NEGOTIATING THE ASYLUM:
AGENCY AND AUTHORITY IN LANCASTER COUNTY ASYLUM, 1840-1915

A dissertation submitted in partial fulfilment of the degree of PhD

By

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Abstract

This thesis examines the history of Lancaster Asylum, Lancashire's first county asylum, from 1840 to 1915 to explore the relationship between asylum authority and patient agency in the institution. Whereas current historiography has dichotomized patients' responses to asylum life as passive or resistant, this thesis advocates for a more nuanced definition of agency. A broader framework for thinking about the agency of marginalized groups, including asylum patients, is suggested. Patient resistance, coping mechanisms and engagement are considered as mechanisms of agentive behaviour. The relationship of patient agency and asylum authority is explored to illuminate the implications of power relationships in the asylum for the development of the institution. By focussing on a single institution over a 75-year period, this thesis traces the impact of patient agency on the development of psychiatric medicine in Lancaster Asylum.

The relationship between patient agency and asylum authority is explored through two interconnected levels. Firstly, an in-depth qualitative analysis of casebooks permits a discussion of incidents of conflict, accommodation, and cooperation between patients and asylum authorities. Secondly, these incidents are related to the built and material world of the institution. By analysing visual and material sources alongside patients' casebooks this thesis highlights the gap between intention and practice in the material world of the asylum. Despite being arranged to control patients' behaviour, the spaces and objects of the asylum could be appropriated by patients to facilitate agency. This affords a more active role to the patient in the history of psychiatry than previous research, underlining the collaborative, as well as the paternalistic, aspects of the medical encounter. The asylum is re-positioned, not just as the product of the medical profession, nineteenth-century reformers, or the Poor Law, but as a negotiated entity which was shaped by the complex interaction of a range of agendas, including those of patients.

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Case Notes and Anonymity

This thesis draws on casebook records, which detail the medical histories of individuals admitted to Lancaster Asylum in the period 1840-1915. These records present detailed information about the symptoms, conditions and life events of the individuals about whom they were written. These documents present information about what, in many cases, would undoubtedly have been some of the worst, most challenging, and most vulnerable moments in the lives of those admitted to Lancaster Asylum. They not only provide detail about patients' physical and mental conditions, but also intimate details about experiences of bereavement, romantic disappointment, and grief. These are the features of the case record that make it such a valuable source for historians who attempt to write medical histories that put the patient voice at their centre. However, these features also raise significant ethical questions with which I have wrestled throughout the production of this thesis. Although the records referenced throughout are freely available under the 100-year rule that governs access to historical medical records, the legality of consulting such documents does not necessarily assuage the attendant ethical concerns.

It is impossible to obtain the consent of the individuals whom I have written about in this thesis, and it is fair – I think – to assume that such consent may not have been freely given. I believe, however, that there is an onus on historians to use these documents, whilst taking seriously how we can treat them ethically. Questions of past patients' rights to privacy must be balanced with considerations of contemporary challenges surrounding the stigmatisation of mental illness. If historians were to ignore case records, and thus not talk about patients' experiences of mental illness in the past, we would surely be contributing to the perpetuation of this stigma. Case notes offer insights into patients' experiences of insanity, of the asylum, and of psychiatry. Without these insights, histories of mental illness and its treatment could only be understood as doctors saw them, which, as I hope to show throughout this thesis, is only a fraction of the story.

In order to offer some privacy to the patients discussed throughout this thesis, I have partially anonymised the names of those individuals about whom I have written. Patients are identified by their first name, and the initial of their surname when they are discussed in my writing. Where the names of patients are included in direct quotations from casebooks, I have anonymised them in the same way, indicating this using square brackets. I have chosen to

include patients' first names, rather than just using initials, because I do not wish to remove their humanity in any way. The mode of anonymisation adopted in this thesis aims to offer a degree of privacy to the individuals discussed, without depriving them of their personhood.

1. Introduction

1.1 Agency in the Asylum

The nineteenth and early twentieth centuries saw significant changes in the treatment of insanity, and particularly the treatment of the insane poor. This period saw the rise of county asylums – large, public institutions in which pauper patients were confined.[1] The nineteenth century also saw the culmination of campaigns for non-restraint and 'moral treatment', which had begun in the previous century.[2] Consequently, the ways in which medical authority was exercised over the insane were transformed. The treatment of patients without restraint necessitated the developments of new modes of managing their behaviour. A system of rewards and punishments was adopted in asylums to encourage good behaviour and discourage bad behaviour amongst patients.[3] Andrew Scull has suggested that such systems taught patients to internalize the morality of their middle-class doctors.[4] However, there is little evidence, in the work of Scull and other 'revisionist' scholars, to suggest that patients did internalize these behavioural standards. This thesis seeks to address this historiographical silence on patient responses to asylum authority.

This thesis explores patient agency in Lancashire County Asylum, Lancaster, in the period 1840-1915. In particular it will explore the relationship of patient agency with asylum authority in order to trace the effects that this dynamic had on the institution. The nature of this relationship will be explored through the following research questions:

1. How did patients in Lancaster Asylum exercise agency in the institution?
2. How did medical authorities respond to, and cope with, patient agency?
3. To what extent did the interaction between patient agency and asylum authority shape the treatment of insanity in Lancaster Asylum?

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[1] Leonard Smith, "*Cure, Comfort and Safe Custody": Public Lunatic Asylums in Early Nineteenth-Century England* (New York, 1999).
[2] Akihito Suzuki, 'The Politics and Ideology of Non-Restraint: The Case of the Hanwell Asylum', *Medical History*, 39(1) (1995), 1-17.
[3] Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge and New York, 1985).
[4] Andrew Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England* (London: 1979).

Drawing on casebooks, material culture, photography, and managerial records, this thesis aims to understand not only how patients experienced their confinement in Lancaster Asylum, but how their behaviour and responses to institutionalisation affected medical treatment. Rather than focussing on medical textbooks and journals as evidence of the nature of asylum treatment, this thesis examines how nineteenth- and early twentieth-century medical ideas about insanity were borne out in practice.

This study focuses on Lancashire's first county asylum at Lancaster (referred to throughout as Lancaster Asylum). Lancashire provides a particularly interesting location to explore the agency of pauper asylum patients due to its strong working-class medical tradition, which saw significant resistance to the incursion of medical power over the bodies of the poor.[5] Furthermore, the availability of both textual and material culture sources for Lancaster Asylum has facilitated the methodological approaches that allow an investigation of patient agency in a pauper institution. The casebooks of Lancaster Asylum, which are the main primary source material used throughout this thesis, span the period 1826-1953 providing a detailed and continuous record of patients' daily lives. The material culture of Lancaster Asylum also survives well: the asylum buildings, various maps and plans, and a large museum collection facilitate an analysis of agency and authority through the material world of the institution. Through focussing on a single institution over a 75-year period, this thesis explores the changing relationship between patient agency and asylum authority in the context of changes in the psychiatric profession, and in English society more broadly.

This research is focussed on the nineteenth-century history of Lancaster Asylum, beginning in 1840, when moral treatment was introduced to the institution. Lancaster Asylum has a much longer history than this, and this period has been selected to facilitate investigation of the research questions outlined above. This period is of particular interest in connection with the relationship between agency and authority because of the ways in which moral treatment affected the structure of authority in asylums.[6] Moral treatment produced a particular type of institutional authority, which had a complex relationship with patient agency. At the heart of moral treatment, there was a contradiction in the medical profession's

[5] Lucinda McCray Beier, *For Their Own Good: The Transformation of English Working-Class Health Culture, 1880-1970* (Columbus OH, 2008).
[6] The significance of authority to moral treatment has been well documented, most recently in James Dunk, 'Authority and the Treatment of the Insane at Castle Hill Asylum, 1811-25' *Health and History,* 19(2) (2017), 17-40.

understanding of asylum patients' capacity to act. They were simultaneously considered as totally devoid of agency, and as individuals to whom agentive capacity was being restored. This tension had significant implications for how asylum treatment was administered. Patients were considered irrational, as in need of close observation and control by medical professionals. At the same time, the aim of asylum doctors was to facilitate the progress of patients to a point where their rationality was restored, and they no longer needed to be observed as their capacity for self-control had been recovered. The asylum thus needed to simultaneously exercise authority over patients, whilst allowing them to begin to act autonomously. Patients were thus allowed some room to exercise agency, but this room was strictly delimited, and their agency could not be allowed to undermine medical authority. This contradiction between cure and control inherent to moral treatment gave rise to a particularly tense and dynamic relationship between patient agency and medical authority in the setting of the asylum.

This study ends in 1915, a date imposed by the 100-year rule governing access to patient casebooks as it applied when this research began. Given the centrality of patient records to the methodology adopted in this project, it was not possible to proceed beyond the early years of the twentieth century, after which these sources are no longer accessible. The post-1915 period marked the beginning of significant changes in residential psychiatric treatment and in the exercise of authority in asylums. The First World War brought major changes in these areas in both the short the long term. In the short term, the impact of new conditions such as shell-shock after the First World War[7] and the effects of military service on doctor-patient relationships changed the ways in which psychiatry was practised in institutions like Lancaster Asylum. In the long term the impact of psychoanalysis and pharmaceuticals during the latter half of the twentieth century further altered the practice of psychiatry and the relationship between psychiatrist and patient. Thus, the period after 1915 saw such significant changes in psychiatric medicine that the character of psychiatric authority also inevitably changed. As such, this period has remained outside the scope of this study, which is interested in the particular type of medical authority that emerged in the period of moral treatment.

[7] For a discussion of shell-shock see, Harold Merskey, 'Shell-shock', in German Berrios and Hugh Freeman (eds.), *150 Years of British Psychiatry* (London, 1991), pp. 245-67.

