20/4/82	Recovered

Emily Watch fell shortly after her daughter was born and began to suffer from fits. She was admitted with a diagnosis of puerperal mania and during her eighteen-month stay her daughter lived with grandparents, while her husband continued to live at their home.

Watton, Benjamin*

Admission no	From	To	Outcome
7567	20/6/95	27/11/95	Died

Benjamin Watton was born in Holdenhurst in 1822, the fourth of thirteen children born to Richard and Maria Watton. He did very well in life, starting as a labourer, becoming a brickmaker and later proprietor of a small brickyard and a small farmer. He married for the first time in 1842 and his wife, Charlotte, died almost twenty years later, giving birth to her eighth child. Six months later he married Sarah Duffet, twenty years his junior. Together they had four more children. These two families appear to have caused Benjamin some trouble over the years. His oldest children were probably the same age as his second wife and there appear to have been disputes about property after his death. He was admitted, as a private patient, suffering from senile dementia, having been cared for at home until his wife's ill health and his increasing violence and tendency to wander from home with no clothes on, made it impossible to continue. His wife, who was hemiplegic by 1895, was looked after her daughter at home until she died in 1904. His brother, George Watton, was also admitted a few years later, suffering from senile dementia and his niece **Elizabeth Watton** spent a brief period there in the late 1890s.

Watton, Elizabeth*

Admission no	From	To	Outcome
7888	30/10/96	29/1/97	Recovered

Elizabeth was a single woman in her forties who worked in a collar factory. She lived at home with her father, George Watton, who was to die in the HCA five years later. She was the niece of **Benjamin Watton**. When admitted she was very depressed but had also behaved in a very excited way, threatening those around her with a knife.

Welch, Ann

Admission no	From	To	Outcome
250	10/7/53	16/2/56	Relieved

Ann Welch was a 30-year-old labourer's wife, from Fordingbridge. She was admitted in a feeble state of health suffering from 'hysterical mania', having been ill for about a month. She was not really considered to have recovered when she was discharged at her husband's request, in 1856, but she had a family to look after and was needed at home.

Wells, Ellen

(see Adams)

Admission no	From	To	Outcome

Whebell, Eliza

Admission no	From	To	Outcome
4918	17/2/82	6/10/82	Died

Eliza Whebell was 28 years old and in an advanced state of phthisis when she was admitted. She had been in a sanatorium and various nursing establishments but had become too troublesome for them to handle. Her family wrote to enquire after her health but did not visit.

Wilcox, Isaac

Admission no	From	To	Outcome
4579	21/4/80	22/7/80	Died

Isaac Wilcox, who had formerly been in business as a grocer and baker had lost his memory altogether, did not know his own name and was violent towards his wife and towards the public when he managed to escape into the street. His son testified that he had been deteriorating since his business had started to fail three years before and he was now incontinent and incoherent. His family summoned on July 18th and he died a few days later. His wife, Ann, moved in with their daughter's family.

Wild, William

Admission no	From	To	Outcome
268	12/10/53	18/11/53	Relieved

William Wild was a 25-year-old shoemaker who was admitted because he was suicidal. His father removed him almost immediately in spite of advice to the contrary.

Wilkinson, Hannah

Admission no	From	To	Outcome
87	25/1/53	29/10/53	Recovered

Hannah was suffering from melancholia when she was admitted in January and was also in frail health. However, she was considered sufficiently recovered to be discharged by August. Unfortunately her husband did not respond very quickly to the request to remove her and she spent another two months in the HCA.

Wiseman, Ellen

Admission no	From	To	Outcome
1107	9/7/59	22/9/59	Recovered
1198	10/4/60	5/7/60	Recovered
2081	31/8/65	25/11/65	Recovered
2859	3/5/70	2/8/70	Recovered
3361	22/7/73	28/10/73	Recovered
3575	2/12/74	29/4/75	Recovered

Ellen's story is told in detail in chapter seven.