This short, introductory chapter provides a brief overview of the history of Lancaster Asylum to more clearly situate the period on which this thesis is focussed within the wider history of the institution. Although Lancaster Asylum has received some attention in existing studies, these are focused on just a handful of years out of its long history.[8] Consequently there is no existing literature that provides a comprehensive overview of the development of this institution. Furthermore, by exploring the earlier and later periods of the institution's history in this chapter, the distinct character of institutional authority in the era of moral treatment is clearly illuminated. As this thesis will demonstrate, patient agency cannot be understood apart from the structures of institutional authority in which is operated. The overview of the development of the Lancaster Asylum provided in this chapter will therefore provide much needed context to the discussion of patient agency that follows in the remainder of this thesis.

1.2 The Early Decades of Lancaster Asylum, 1816-1841

Plans for the construction of an asylum for Lancashire commenced soon after the passage of the 1808 County Asylums Act, which permitted – but did not compel – County governments to collect rates to fund specialist institutions for the insane poor in their locales.[9] The asylum opened on 18 July 1816 under the management of Superintendent Paul Slade Knight.[10] In its first year, 60 patients were admitted to the institution, however, demand soon outstripped the available accommodation. To meet the unforeseen demand for asylum treatment, a series of building extensions were begun in 1824, with new wings being added to the existing structure. By 1836 Lancaster Asylum's population had increased to 406, a far larger number of patients than had been anticipated.[11] When the asylum opened, it had been decided that it

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[8] John Walton, 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816-1870', in Andrew Scull (ed.), *Madhouses, Mad Doctors and Madmen: The Social History of Psychiatry in the Victorian Era* (London, 1981), pp. 166-98; John Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in William Bynum, Roy Porter and Michael Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry*, Vol. II (London, 1985) pp. 132-46; Andrew Scull, Charlotte MacKenzie and Nicholas Hervey, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, NJ, 1996) pp. 161-86.

[9] County Asylums Act, 1808. 48 Geo. III, c.96.

[10] Scull, MacKenzie and Hervey, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, NJ, 1996) p. 165.

[11] Lancashire Archives, Preston, HRL/1/12/5, 'Introduction to the History, Description and Problems of Lancaster Moor Hospital', 5 July 1948, p. 1.

would be run using the new 'moral treatment' which had been popularized by reformers such as Philippe Pinel in France, and the Tukes at the York Retreat.[12] Moral treatment was favoured for its supposedly humane treatment of the insane, and for its efficacy in managing lunatics in an institutional environment.[13] Moral treatment stressed that non-restraint, comfortable settings of care, and treating patients with respect were not only kinder, but were more effective in curing insanity.[14] These doctrines were closely connected with principles of non-restraint, which set out that the insane should not to be subjected to physical, mechanical restraint. Instead insanity would be treated by cultivating patients' self-control through providing them with productive occupation, exercise, good diet and routine in the setting of an asylum.[15]

To achieve this environment, moral treatment relied on a low ratio of patients to staff, replacing mechanical restraint with constant attention to patients' behaviour. This was the model which had demonstrated such success at the York Retreat, which was viewed by reformers and medical professionals alike as the prime example of the practice of moral treatment. There was some concern as to whether such a situation could be achieved in a county asylum since these institutions were much larger than the smaller, private facilities in which moral treatment practices had initially been conceived.[16] However, the regime headed by John Conolly at Hanwell Asylum (Middlesex) had proved that even in the context of an especially large Poor Law institution, non-restraint was possible. County asylums at Nottingham and Lincoln had also demonstrated that moral treatment could work in this context.[17] As such, when Lancaster Asylum was opened there was no longer any justification for not employing moral treatment and non-restraint in rate-funded institutions. The asylum at Lancaster was, therefore, conceived of within the context of such contemporary discussions.

Nevertheless, the first decades of the institution's history were characterized by reliance on methods emphasizing physical punishment and restraint. Mechanical restraint was used routinely under the management of Lancaster's first Superintendent, Dr Paul Slade

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[12] Samuel Tuke, *Description of the Retreat: An Institution near York for Insane Persons of the Society of Friends* (York, 1813).
[13] Digby, *Madness, Morality and Medicine*.
[14] Daniel Hack Tuke (ed.), *A Dictionary of Psychological Medicine*, 2 Vols (London, 1892).
[15] Digby, *Madness, Morality and Medicine*, pp. 49-55.
[16] John Conolly, *The Treatment of the Insane Without Mechanical Restraints* (London, 1856).
[17] Walton, 'The Treatment of Pauper Lunatics in Victorian England', pp. 166-98.

Knight. Knight even came up with his own methods of restraining patients, publishing a book on how to employ his bespoke devices.[18] At this time, patients in Lancaster were not only at risk from the physical rigours of restraint, but also from the poor conditions to which they were subject. Whilst moral treatment advocated pleasant, domestic surroundings, warm and comfortable clothing, food and proper medical attention, these amenities were notable by their absence at this time. Patients were dressed improperly, slept on straw, were fed an insufficient diet and lived in unsanitary rooms. Unsurprisingly, death rates at this time were correspondingly high.[19] Knight was dismissed in 1826 for improper treatment of patients, and in his absence some effort was made to implement a regime more in line with moral treatment. In 1831 a visitor to the Asylum noted the productive employment of patients as being 'decidedly beneficial, both as employing them, and as giving a pleasing sense of their being useful and not mere drones in society'; he also commented that the 'order and neatness which reign in every department of the establishment would do credit to the best regulated family'.[20] This trend towards increased emphasis on the employment of moral treatment at Lancaster was spurred on with the appointment of Samuel Gaskell in 1841, and an impending inspection by the newly instated national inspectorate for asylums – the Commissioners in Lunacy.

1.3 From Moral Treatment to Moral Management, 1840-1914

From the beginning of his tenure of the office of Superintendent, Gaskell demonstrated an enthusiasm for continuing to implement moral treatment in Lancaster Asylum. Whilst Gaskell's zeal for reforming the institution was undoubtedly a factor in the changes that followed his appointment, the upcoming inspection from the Commissioners in Lunacy also provided an incentive to magistrates to spend the money necessary to implement changes to the institution, lest they be penalized for improper care of the lunatics in their charge.[21] Patients were no longer to be kept under restraint, diet was improved, and proper medical care was administered. Instead of being chained up all day, patients took part in organized

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[18] Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993).
[19] Walton, 'The Treatment of Pauper Lunatics', pp. 171-2.
[20] *Lancaster Gazette and General Advertiser, for Lancashire, Westmorland, &c.* 28 May, 1831.
[21] Walton, 'The Treatment of Pauper Lunatics'.

activities to keep their minds from morbid thoughts. They were distracted by a series of work and leisure activities organised within the strict routine of the institution. Patients were encouraged to employ themselves in a useful occupation. Men worked on the asylum's farms, in the gardens, in workshops or even on building projects which took place within the institution. Women did needlework, laundry, cleaned or worked in the kitchen. When they were not working, patients took part in reading, sport, sewing or taking outdoor exercise in the grounds of the asylum or airing courts.

This routine was an essential part of institutional life and it was overseen, not by the Superintendent, but by the attendants and nurses who were responsible for the day-to-day care of patients. 'Keepers', whose job it was to restrain patients under lock and key in the early years of the institution, were no more. The staff responsible for the supervision of the insane became attendants or nurses, depending on their gender, and their role was redefined drastically. No longer was their job to ensure that inmates were locked up and kept quiet, they were now responsible for the care and well-being of their patients. This redefinition of the role of asylum attendants and nurses at Lancaster initially met with some resistance. It was after all, far less demanding to perform a role whose main responsibility was to ensure patients were kept locked up and physically restrained, than a role which required a far more comprehensive approach to the day-to-day management of the insane. The insistence of the management that new standards were adhered to ensured that these new roles were adopted by all members of staff.[22] New guidelines were issued as to how staff were expected to behave towards patients, emphasizing that violence was now an offence, that patience and forbearance were key, and that kindness and compassion were to be maintained no matter how challenging situations became.[23] Alongside changes in the status of the patient and the roles of staff, the building itself was also adapted to better suit the aims of moral treatment. Locks were hidden, the bars on windows were removed and the iron gates at the entrance to the asylum were taken down.[24] All outward appearances of coercion were to be disguised, hidden from the patient to whom the institution would appear as an idyllic safe haven, a true asylum from the world in which they had lost their reason.

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[22] Scull, MacKenzie and Hervey, *Masters of Bedlam*, p. 169.
[23] LA, HRL/2/2/1 'Regulations and Orders for the Nurses of the County Lunatic asylum at Lancaster'.
[24] LA, QAM/5/38 *Report of the Lunatic Asylum for the County of Lancaster* (Lancaster, 1841).

Several historians have suggested that from around 1880, asylums in Britain witnessed a surge in the patient population which led to the replacement of moral treatment with so-called moral management.[25] This phenomenon was also highlighted by contemporaries, who were well aware of the increase in asylum populations that occurred during the latter decades of the nineteenth century.[26] Where moral treatment had sought to use occupation, routine, and diet to cure, moral management employed similar techniques to control and manage patient behaviour. Anne Digby suggests that moral treatment had encouraged the patient to adhere to institutional rules and routines through their own volition, whereas moral management enforced adherence to institutional routine and rules using a more coercive discipline. This shift can be seen, according to Digby, in the implementation of a more detailed timetable in which patients were expected to take part in set recreational activities, work, dining etc. when they were told to do so by asylum authorities. In moral treatment, 'the comfort of the patients was…seen as outweighing the convenience of his keepers', whereas in moral management, patient adherence to institutional regulations and timetables was prioritized.[27] This shift enabled institutions to adhere to non-restraint practices, whilst dealing with larger numbers of patients. However, the introduction of moral management also produced more authoritarian asylum regimes.

This phenomenon is visible in the institutional practices of Lancaster Asylum which experienced an increase in patient populations in line with national trends in this period, necessitating a more rigorous approach to enforcing institutional regulations. The increase in the patient population can be seen in the upward trend in the average population of the asylum each year throughout the nineteenth century (see Appendix I). The pressure of patient numbers on the institution can also be observed in the large extensions undertaken to patient accommodation, particularly the addition of the so-called 'Annexe' building which opened in 1883 to accommodate 828 chronic patients.[28] Similarly, local newspapers point to the increasing cost of institutional provision for the insane, expressing concern over the burden being placed on the county rates by the seemingly ever expanding insane pauper population.[29]

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[25] E. Fuller Torrey and Judy Miller, *The Invisible Plague: The Rise of Mental Illness from 1750 to the Present* (Brunswick, NJ and London, 2001).
[26] *The Times,* 21 August 1896, 22 March 1897.
[27] Anne Digby, 'The Changing Profile of a Nineteenth-Century Asylum: the York Retreat', *Psychological Medicine,* 14(4) (1984), 739-48.
[28] LA, HRL/1/12/5, 'History, Description and Problems'.
[29] *Lancaster Gazette,* 2 December 1854; *Preston Guardian*, 20 January 1866; the impact of Irish immigration into Lancashire on the populations of Asylums was also discussed

That increases in patient numbers led to a shift from moral treatment to moral management can be seen in the construction and installation of new recreational facilities and activities such as cricket pitches, a library, and a theatre complete with a grand piano.[30] Increased varieties of recreational activities at Lancaster mimicked similar developments identified by Digby in signalling the adoption of moral management at the York Retreat, which were geared towards producing a 'daily timetable that features varied amusements' to replace 'a routine that gave each ordered part of the day a moral purpose'.[31] This trend towards moral management may have been exacerbated at Lancaster by the appointment of Mr Broadhurst as Samuel Gaskell's successor after Gaskell left to take an appointment as Commissioner in Lunacy.[32] Although Broadhurst had been Gaskell's assistant, he was noted to be a conservative Superintendent, which perhaps explains the lack of alteration to Gaskell's regime despite increasing pressure from patient numbers.[33]

The building programme continued at Lancaster Asylum through to the opening decade of the twentieth century. Under the leadership of David Campbell, who became Superintendent in 1876, the 1883 Annexe building had been constructed and several additional wards and an Attendants' Block were added before the end of the nineteenth century.[34] Prior to 1915, the Men's Infectious Hospital, two additional wards, and the Ladies' Villa were completed.[35] This constituted the final major building project of the early twentieth century, as the outbreak of the First World War halted not only the creation of additional asylum space, but also the maintenance of existing structures. From 1915, the asylum buildings fell into such as state of disrepair that in a 1948 report, a local architect stated that 'irreparable injury' had been caused to the structures.[36] Any repairs or further

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frequently in local newspapers, see, Catherine Cox and Hilary Marland, '"A Burden on the County": Madness, Institutions of Confinement and the Irish Patient in Victorian Lancashire', *Social History of Medicine*, 28(2) (2015), pp. 263-87.

[30] Mary-Ann Watts-Tobin, 'A History of Lancaster Moor Hospital', *Morecambe Bay Medical Journal*, 6, (2010) pp. 71-4.

[31] Digby, 'The Changing Profile of a Nineteenth-Century Asylum', p. 746.

[32] See Chapter Six of, Andrew Scull, Charlotte MacKenzie, and Nicholas Hervey, *Masters of Bedlam.*

[33] LA, HRL/2/9/2, 'A Study in Contrasts: One Hundred Years Ago and To-day. Lancaster County Asylum Centenary' Reprinted from *Lancaster Observer,* 27 October 1916.

[34] LA, HRL/1/12/5, 'History, Description and Problems'.

[35] LA, HRL/1/12/5, 'History, Description and Problems'.

[36] A local architect, Harold Davies, reported this to Superintendent, Dr Silverstone for the 1948 survey of the hospital buildings, LA, HRL/1/12/5, 'History, Description and Problems', p. 1.

building work that were needed were precluded by the outbreak of the First World War, and it was not until the 1930s that any significant alterations were planned to the fabric or running of the institution.

1.4 The Mental Treatment Act, the NHS, and Care in the Community, 1930-2000

The Mental Treatment Act of 1930 reversed the trend set by the 1890 Lunacy Act, which had emphasized the segregation of 'lunatics' in locked and secure asylums, and instead emphasized the importance of links between the institution and the wider community.[37] This Act also brought about a change in the vocabulary of insanity, with asylums being referred to as mental hospitals, and patients being referred to as mentally ill rather than insane. Individuals who believed themselves in need of medical intervention to alleviate mental distress were now able to admit themselves voluntarily to mental hospitals, resulting in increases to patient populations throughout the country. The introduction of voluntary admissions further opened up the hospitals to the wider community. Unlocked wards were introduced, patients were allowed out on 'parole', and outpatient clinics were established to allow convalescent patients to leave the asylum earlier than they would have been able to in previous eras. The central elements of moral management were retained, albeit in slightly altered forms. Occupational therapy was introduced, and a range of activities was still considered important for patient rehabilitation.[38] This was not a straightforward picture of progression towards more open hospitals for the mentally ill; the introduction of voluntary admissions led to an increase in hospital populations, and saw the beginning of 'revolving door' admissions in which patients were discharged but then promptly re-admitted as their mental health deteriorated again. Although the Act allowed patients to admit themselves easily, self-discharge was not as straightforward as the language of the Act suggested.[39]

The 1930s were a period of significant change in Lancaster Asylum with the passing the Mental Treatment Act and the appointment of a new Superintendent. The changes in the lexicon of insanity which were formalized by the Act resulted in the renaming of Lancaster

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[37] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997).
[38] Kathleen Jones, 'The Culture of the Mental Hospital', in Berrios and Freeman (eds.), *150 Years of British Psychiatry* (London, 1991), p. 24.
[39] Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London and New York, 1998), pp. 40-4.

Asylum as Lancaster Moor Hospital. The introduction of voluntary patient status did not have the desired effect of reducing patient populations, as the number of people admitted to the Moor Hospital continued to increase to its peak of 3,200 in 1940.[40] Nevertheless, the hospital's ratio of discharges to admissions remained significantly above national averages, despite the deficiencies of the facilities on site. The issues with the maintenance of the Moor Hospital's structures was highlighted in a report compiled by Joseph Silverston who was appointed as Superintendent in 1937.[41] The buildings had fallen into disrepair throughout the early decades of the twentieth century, due to the outbreak of the First World War.[42] Silverston planned significant improvements to the site including an admissions unit, an occupational therapy building, a hospital ward for female patients suffering from physical complaints, as well as improvements and proper maintenance of the older buildings.[43] The outbreak of the Second World War in 1939 put a stop to the building plans which were not resumed until 1948.[44]

Initial discussions as to whether Mental Hospitals would be incorporated into the National Health Service commenced in 1943, when the Minister of Health suggested that only the treatment of physical illness would be incorporated into the scheme. This ruling was reversed by a 1944 White Paper which discussed the link between mind and body in producing mental disorder, arguing that this interaction of biological and psychological causation meant that mental hospitals should be included in the NHS. *The Future Organization of the Psychiatric Services* (1945), co-created by the Royal Medico-Psychological Association, the British Medical Association, and the Royal College of Physicians also set out the importance of including psychiatry within the remit of general medicine.[45] This resulted not only in the incorporation of mental health services under the umbrella of the NHS, but also signalled the acceptance of a biological model of the aetiology of mental illness. This had important implications for the type of treatments that would be administered in mental hospitals including lobotomy, insulin coma, electro-convulsive

[40] Watts-Tobin, 'A History of Lancaster Moor Hospital', p. 72.
[41] Watts-Tobin, 'A History of Lancaster Moor Hospital', p. 72.
[42] See Gittins, *Madness in its Place* pp. 60-2, for a discussion of some of the effects of the First World War on staffing and maintaining asylums.
[43] LA, HRL/1/12/5, 'History, Description and Problems'.
[44] LA, HRL/1/12/5, 'History, Description and Problems'.
[45] Jones, *Asylums and After*.

therapy, and various drug treatments.[46] Several of these somatic interventions necessitated hospital admission. However, drug-based interventions would make possible the implementation of community care initiatives which received increasing support at a policy level throughout the 1950s.