Young, Andrew

Admission no	From	To	Outcome
3461	5/3/74	19/6/74	Recovered
3587	4/1/75	24/8/78	Recovered
5513	24/3/85	21/9/85	Recovered
7748	23/4/96	7/7/96	Not improved

Andrew Young was a violent man whose wife and children lived in fear and whose neighbours regularly became involved in his violent scenes. In spite of his wife's misgivings he returned to his family on discharge and several years passed between each admission. His daughter Alice was a patient from 1894 and he and she were both transferred to the Isle of Wight asylum when it opened in 1896.

Bibliography

Archival Sources

Documents consulted in the Hampshire County Lunatic Asylum Archive at the Hampshire Record Office.

The Accession number for the Asylum Archive is 48M94/ and all the following document numbers should be prefaced by this.

Patients' Records

Accession Numbers	Dates	Patients' admission numbers
Registers of Admission		
B1/1	13/12/1852-31/12/1856 (Private Patients 1854-71)	1-694
B1/2	1/1/1857-29/12/1860	695-1305
B1/3	3/ 1/1861-31/12/1865	1306-1963
B1/4	5/1/1865-31/10/1868	1964-2608
B1/5	1/11/1868-22/11/1872	2609-3256
B1/6	23/11/1872-8/2/1877	3257-3930
B1/7	12/2/1877-12/6/1880	3931-4612
B1/8	14/6/1880-12/9/1889	4613-5969
B1/9	13/9/1889-16/6/1894	5970-7328
B1/10	16/6/1894-9/8/1899	7329-8619
B1/11	10/8/1899-31/12/1899	8620-8704
Registers of Discharges and Deaths		
B7/1	January-October 1853	
B7/2	1/11/1853-31/12/1866	
B7/3	1/1/1867-31/12/1877	
B7/4	1/1/1878 -10/1888	
B7/5	10/1888 -7/1897	
Registers of Discharges and Transfers		
B8/1	1907-1910	
B8/2 – 6	1910-1930	
Registers of Deaths: Pauper Patients		
B11/1	1907-1912	
B11/2-4	1912-1930	
Burials Registers		
E2/1	1877-1893	
E2/2	1893-1909	
Alphabetical Register of Patients		
B23/1	1860-1921	

Case Books: Male and Female 1852 – 1876

B14/1	13/12/1852-16/2/1854	1-304
B14/2	4/?/1854-24/5/1856	305-576
B14/3	24/5/1856-27/3/1857	577-768
B14/4	27/3/1857-14/6/1858	769-960
B14/5	1/7/1858-23/1/1860	971-1170
B14/6	26/1/1860-11/6/1861	1171-1381
B14/7	12/6/1861-26/8/1862	1382-1596
B14/8	27/8/1862-27/12/1863	1597-1800
B14/9	28/12/1863-5/4/1865	1801-2001
B14/10	6/4/1865-11/5/1866	2002-2200
B14/11	11/5/1866-29/7/1867	2201-2406
B14/12	29/7/1867-9/11/1868	2407-2612
B14/13	9/11/1868-28/12/1869	2613-2800
B14/14	28/12/1869-26/2/1871	2801-2987
B14/15	27/2/1871-30/8/1871	2988-3089
B14/16	31/8/1871-30/5/1872	3090-3191
B14/17	1/6/1872-4/2/1873	3192-3292
B14/18	6/2/1873-1/10/1873	3293-3391
B14/19	5/10/1873-23/5/1874	3392-3493
B14/20	27/5/1874-27/1/1875	3494-3595
B14/21	27/1/1875-13/9/1875	3596-3700
B14/22	13/9/1875-5/5/1876	3701-3800
B14/23	B/5/1876-16/12/1876	3801-3902

Case Books: Male 1876-1901

B15/1	16/12/1876-8/2/1878	3903-4111
B15/2	13/2/1878-3/10/1879	4112-4470
B15/3	19/8/1879-27/5/1881	4471-4771
B15/4	27/5/1881-15/10/1882	4772-5044
B15/5	20/10/1882-27/5/1884	5045-5332
B15/6	12/6/1884-1/1/1886	5360-5653
B15/17	6/1/1886-11/4/1887	5656-5893
B15/7	13/4/1887-29/3/1889	5895-6228
B15/8	3/4/1889-21/10/1890	6230-6519
B15/9	27/10/1890-12/4/1892	6520-6839
B15/10	12/4/1892-19/10/1894	6840-7409
B15/11	7/11/1894-28/12/1896	7414-7923
B15/12	1/1/1897-28/11/1898	7925-8432
B15/13	4/12/1898 -31/12/1899	8435-8704