Lancaster Moor was incorporated into the NHS along with the other mental hospitals throughout the nation. The Second World War had led to a surge in admissions due to the treatment of soldiers, which led the institutional population to peak in 1940 as noted above.[47] Following this peak, however, Lancaster Moor mirrored wider national trends in the treatment of mental illness, moving towards increased emphasis on community-based services. Throughout the 1950s, government policy emphasized the continued need for hospital provision for those who needed such treatment, however, stress was also placed on the need for community services to be improved so as to provide non-institutional options.[48] The 1959 Mental Health Act reinforced the significance of community-based treatments, making voluntary admissions and self-discharge the norm for mental hospitals. Whilst it still allowed for compulsory detention through sectioning, the 1959 Act went further than the 1930 Mental Treatment Act in facilitating voluntary status as the norm for in-patient facilities.[49] This was reflected in the composition of patients in Lancaster Moor, where after 1959 the bulk of admissions were voluntary.[50] Voluntary admissions, combined with the increased life-expectancy of long-stay elderly patients meant that the hospital population was especially high and necessitated the exploration of non-residential care options. Psychiatric social work took on a significant role in facilitating out-patient treatment at the Moor, with an on-site facility for social work being established. Boarding out also became common, with patients staying with selected landladies in Morecambe, and in rehabilitation wards and hostels in the community.[51] Out-patients were monitored by hospital staff and many returned to the hospital every day for employment.[52] Community care was facilitated by the development of psychotropic drugs which provided a potential alternative to reliance on

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[46] Andrew Scull, *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine* (London, 2015), pp. 290-321.
[47] Watts-Tobin, 'A History of Lancaster Moor Hospital', p. 72.
[48] John Welshman, 'Rhetoric and Reality: community care in England and Wales, 1948-74', in Peter Bartlett and David Wright (eds.), *Outside the Walls of the Asylum. The History of Care in the Community 1750-2000* (London and New Brunswick, NJ, 1999), p. 209.
[49] Gittins, *Madness in its Place*, pp. 45-6.
[50] Watts-Tobin, 'A History of Lancaster Moor Hospital', p. 72.
[51] Watts-Tobin, 'A History of Lancaster Moor Hospital', p. 72.
[52] Watts-Tobin, 'A History of Lancaster Moor Hospital', p. 72.

institutional treatment.[53] By the middle of the 1950s, these changes meant that large areas of the Moor were unused, and as such the Management Committee advocated for the hospital to incorporate units for treatment of physical illness as well as mental health units.[54] Facilities were added for orthopaedic surgery, ophthalmology, post-acute medical wards, neurosurgery and geriatric medicine.[55]

The 1980s marked an era of gradual closing down for the Moor Hospital, mirroring the national trend of a gradual reduction of psychiatric beds.[56] Psychiatric patients were transferred to their home areas, to community services near to their homes. A number of other areas of the hospital were emptied when a locked ward opened at the nearby Ridge Lea facility, and the department of geriatric medicine was relocated to the Royal Lancaster Infirmary in 1986.[57] Further facilities were closed through the 1990s, including the specialist children's psychiatric unit and alcohol treatment centre, with the Moor Hospital finally closing altogether in 2000.[58] The site and the remaining buildings were converted into housing and luxury apartments from 2004.[59]

1.5 Conclusion

The overview of the history of Lancaster Asylum provided in this chapter demonstrates that the period 1841-1915 represented the height of moral treatment in Lancaster Asylum. During this period authority was exercised over patients in distinct ways. Focus was ostensibly removed from exercising authority directly over the patient's body which had been the target of institutional interventions in the early decades of the nineteenth century and which was to become the focus of interventions again in the post-WWI era as new drugs to treat mental symptoms became increasingly available. In the period upon which this study is focussed,

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[53] Roy Porter, 'Psychiatry', in Roy Porter (ed.), *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London, 1997), pp. 493-524.
[54] LA, HRL/1/14/9, North Lancashire and South Westmorland Hospital Management Committee Review of Hospital Services, 30 August 1968.
[55] Watts-Tobin, 'A History of Lancaster Moor Hospital', p. 73.
[56] Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford, 1987).
[57] See, LA, HRL/1/14/10, Report by the Health Service Hospital Advisory Service on the unit for Geriatric and Chronic Sick patients in the Lancaster District of the Lancashire Area Health Authority at the Lancaster Moor Hospital, August 1975.
[58] Watts-Tobin, 'A History of Lancaster Moor Hospital', p. 73.
[59] *Lancaster Guardian*, 19 July 2014, https://www.lancasterguardian.co.uk/news/new-homes-well-under-way-at-old-city-hospital-site-1-6734578 [accessed 04/07/2018].

authority was intended to be asserted over the patient through the institutional timetable and the movement of the patient through the institution. Although this 'ideal' may not always have transpired in reality, as we will see throughout the chapters that follow, it represented a distinct mode of institutional authority that was unique to this period of Lancaster Asylum's history. This mode of authority provided the framework which governed patients lives in the institution and provided the structure in and against which patient agency operated. As we will see in the following chapter, understanding this structure is essential if we are to understand the relationship between patient agency and asylum authority which this thesis seeks to illuminate.

2. From Social Control to the Agentive Turn

2.1 Introduction

In this chapter, the development of the field of asylum history will be explored to explain why the patients' point of view has become such a priority for researchers since the 1980s. Section 2.2 will examine the broad historiographical developments in studies of the asylum, charting the shift from histories influenced by theories of social control, towards histories concerned with accessing patients' voices. Section 2.3 discusses social control theory in greater detail to explain the nature of its limitations, and the role of those limitations in precipitating the agentive turn. Section 2.4 explores agency in the social sciences, particularly within the fields of history, sociology and anthropology to understand how greater interest in the role of human agency has illuminated processes of historical change more effectively than social control narratives. Section 2.5 discusses the ways in which the agentive turn has influenced studies of the asylum, and comparable institutions, and summarizes their relevance for this thesis.

It will be demonstrated that whilst the agency of inmates and patients has been more thoroughly examined in recent studies, agency has been framed within an oppositional relationship to power, leading to the conflation of agency and resistance. This approach to agency is far more common in historical research than in the work of sociologists and anthropologists, who have increasingly argued for a more nuanced theorization of the concept of agency. By bringing approaches from sociological and anthropological studies into dialogue with historical approaches to agency, it will be suggested that moving towards a broader definition of human agency in studies which are concerned with institutional populations, will further illuminate the relationship between agency and authority and highlight the role of this relationship in the development of these institutions.

2.2 The Historiography of the Asylum

Until the 1970s, interest in the history of insanity was largely confined to psychiatrists interested in the genealogy of their own profession.[1] This paucity of interest reflected the

[1] Richard Hunter and Ida Macalpine, *Three Hundred Years of Psychiatry: 1535-1860* (London, 1963); Richard Hunter and Ida Macalpine, *George III and the Mad* Business

lower-priority afforded to mental health services in relation to funding within welfare states.[2] There were some notable exceptions,[3] including William J. Parry's investigation into the so-called 'trade in lunacy' in Britain, which examines the system of private madhouses that constituted the main provision for the insane throughout the eighteenth century.[4] Kathleen Jones' histories of mental health services in England, although still useful for its treatment of the legislative changes in the management of the insane in the nineteenth and twentieth centuries, was significantly flawed by its commitment to a Whiggish, medical progress narrative.[5] Jones' work gives a teleological account of the emergence of the asylum as the hard-won victory of middle-class reformers; the asylum is framed as the well-intentioned project of enlightened individuals, that went awry due to poor management, overcrowding, and underfunding.[6]

Interest in the history of insanity, most would agree, erupted in the wake of Michel Foucault's scathing critique of the psychiatric profession.[7] *Madness and Civilisation* was first published at the height of the anti-psychiatry movement.[8] These critiques coincided with a period when institutions were being undermined from various quarters. Research by sociologists demonstrated the effects of institutionalization on patients, and the poor

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(London, 1969); Richard Hunter and Ida Macalpine, *Psychiatry for the Poor, 1851. Colney Hatch Asylum, Friern Hospital 1973: A Medical and Social History* (London, 1974).

[2] Joseph Melling, 'Accommodating Madness: New Research in the Social History of Insanity and Institutions', in Joseph Melling and Bill Forsythe (eds.), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London, 1999), p. 1.

[3] For a full discussion of these see, Roy Porter, 'History of Psychiatry in Britain', *History of Psychiatry*, 2 (1991), p. 271.

[4] William Parry-Jones, *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London, 1971).

[5] Kathleen Jones, *Lunacy, Law and Conscience, 1744-1845: The Social History of the Care of the Insane* (London, 1955); Kathleen Jones, *Mental Health and Social Policy, 1845-1959* (London, 1960); Kathleen Jones, *A History of the Mental Health Services* (London, 1972).

[6] For a similarly 'Whiggish' account of such developments in the United States see Gerald Grob, *Mental Institutions in America. Social Policy to 1875* (New York, 1973).

[7] Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (trans.), Richard Howard (London, 1967). Nb. The original French text was published in 1961.

[8] R. D. Laing, *The Divided Self: An Existential Study in Sanity and Madness* (London, 1960); David Cooper, *Psychiatry and Anti-Psychiatry* (London and New York, 1967); Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (London, 1972).

standards of care within psychiatric facilities were revealed.[9] Public scandals such as the Ely Scandal (1969) galvanised public opinion in favour of the abolishment of 'total institutions' in favour of community care.[10] Government opinion had been moving towards community care for some time. Throughout the 1950s, Government papers proposed the large-scale replacement of mental health beds with community-based services. In the 1954 Parliamentary debate on mental health, and the ensuing report compiled by the Royal Commission on Mental Health (1957), it was suggested that local authorities needed to take more responsibility for caring for the mentally ill in non-institutional settings. John Welshman notes that the Royal Commission was particularly enthusiastic about care in the community approaches, but provided very limited funding to facilitate them.[11] The recommendations of the Royal Commission influenced the 1959 Mental Health Act, which empowered local authorities to establish alternative facilities to the hospital.[12] This shift from hospital to community in government policy was supported by the availability of new drug treatments such as anti-psychotics.[13] From 1954 to 1982, the number of psychiatric beds available in England fell from 152,000 to 72,000, and by 1993-4 there were only 43,000 beds available.[14]

Foucault's work inevitably struck a chord in this climate, yet despite this and its influence on subsequent scholarship, Foucault's account of the emergence of a network of disciplinary institutions over the nineteenth-century was, from an historical perspective, deeply flawed. It failed to take account of the historical circumstances of the societies about which he wrote, favouring the provision of a grand narrative over historical accuracy.[15] Thus, the revisionist histories that emerged from the 1970s were, as Melling posits, 'at least as concerned to refine and correct the extravagant historical inaccuracies of Foucault's grand narrative of the history of madness as [they were] to interrogate his profound insights into the processes of institutional growth and intellectual classification'.[16] The work of Andrew Scull

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[9] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961; repr. London, 1991); J. K. Wing and G. W. Brown, *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals, 1960-1968* (London, 1970).
[10] Ian Butler and Mark Drakeford, *Scandal, Social Policy and Social Welfare* (Second Edition) (Basingstoke, 2003), pp. 33-60.
[11] Welshman, 'Rhetoric and Reality: Community Care in England and Wales, 1948-74', p. 209.
[12] Unsworth, *The Politics of Mental Health Legislation*.
[13] Jones, *Asylums and After*, pp. 148-56.
[14] Sarah Payne, 'Outside The Walls of the Asylum? Psychiatric Treatment in the 1980s and 1990s', in Bartlett and Wright (eds.), *Outside the Walls of the Asylum,* p. 247.
[15] Foucault, *Madness and Civilisation*.
[16] Melling, 'Accommodating Madness', p. 2.

is exemplary of this trend in revisionist scholarship in which writers were at the same time influenced by, and concerned to critique Foucault's 'Great Confinement'. Scull's work aimed to contextualize the emergence of the asylum in England against the backdrop of an industrializing nation. He argued that the asylum provided a means by which unproductive members of society could be removed from their homes, where their erratic behaviour became disruptive to the productivity of other members of the household. Once admitted to the asylum, their behaviour could be modified by professional mad-doctors, and moulded to conform to Victorian, middle-class ideals. If this behavioural modification was not achieved, the insane would remain in the asylum, which increasingly functioned to warehouse unproductive and disruptive members of society.[17] Where Foucault had failed to provide consideration of the particular social and economic conditions which gave rise to asylums, Scull accounted for the emergence of English asylumdom with reference to the emerging capitalist economy. Similar explanations of the emergence of the asylum were produced about the situation in France and in America, positioning the asylum as a mechanism of social control employed by the bourgeoisie to ensure a docile industrial workforce.[18]

Key to Scull's account was the development of 'moral treatment'. Like Foucault, Scull saw moral treatment as a means by which asylum doctors aimed to re-shape the behaviour of the insane. For Scull, this was achieved by encouraging the mad to conform to the behavioural standards of the Victorian middle-classes.[19] Scull also argued that the endorsement of moral treatment by the nascent psychiatric profession was a means by which they sought to consolidate their professional authority. They claimed to be the only group capable of administering moral treatment, and they emphasized the necessity of it taking place in a specialized institution, under professional supervision. Scull argues that this led to the wholesale endorsement of the asylum in England, where it rapidly became perceived as the only proper response to insanity.[20]

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[17] Andrew Scull, *Decarceration: Community Treatment and the Deviant: A Radical View* (Englewood Cliffs, NJ, 1977); Scull, *Museums of Madness.*
[18] Robert Castel, *The Regulation of Madness: The Origins of Incarceration in France*, (trans.), W. D. Halls (Cambridge, 1988); David Rothman, *The Discovery of the Asylum* (Boston, 1971).
[19] Andrew Scull, 'Moral Treatment Reconsidered: Some Sociological Comments on an Episode in the History of British Psychiatry', *Psychological Medicine*, 9(3) (1979), 421-8.
[20] Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven, CT, 1993).

This assessment of the asylum as the result of professional self-interest and capitalist social relations was modified by a number of scholars who sought to examine other influences on the emergence of asylumdom. Anne Digby's influential study of moral treatment at the York Retreat examined the role of religion, specifically Quakerism, in shaping this approach to treating insanity. Rather than viewing moral treatment as an insidious means by which patients were forced to conform to middle-class values, Digby noted the importance of Quakerism in shaping this approach to managing insanity.[21] Digby also noted that pragmatic considerations of managing patients' behaviour became increasingly important in shaping the nature of asylum treatment.[22]

Thus, following Scull's work, scholars like Digby identified different social, cultural and economic forces which shaped institutional responses to insanity. Scull's work had focussed on the ways in which class conflict was played out through the asylum.[23] However, the influence of class on the treatment of the insane went much further than this. Patients of different social classes received treatment in different asylums, private institutions for the rich and middle-classes, and in pauper institutions for those unable to pay for their care. The social class of patients also influenced how moral treatment was administered in asylums; private patients were considered more receptive to therapies such as producing artwork and reading, whilst pauper patients were considered better suited to more labour-intensive occupations such as farm work, doing laundry, or cleaning.[24] Similarly, a patient's social class was seen to influence the types of mental disorders to which they were susceptible, for example, middle and upper class patients were believed to be more susceptible to 'fashionable' nervous diseases like neurasthenia.[25] Nor were class distinctions purely based on the economic situations of patients; Lorraine Walsh points out that considerations of

[21] Digby, *Madness, Morality and Medicine*.
[22] Digby, 'The Changing Profile of a Nineteenth-Century Asylum', 739-48.
[23] Scull, *The Most Solitary of Afflictions*.
[24] Sarah Chaney, 'Useful Members of Society or Motiveless Malingerers? Occupation and Malingering in British Asylum Psychiatry, 1870-1914', in Waltraud Ernst (ed.), *Work, Psychiatry and society, c.1750-2015* (Manchester, 2016), pp. 277-97.
[25] Charlotte MacKenzie, *Psychiatry for the Rich: A History of the Private Ticehurst Asylum, 1796-1914* (London, 1992), p. 152; Heather R. Beatty, *Nervous Disease in Late Eighteenth-Century Britain: The Reality of a Fashionable Disorder* (London, 2012).

respectability were as important to asylum staff in determining the class to which patients belonged.[26]

Just as class shaped how patients were treated in asylums, gender too played a role in determining the type of treatment that patients received. Female patients were more likely to be encouraged to take up indoor occupations, whereas male patients were allowed to work and spend leisure time outdoors.[27] Elaine Showalter and Jane Ussher argued that it was not just the treatment of women that differed inside asylums, but that insanity was also regarded as a particularly 'female malady'.[28] They argued that women were portrayed as being particularly susceptible to madness, and were more likely to be confined as a result of male bourgeois oppression.[29] In this analysis, the asylum was used as a tool of control over wayward women whose behaviour violated gender norms.[30] The analysis of madness as a particularly female malady has been nuanced by studies which explored the ways in which male and female experiences of insanity were influenced by gender.[31] Gender has since been understood as a category shaping asylum care which affected both male and female patients in varying ways.[32]

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[26] Lorraine Walsh, 'A Class Apart? Admissions to the Dundee Royal Lunatic Asylum', in Jonathan Andrews and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam and New York, 2004), pp. 249-70.
[27] Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Basingstoke, 2014).
[28] Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London, 1987); Jane M. Ussher, *Women's Madness: Misogyny and Mental Illness* (Hemel Hempstead, 1991)
[29] Anne Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London, 2014).
[30] For a more detailed survey of feminist approaches see Phyllis Chesler, *Women and Madness* (London, 1974); Vieda Skultans, *English Madness: Ideas on Insanity 1580–1890* (London, 1979); Nancy Tomes, 'Feminist Histories of Psychiatry', in Mark S. Micale and Roy Porter (eds.), *Discovering the History of Psychiatry* (New York and Oxford, 1994), pp. 348–83; Nancy Theriot, 'Diagnosing Unnatural Motherhood: Nineteenth-century Physicians and "Puerperal Insanity"', *American Studies,* 30(2) (1989), 69-88.
[31] Joan Busfield, 'The Female Malady? Men, Women and Madness in Nineteenth Century Britain', *Sociology,* 28(1) (1994), 259-77; Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (Basingstoke, 1996).
[32] For example see, Mark S. Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, MA and London, 2008); Jade Shepherd, 'Victorian Madmen: Broadmoor, Masculinity and the Experiences of the Criminally Insane, 1863-1900' (Unpublished PhD Thesis, Queen Mary University of London, 2013); Helen Goodman, '"Madness and Masculinity": Male Patients in London Asylums and Victorian Culture', in

Historians have also highlighted the role played by race in the treatment of insanity. This is apparent in histories examining the exportation of asylums from European countries to their colonies, and in studies which consider facilities in which white and non-white patients were treated in the same institution. Exporting asylums to colonies fitted well with the principles of the 'civilising mission' of the British Empire.[33] Leonard Smith has noted that moral treatment was particularly well-suited to the colonial mission.[34] Exporting asylumdom has also been considered as a further mechanism by which native populations were constituted as objects of medical science.[35] Racial hierarchies were reinforced through the ways in which indigenous susceptibility to insanity was highlighted.[36]

Many of the studies discussed so far explored the emergence of the asylum through single-institutional case studies. By exploring the history of one institution, scholars were able to explain in rich detail the particular local social, economic and political forces that shaped the emergence of an asylum. As discussed above, Digby's account of the Retreat at York was able to highlight the role played in its development by religious beliefs.[37] The ways in which social class shaped the nature of asylums was explored through studies of Colney Hatch Asylum, a pauper institution, and in studies which focussed on asylums for the social elite.[38] Other single-institution studies illuminated broader strategies for managing the insane in local areas that went beyond the asylum. John Walton's study of Lancaster Asylum, for example, demonstrated a high turn-over of patients, indicating that for those patients who were discharged quickly, other mechanisms of care must have been operating in the wider community.[39] Thus, despite being centred on institutions, studies like Walton's prompted

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Thomas Knowles and Serena Trowbridge (eds.), *Insanity and the Lunatic Asylum in the Nineteenth Century* (London, 2015), pp. 149-67.