Case Books: Female. 1876 – 1899

B16/1	17/12/1876-21/1/1878	3904-4105
B16/2	11/10/1878-24/4/1880	4297-4581
B16/3	26/4/1880-21/11/1881	4582-4877
B16/4	24/11/1883-3/11/1883	4879-5202
B16/5	27/9/1883-3/11/1884	5207-5436
B16/6	14/11/1884-26/1/1886	5437-5670
B16/7	1885-1889	Private 39-86
B16/8	5/2/1886-29/9/1887	5672-5973
B16/9	1/10/1887-25/4/1889	5975-6240
B16/10	26/4/1889-20/11/1890	6241-6534
B16/11	21/11/1890-23/2/1892	6535-6806
B16/12	6/3/1892-1/3/1894	6811-7260
B16/13	2/3/1894-20/4/1896	7261-7746
B16/14	25/4/1896-12/3/1898	7749-8250
B16/15	13/3/1898-31/12/1899	8251-8703

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B6/1	1852	1-49
B6/2	1853	50-291
B6/3	1854	292-415
B6/4	1855	416-512
B6/5	1856	513-694
B6/6	1857	695-896
B6/7	1858	898-1036
B6/8	1859	1037-1161
B6/9	1860	1162-1305
B6/10	1861	1306-1467
B6/11	1862	1468-1658
B6/12	1863	1659-1801
B6/13	1864	1802-1963
B6/14	1865	1964-2141
B6/15	1866	2142-2303
B6/16	1867	2304-2475
B6/17	1868	2476-2632
B6/18	1869	2633-2803
B6/19	1870	2804-2956
B6/20	1871	2957-3133
B6/23	1874	3426-3585
B6/24	1875	3586-3750
B6/25	1876	3752-3910
B6/26	1877	3911-4094
B6/27	1878	4096-4323
B6/28	1879	4324-4532
B6/29	1880	4534-4699
B6/33	1884	5401-5468
B6/34	1885	5469-5652

B6/35	1886	5653-5833
B6/36	1887	5834-6020
B6/37	1888	6021-6193
B6/38	1889	6194-6348
B6/39	1890	6349-6558
B6/40	1891	6559-6773
B6/41	1892	6774-6992
B6/42	1893	6993-7219
B6/43	1894	7220-7452
B6/44	1895	7453-7676
B6/45	1896	7677-7924
B6/46	1897	7925-8189
B6/47	1898	8190-8457
B6/48	1899	8458-8704

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A1/1	Visiting committee minutes	1853-1863
A1/2	Visiting committee minutes	1863-1882
A1/3	Visiting committee general and quarterly meetings	1882-1948
A1/4	General and quarterly meetings	
A3/1	House committee journal	1854-1870
A3/2	House committee journal	1870-1925
A7/1	Letter Book	1884-1894
A9/1	Asylum Annual Reports	1850-1867
A9/2	Asylum Annual Reports	1867-1874
A9/3	Asylum Annual Reports	1879-1881
A9/4	Asylum Annual Reports	1882-1887
A9/5	Asylum Annual Reports	1888-1894
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A11/1	Rules for Attendants and Servants	1872
A11/2	Regulations for Male and Female Attendants	1908