[33] For further discussion of colonial psychiatry see, James Mills, *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857-1900* (Basingstoke, 2000); Sloane Mahone and Megan Vaughan (eds.), *Psychiatry and Empire* (Basingstoke, 2007); Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914* (Basingstoke, 2014).

[34] Leonard Smith, '"A Powerful Agent in Their Recovery": Work as Treatment in British West Indian Lunatic Asylums, 1860-1910', in Ernst (ed.), *Work, Psychiatry and society*, pp. 142-62.

[35] Bernard Harris and Waltraud Ernst, *Race, Science and Medicine, 1700-1960* (London and New York, 1990).

[36] Jock McCullock, *Colonial Psychiatry and 'the African mind'* (Cambridge, 1995).

[37] Digby, *Madness, Morality and Medicine*.

[38] Hunter and MacAlpine, *Psychiatry for the Poor*; MacKenzie, *Psychiatry for the Rich*.

[39] Walton, 'Lunacy in the Industrial Revolution', 1-22.

researchers to look outside the asylum, and to focus on actors other than the medical profession in relation to how insanity was treated in Victorian England.[40]

Whereas Scull's work concentrated on the role of the psychiatric profession in the rise of English asylumdom, subsequent research aimed to recover the roles played by other parties.[41] Work by Peter Bartlett emphasized the importance of understanding the emergence of asylums in Britain within their context as a Poor Law institution. Bartlett explored the roles played by Magistrates, Poor Law Guardians and the families of the insane in shaping asylums at the local level.[42] Understanding asylums within local networks of provision for the poor led some scholars to contextualise the use of asylums by local communities within strategies linked to the family life cycle.[43] Focusing on Earlswood Asylum for idiots and imbeciles, David Wright has stressed the importance of family networks in determining patients' admissions and discharges.[44] Akihito Suzuki similarly emphasized the continued prevalence of home-care for the insane throughout the nineteenth-century.[45] Thus as Melling explains, although many revisionist accounts following Scull's have adopted different methods and reached different conclusions, they have largely continued to take Scull as their starting point in their accounts of the structural forces that shaped the landscape of insanity in Victorian Britain.

The other major force in shaping significant swathes of existing scholarship on the asylum is the work of Roy Porter. Whereas Scull was concerned to explain the rise of asylumdom with reference to the psychiatric profession, Porter was interested in the patient's view. In 1980, Roy Porter challenged historians to place patients and their experiences at the

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[40] Further discussion of the high rates of patient turnover which suggested that extra-mural provisions for the insane existed alongside institutional care can be found in Laurence Ray, 'Models of Madness in Victorian Asylum Practice', *European Journal of Sociology,* 22(2) (1981), 229-64; Allan Beveridge, 'Madness in Victorian Edinburgh: A Study of Patients Admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873-1908 Part II', *History of Psychiatry,* 5 (1995), 133-56.

[41] The significance attributed by Scull to members of the psychiatric profession in shaping responses to insanity is reflected in the biographies of prominent alienists collected in Scull, MacKenzie, and Hervey, *Masters of Bedlam.*

[42] Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London and Washington, 1999).

[43] Walton, 'Casting Out and Bringing Back', pp. 132-46.

[44] David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine,* 10(1) (1997), 137-55.

[45] Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820-1860* (Berkeley, CA, 2006).

centre of the history of medical encounters.[46] Previous work had placed emphasis on the doctors' role in this encounter, on the role of industrial capitalism, on the various agencies of the Poor Law, or on the patients' families. These perspectives had ignored how the individuals for whom the asylum system was designed actually experienced it. The commitment of Porter to recovering the perspective of the patient came to fruition in *A Social History of Madness*.[47] In this book, Porter drew on patient accounts of confinement to recover the voices of the insane through their autobiographical writings, demonstrating that the patient's point of view was retrievable. The insane left accounts of their experiences and memoirs of their confinement through which the other half of the medical encounter could be explored.

Porter's reliance on published accounts of the asylum provides one way in which we might access patient voices. This group of sources is, however, rather limited in scope. These memoirs privilege the perspective of upper and middle-class lunatics, since these were the individuals most likely to produce published accounts. This is a significant limitation in their utility for accessing the voices of patients confined in county asylums like Lancaster. These patients were predominantly paupers, and although this catch-all term masks some social stratification, it remains true that these individuals did not have access to the same educational advantages, social connections, and possibilities for publication as Porter's patients.[48] Furthermore there is little consideration of how the social class or even gender of a mad person might have affected their experience of insanity and treatment, despite there being much evidence to suggest that such categories were important.[49]

Nevertheless, historians following Roy Porter's call for a patient-centred psychiatric history have contributed to a richer and more nuanced understanding of asylum history. Jonathan Andrews discusses the ways in which case notes and case histories might be used to recover the patient experience.[50] More recently, patient letters have been used to gain a better

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[46] Roy Porter, 'The Patient's View: Doing Medical History from below', *Theory and Society*, 14(2) (1985), 175-98.
[47] Roy Porter, *A Social History of Madness: Stories of the Insane* (London, 1987).
[48] Peter Bartlett, *The Poor Law of Lunacy*.
[49] Showalter, *The Female Malady*; Hide, *Gender and Class*; Goodman, '"Madness and Masculinity"'.
[50] Johnathan Andrews, 'Case Notes, Care Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11(2) (1998), 255-81.

understanding of their experiences within institutions.[51] Others have undertaken to recover ways in which asylum patients expressed their individuality and subjectivity through the adaptation of their uniforms.[52] The ways in which patients interacted with and responded to the architecture and the decoration of asylums has also been examined to understand how patients felt about living in these institutions.[53]

However, despite these strides towards recovering the perspectives of patients, a recent assessment of the work done since the so-called 'patient's turn' suggests that Porter's challenge to write a social history of medicine 'from below' over thirty years ago has still not been fully met, and that many aspects of patient experience remain misunderstood or simply unknown.[54] It is the contention of this thesis that the patient experience cannot be understood without a more thorough attempt to recognize the role of patients in actively shaping the parameters of their confinement.[55] Whilst the work discussed above does much to explore how patients may have felt about their illness experience, being detained against their will, and even about how they experienced the material worlds in which they were confined, few

[51] Allan Beveridge, 'Life in the Asylum: Patients' Letters from Morningside, 1873-1908', *History of Psychiatry,* 9 (1998), 431-69; Catharine Colebourne, 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880-1910', *Social History of Medicine,* 19(3) (2006), 426-42; Louise Wannell, 'Patients' Relatives and Psychiatric Disorders: Letter Writing in the York Retreat, 1875-1910', *Social History of Medicine*, 20(2) (2007), 297-313; Leonard Smith, '''Your Very Thankful Inmate': Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine,* 21(2) (2008), 237-52.

[52] Jane Hamlett and Lesley Hoskins, 'Comfort in Small Things? Clothing, Control and Agency in County Lunatic Asylums in Nineteenth- and Early Twentieth-Century England', *Journal of Victorian Culture,* 18(1) (2013), 93-114; Rebecca Wynter, '"Good in All Respects": Appearance and Dress at Staffordshire County Lunatic Asylum, 1818-54', *History of Psychiatry*, 22(1) (2010), 40-57.

[53] Jane Hamlett, *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian and Edwardian England* (Basingstoke, 2014); Jane Hamlett, Lesley Hoskins, Rebecca Preston (eds.), *Residential Institutions in Britain, 1725-1970: Inmates and Environments* (London and New York, 2013).

[54] Alexandra Bacopoulos-Viau and Aude Fauvel, 'The Patient's Turn: Roy Porter and Psychiatry's Tales, Thirty Years On', *Medical History*, 60(1) (2016), 1-18.

[55] Flurin Condrau suggests that a careful reading of Porter's article on the patient's view reveals how much emphasis Porter placed on recovering patient agency, a challenge that has been missed by many scholars doing medical history from below who have focused on patient experience rather than on patients' active roles in the medical encounter, Flurin Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine,* 20(3) (2007), 525-40.

of these projects have discussed the patient as an active agent whose responses to illness and confinement shaped the medical encounter.

2.3 The Influence of Social Control Theory in Institutional Studies

The lack of attention given to patient agency in much of the revisionist scholarship discussed above can be explained by the popularity of social control theory amongst social historians writing in the 1970s and 80s.[56] The asylum was part of a much larger institutional landscape in this period, with reforms of prisons seeing the rise of new carceral solutions for dealing with the criminal, and the emergence of the workhouse as the primary means of affording relief to the poor. Non-carceral institutions also proliferated at this time including hospitals[57], schools[58], lodging houses[59] and charity missions.[60] The emergence of these institutions was explained from the nineteenth-century until the middle of the twentieth, using the language of those responsible for the creation of this new system of detaining or caring for deviant populations.[61] Similar narratives can be found in early attempts to explain the replacement of corporeal punishment of criminals with incarceration in institutions where the criminal would

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[56] F. M. L. Thompson, 'Social Control in Victorian Britain', *Economic History Review,* 34(2) (1981), 189-208.

[57] Jeremy Taylor, *Hospital and Asylum Architecture in England, 1840-1914: Building for Health Care* (London, 1991); Lindsay Granshaw, 'The Rise of the Modern Hospital in Britain', in Andrew Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge, 1999), pp. 197-218; Christine Stevenson, *Medicine and Magnificence: British Hospital and Asylum Architecture, 1660-1815* (London, 2000).

[58] Norman Vance, 'The Idea of Manliness,' in Brian Simon and Ian Bradley (eds.), *The Victorian Public Schools: Studies in the Development of an Educational Institution* (Dublin, 1975); Fabrice Neddam, 'Constructing Masculinities under Thomas Arnold of Rugby (1828-1842): Gender, Educational Policy and School Life in an Early-Victorian Public School', *Gender and Education*, 16(3) (2004), 303-26.

[59] Stanley D. Chapman and Anthony S. Wohl (eds.), *A History of Working-Class Housing* (Newton Abbot, 1971); Anthony S. Wohl, *The Eternal Slum: Housing and Social Policy in Victorian London* (New York, 1977); Tom Crook, 'Accommodating the Outcast: Common Lodging Houses and the Limits of Urban Governance in Victorian and Edwardian London', *Urban History,* 35(3) (2008), 414-36; Eleanor Fisher, 'Local Authorities and the Management of the Common Lodging-House in Lancashire, 1851-1914' (Unpublished PhD Thesis, Lancaster University, 2009).

[60] Robert Humphreys, *Poor Relief and Charity, 1869-1945: the London Charity Organization Society* (Basingstoke, 2001); Robert Humphreys, *Sin, Organized Charity and the Poor Law in Victorian England* (New York, 1995); Christopher Prom, 'Friendly Society Discipline and Charity in Late-Victorian and Edwardian England', *Historian,* 72(4) (2010), 888-908.

[61] Jones, *Lunacy, Law and Conscience;* Jones, *Mental Health and Social Policy*; Jones, *A History of the Mental Health Services*.

be reformed.[62] The teleology inherent in such accounts provided a justification for such institutions in the present, and in the radical political climate of the 1960s, many social control theorists sought to interrogate and correct this in their revisionist histories.[63]

The revisionist histories that emerged with social control theory at their core thus had an inherently political nature, often Marxist, and explicitly offered intellectual support to movements campaigning for the rights of patients, prisoners, and welfare recipients. Social control theory was used to explain many developments in Victorian Britain. Schools, police forces, prisons, charities and workhouses numbered amongst the institutions identified as having emerged to maintain middle-class hegemony in the wake of industrialisation.[64] Social control theorists argued that prior to industrial capitalism, communities were small enough that the behaviour of individuals within those communities could be regulated by familial and kinship networks, and the paternalistic relationship between landlord and leaseholder. Urbanisation and industrialisation, however, saw the breakdown of these face-to-face paternalistic relationships, precipitating a crisis in authority. This led to a sense of crisis amongst higher social orders, and a pervasive fear of the threats posed by disorder amongst the lower classes. This fear drove the middle and upper classes to seek to replace older forms of communal authority, with new social controls which would inculcate self-discipline, punctuality, industry, and thrift in the lower classes.[65]

Revisionist scholarship was characterized by scepticism of the avowed motives of reformers. Work on carceral institutions dismissed earlier notions of progress and instead situated the institutional archipelago of the nineteenth century within broader histories of class relations.[66] This early revisionist scholarship was exemplified in the works of Foucault,

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[62] Negley D. Teeters, *The Cradle of the Penitentiary: The Walnut Street Jail at Philadelphia, 1773-1835* (Philadelphia, PA, 1955); David W. Lewis, *From Newgate to Dannemore: The Rise of the Penitentiary in New York, 1796-1848* (Ithaca NY, 1965); David D. Cooper, *The Lesson of the Scaffold: The Public Execution Controversy in Victorian England* (Athens OH, 1974); John R. S. Whitting, *Prison Reform in Gloucestershire, 1775-1820* (London, 1975); Eric Stockdale, *A Study of Bedford Prison, 1660-1877* (London, 1977).
[63] A. P. Donajgrodski (ed.), *Social Control in Nineteenth-Century Britain* (London, 1977).
[64] Quintin Hoare and Geoffrey Nowell Smith (eds. and trans.), *Selections from the Prison Notebooks of Antonio Gramsci* (London, 1971).
[65] John A. Mayer, 'Notes towards a Working Definition of Social Control in Historical Analysis', in Stanley Cohen and Andrew Scull (eds.), *Social Control and The State: Historical and Comparative Essays* (Oxford, 1983), p. 17.
[66] Michael Ignatieff, 'State, Civil Society and Total Institutions: A Critique of Recent Social Histories of Punishment', *Crime and Justice,* 3 (1981), 153-92.

discussed above, David Rothman's *The Discovery of the Asylum* and Michael Ignatieff's *A Just Measure of Pain*.[67] These accounts saw the nineteenth-century institutional landscape as a mechanism of control employed by the ruling classes. Asylums, prisons, workhouses, urban schools etc. were a means by which the populations of urban settlements could be kept in order, ensuring that a productive and compliant workforce was available to fuel the burgeoning capitalist economy.[68] Revisionist historians influenced by social control theory debated the locus of social control – it was not just the social elite who used institutions to regulate problematic behaviour but local magistrates, poor law officials, religious groups, and the families of the insane.[69] Thus the idea of social control became ever more complex, and the agents of social control multiplied.

Social control theory ran into serious critiques by the 1980s. Most seriously, this schema of explanation was criticized for its lack of explanatory power. Stanley Cohen, a prominent proponent of social control theory,[70] argued that by the mid-1980s, the theory had become a 'Mickey Mouse' concept in sociology; it had been used too often and in relation to such an array of situations and institutions that its meaning had been obscured.[71] Gareth Stedman Jones argued that the frequency with which historians adopted the term casually, as a result of 'theoretical eclecticism', robbed it of meaning. Stedman Jones highlighted that there were serious problems with the concept that were related to a lack of precision in its deployment, failure to identify instigators of control programs, lack of criteria to assess

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[67] Rothman, *The Discovery of the Asylum*; Michael Ignatieff, *A Just Measure of Pain: The Penitentiary in the Industrial Revolution, 1750-1850* (London, 1978).
[68] For further examples of revisionist scholarship which used social control theory to explain the emergence of nineteenth-century institutions see Michael Katz, *The Irony of Early School Reform* (Cambridge, MA, 1968); Anthony M. Platt, *The Child Savers: The Invention of Delinquency* (Chicago, IL, 1969); Marvin Lazerson, *The Origins of the Urban School: Public Education in Massachusetts* (Cambridge, MA, 2013); Francis F. Piven and Richard Cloward, *Regulating the Poor: The Functions of Public Welfare* (New York, 1971).
[69] Digby, *Madness, Morality and Medicine*; Walton, 'Casting Out and Bringing Back'; David Wright, 'Getting out of the Asylum'; Bartlett, *The Poor Law of Lunacy*; Suzuki, *Madness at Home*.
[70] Stanley Cohen, *Folk Devils and Moral Panics: The Creation of the Mods and Rockers* (London, 1972).
[71] Stanley Cohen, *Visions of Social Control: Crime, Punishment and Classification* (Cambridge, 1985).

whether social control had broken down, and lack of a 'yardstick' by which to measure when social control had been successfully (re)imposed.[72]

In addition to problems with lack of specificity, social control theory also assumes a top-down, explanatory schema of historical change, seeing the development of institutions as imposed by, and serving, particular (often elite) social groups. Even in revisionist accounts which are not just focussed on the psychiatric profession or a vague 'middle class' elite, sane family members, magistrates, and local governmental bodies remained the objects of research – different elite groups, but elite groups nonetheless. In these accounts, institutions were argued to have been used by privileged groups to control behaviour which they found to be problematic. These accounts could not explain the ways in which patients, inmates, pupils, etc., experienced, negotiated, understood, or resisted the institutions which were intended to control them. As the limits of social control theory were reached in attempting to explain and understand the development of new forms of institutions during the nineteenth century, sociologists and historians began to look at these developments from a different angle; to pursue medical history from below, restoring not only patients' voices and experiences to the histories of these institutions, but also patients' agency.

2.4 The Agentive Turn

The limitations of the explanatory power of social control theory pushed scholars to look for new ways in which institutional history could be approached. Sociologists and historians of the social control school totally disregarded the individual, seeing them as 'devoid of any initiative or control, striving to goals set for them, along strictly predetermined paths, guided by values and following norms imposed on them from above.'[73] This change in the focus of scholarship must also be seen, at least in part, as a reaction to the work of Michel Foucault. For many, Foucault's work was problematic precisely because of its implications for human agency.[74] In Foucault's work, power is so pervasive as to leave, apparently, very little room

[72] Gareth Stedman Jones, 'Class Expression versus Social Control? A Critique of Recent Trends in the Social History of "Leisure"', *History Workshop,* 4 (1977), 162-70.
[73] Piotr Sztompka, *Society in Action: The Theory of Social Becoming* (Chicago, IL, 1991), p. 53.
[74] Sandra Lee Bartky, 'Subjects and agents: the question for feminism', in Judith Kegan Gardiner (ed.), *Provoking Agents: Gender and Agency in Theory and Practice* (Chicago IL, 1995), pp. 194-207; David Couzens Hoy, *Foucault: A Critical Reader* (Oxford, 1986).

for agency.[75] His work never explains how power is enforced, nor does he explore the processes of resistance that he identifies as being present in opposition to power. This argument has been critiqued by a number of scholars who suggests that the circularity of Foucault's argument is 'a form of theoretical overtotalization'.[76]

Others, however, have argued that Foucault's theory of power does allow for the possibility of human agency, since power in Foucault's framework is dynamic, and thus agency and power operate in a dialectical relationship.[77] This reading of Foucault has influenced much of the analysis undertaken in this thesis. The notion of power and agency as operating in a productive relationship is most apparent in Foucault's later work.[78] However, as Laura Ahearn points out, his emphasis is focussed far more on the manifestations of power through discourses, than on how the agency of human actors operates.[79] Consequently, agency remains largely absent in Foucault's accounts. Yet, in his works on power, Foucault's analysis of the relationship between the powerful and the marginalized does offer a way to think about agency. This entry point is important in discussions of agency in the context of power relationships in the asylum in the following chapters. This reading of Foucault was not particularly widespread during the 1970s-90s, with the 'Foucault of discipline' being far more influential than the 'Foucault of power'.[80] Given the pervasiveness of this reading of Foucault, it is perhaps unsurprising that it was not to his works that researchers turned when seeking to move away from social control analyses.