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Comparative Statement of Number of Insane Paupers chargeable to Poor Rates	1871	(140E) lix.401
Return of Pauper Inmates of County, Borough and private Lunatic Asylums and Licensed Houses in England and Wales, Sept 1877	1878	(390) lxiii.511
Return of Lunatic Asylums in England, Wales, Scotland and Ireland, Jan 1878	1878	(370) lxiii.467
Return of the Number of Licensed Houses In England, Wales, Scotland and Ireland for Care of Lunatics	1878	(375) lxiii.499
Return of Lunatic Asylums in England, Wales, Scotland and Ireland, Jan 1887	1888	(101) lxxxii.585
Return of Lunatic Asylums in England, Wales, Scotland and Ireland, Jan 1894	1895	(434) lxxxi.635
Report of the Metropolitan Commissioners in Lunacy	(HL) 1844	(001) xxvi.1
Report of the Commissioners in Lunacy to the Lord Chancellor 1846	1847	(471) xxxvi. 339
Second Annual Report	1847-48	(34) xxvi. 225
Further Report	1847-48	(858) xxxii.371
Third Annual Report	1849	(1028) xxii. 381
Fourth Annual Report	1850	(291) xxiii. 363
Fifth Annual Report	1850	(735) xxiii. 393
Sixth Annual Report	1851	(668) xxiii. 353
Seventh Annual Report	1852-3	(285) xl ix.1
Eighth Annual Report	1854	(339) xxix.1
Ninth Annual Report	1854-5	(240) xvii.533
Tenth Annual Report	1856	(258) xviii.495

Eleventh Annual Report	1857	(157) xvi.351
Twelfth Annual Report	1857-8	(340) xxiii.583
Thirteenth Annual Report	1859	(204) xiv.529
Fourteenth Annual Report	1860	(338) xxxiv.231
Fifteenth Annual Report	1861	(314) xxvii.1
Sixteenth Annual Report	1862	(417) xxiii.1
Seventeenth Annual Report	1863	(331) xx.437
Eighteenth Annual Report	1864	(389) xxiii.1
Nineteenth Annual Report	1865	(387) xxi.1
Twentieth Annual Report	1866	(317) xxxii.1
Twenty-first Annual Report	1867	(366) xviii.201
Twenty-second Annual Report	1867-8	(332) xxxi.1
Twenty-third Annual Report	1868-9	(321) xxvii.1
Twenty-fourth Annual Report	1870	(340) xxxiv.1
Twenty-fifth Annual Report	1871	(351) xxvi.1
Twenty-sixth Annual Report	1872	(279) xxvii.1
Twenty-seventh Annual Report	1873	(256) xxx.1
Twenty-eighth Annual Report	1874	(284) xxvii.1
Twenty-ninth Annual Report	1875	(337) xxxiii.1
Thirtieth Annual Report	1876	(383) xxxiii.1
Thirty-first Annual Report	1877	(403) xli.1
Thirty-second Annual Report	1878	(337) xxxix.1
Thirty-third Annual Report	1878-9	(342) xxxii.1
Thirty-fourth Annual Report	1880	(321) xxix.1
Thirty-fifth Annual Report	1881	(401) xlvi.1
Thirty-sixth Annual Report	1882	(357) xxxii.1
Thirty-seventh Annual Report	1883	(262) xxx.1
Thirty-eighth Annual Report	1884	(280) xl.1
Thirty-ninth Annual Report	1885	(285) xxxvi.1
Fortieth Annual Report	1886	(196) xxxiii.1
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Forty-second Annual Report	1888	(289) lii.1
Forty-third Annual Report	1889	(207) xxxvii.1
Forty-fourth Annual Report	1890	(274) xxxv.1
Forty-fifth Annual Report	1890-1	(286) xxxvi.1
Forty-sixth Annual Report	1892	(320) xl.1
Forty-seventh Annual Report	1893-4	(242) xlvi.1
Forty-eighth Annual Report	1994	(172) xlvi.1
Forty-ninth Annual Report	1895	(311) liv.1
Fiftieth Annual Report	1896	(304) xxxix. 1.1
Fifty-first Annual Report	1897	(279) xxxviii.65
Fifty-second Annual Report	1898	
Fifty-third Annual Report	1899	(255) xl.1
Fifty-fourth Annual Report	1900	(246) xxxvii.1
Special Report to the Lord Chancellor on the Alleged Increase in Insanity	1897	(87) xxxviii.1

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