Initial responses to the over-emphasis on social structures in social control theory was a sharp turn in the opposite direction, a turn towards human agency which emphasized individual autonomy above all else; so-called 'micro-theories' of society.[81] The emergence of

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[75] Michel Foucault, *The History of Sexuality,* Vol. I (trans.), Robert Hurley (London: Allen Lane, 1979).
[76] Edward Said, *The World, the Text, and the Critic* (Cambridge, MA, 1983), discussed in Laura M. Ahearn, 'Language and Agency', *Annual Review of Anthropology*, 30, (2001) p. 118.
[77] Daniel T. O'Hara, *Radical Parody: American Culture and Critical Agency After Foucault* (New York, 1992); David M. Halperin, *Saint Foucault: Towards a Gay Hagiography* (New York, 1995).
[78] Michel Foucault, *Psychiatric Power: Lectures at the College de France, 1973-1974* (ed.), Jacques Lagrange, (trans.), Graham Burchell (Basingstoke, 2008).
[79] Ahearn, 'Language and Agency', p. 117.
[80] John Haslam, *Fitting Sentences: Identity in Nineteenth- And Twentieth-Century Prison Narratives* (Toronto, 2005), pp. 10-11
[81] Piotr Sztompka, 'Introduction', in Piotr Sztompka (ed.), *Agency and Structure: Reorienting Social Theory* (Abingdon, 2015), p. xii.

such a drastic revisionism clearly reflected the prevalent discontent with the emphasis on structure propounded by social control theorists.[82] Whilst, of course, there is no room to deny that human action occurs within a field delimited by structures, 'a purely constraint-based theory, without attention to either human agency or to the processes that produce and reproduce those constraints – social practices – was coming to seem increasingly problematic'.[83] Equally, however, theories which emphasized human agency at the expense of accounting for structures were similarly insufficient, sacrificing any analysis of structures to focus solely on the 'microsociology of interpersonal interaction'.[84] This over-emphasis on agency can be seen in the work of practitioners of 'interactionism' such as Erving Goffman.[85] Practice theory thus emerged as an attempt to address the absence of human actors common to structuralist accounts, whist still accounting for social structures. They did this by suggesting that there was a dialectical relationship between social actors and social structures.[86] Social actors were still understood to be subject to constraints, yet in this dialectical framework, social structures were equally understood to be susceptible to the influence of social actors.[87] Thus, practice theory offered a potential solution to the problems created by structuralism; it restored social actors to historical processes without losing sight of the larger social structures in which actors operated. Practice theory, therefore, was highly influential in shaping the nature of the agentive turn.

Why did academics become so concerned with restoring human agency to historical and sociological accounts at this time? Ellen Messer-Davidow reflected on the agentive turn

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[82] J. C. Alexander, 'The New Theoretical Movement', in Neil J. Smelser (ed.), *Handbook of Sociology* (Newbury Park, CA, 1988) pp. 77-102.
[83] Sherry B. Ortner, *Anthropology and Social Theory: Culture, Power, and the Acting Subject* (Durham, NC: Duke University Press, 2006) p. 2.
[84] Ortner, *Anthropology and Social Theory*, p. 2.
[85] Erving Goffman, *The Presentation of the Self in Everyday Life* (New York, 1959); Erving Goffman, *Interaction Ritual: Essays on Face-to-Face Behaviour* (New York, 1967).
[86] Pierre Bourdieu, *Outline of a Theory of Practice* (trans.), Richard Nice (Cambridge and New York, 1977); Anthony Giddens, *Central Problems in Social Theory: Action, Structure, and Contradiction in Social Analysis* (Berkeley and Los Angeles, CA, 1979).
[87] The emergence of synthesized accounts of the relationship between structure and agency can be seen in, Pierre Bourdieu, *The Logic of Practice* (trans.), Richard Nice (Stanford, CA, 1990); Jeffrey C. Alexander, *Theoretical Logic in Sociology.* Vols 1-4, (Abingdon, 2014); Anthony Giddens, *The Constitution of Society: Outline of the Theory of Structuralism* (Cambridge, 1986); Anthony Giddens, *Social Theory and Modern Sociology* (Cambridge, 1987); Margaret Archer, *Culture and Agency: The Place of Culture in Social Theory* (Cambridge, 1988).

in scholarship in a range of disciplines.[88] She suggested that to understand the increasing preoccupation with questions of agency, we must look to wider social movements, as well as theoretical debates. Laura Ahearn identifies the theoretical limitations of structuralist and post-structuralist explanations as key in driving the turn to agency, however, she also highlights the importance of the wider social and political climate in which academia is situated. Just as the social control theorists of the 1970s and 1980s were driven to explain the emergence and nature of the explosion of an institutional landscape through the nineteenth century by contemporary political concerns with patients' rights, prisoners' rights etc., so too was the agentive turn spurred on by the political climate in which it emerged.[89] Indeed, concern with the limits of neoliberalism in general, and what is perceived widely as the failure of 'care in the community' initiatives, have shaped the interests of recent institutional scholarship and its focus on inmate experience and inmate agency.

Initial scholarship influenced by the turn towards investigating the agency of subaltern groups, including patients, prisoners, pupils, and inmates, focused on agency as *oppositional* to institutional authority. This can also be seen in scholarship on gender, in which female resistance to patriarchal societies is framed as oppositional to patriarchal dominance.[90] Likewise, scholarship on other forms of economic and social oppression also tend to frame agency as synonymous with resistance or protest.[91] Partly this was the result of the degree of influence exerted by practice theory in explaining the dialectic relationship between social actors and social structures. This can be seen clearly in Giddens' concept of the 'dialectic of control', which holds that the structural systems which constrain actors are necessarily imperfect because the actors have agency and therefore find ways to resist those structures.[92] This tendency to emphasize resistance above any other manifestation of agency was fuelled by the fact that dramatic moments of resistance were most frequently linked with the production of historical change. In other words, we see the impact of social actors upon social structures most starkly at points in history when those actions produce noticeable

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[88] Ellen Messer-Davidow, 'Acting Otherwise', in Gardiner (ed.), *Provoking Agents*, pp. 23-51.
[89] Ahearn, 'Language and Agency', pp. 109-10.
[90] Nancy Fraser, 'Introduction: Revaluing French Feminism', in Nancy Fraser and Sandra Lee Bartky (eds.), *Revaluing French Feminism: Critical Essays on Difference, Agency, and Culture* (Bloomington IN, 1992), pp. 1-24.
[91] For example, Marc Pruyn, *Discourse Wars in Gotham-West: A Latino Immigrant Urban Tale of Resistance and Agency* (Boulder CO, 1999).
[92] Giddens, *Central Problems in Social Theory*.

changes within or to those structures. Such an understanding of agency, as we shall see, is enormously problematic when discussing the strategies of subaltern groups, among whom big moments of protest and resistance are relatively rare. Yet such moments are the type of actions which have been considered as evidence of the agency of subaltern groups such as the inmates of institutions, the peasantry, or the natives of colonized countries.[93] This picture was reinforced by the archival materials available – official records of rebellions provided more detail of the activities of subaltern groups when they constituted a threat to the status quo. Yet, scholarship from the 1990s began to observe that this framework was insufficient for understanding the majority of actions that were constitutive of the agency of marginalized groups.

In his study of the Malaysian peasantry, James Scott observed that outright rebellions and revolutions were rare. When they did occur, they were usually crushed unceremoniously by state powers. Furthermore, the circumstances conducive to producing such overt rebellions manifested themselves infrequently, and often they achieved very little. The more common outcome of rebellions was the reassertion of the status quo through even more coercive mechanisms. For these reasons out-and-out protests, rebellions, revolutions etc. are uncommon occurrences. Yet, according to Scott, this was not symptomatic of a passive peasantry, rather it was a calculated strategy whereby peasants chose to resist oppressive elites through the adoption of low-key strategies. Scott argues that in previous works:

> the emphasis on peasant rebellion was misplaced. Instead, it seemed far more important to understand what we might call *everyday* forms of peasant resistance – the prosaic but constant struggle between the peasantry and those who seek to extract labor, food, taxes, rents, and interest from them. Most of the forms this struggle takes stop well short of collective outright defiance. Here I have in mind the ordinary weapons of relatively powerless groups: foot dragging, dissimulation, false compliance, pilfering, feigned ignorance, slander, arson, sabotage, and so forth.[94]

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[93] For examples, Barrington Moore, *Social Origins of Dictatorship and Democracy: Lord and Peasant in the Making of the Modern World* (London, 1967); Jeffrey M. Paige, *Agrarian Revolution: Social Movements and Export Agriculture in the Underdeveloped World* (New York, 1975); Eric R. Wolf, *Peasant Wars of the Twentieth Century* (New York, 1969); Samuel L. Popkin, *The Rational Peasant: The Political Economy of Rural Society in Vietnam* (Berkeley, CA, 1979).

[94] James C. Scott, *Weapons of the weak: Everyday forms of resistance* (New Haven, CT, 1985) pp. 28-31.

These everyday forms of resistance were, according to Scott, far more common and perhaps even more effective than the big, loud, moments of revolution that are emphasized by the official archive. Scott emphasizes the importance of these everyday acts of resistance to peasant survival strategies. Such an understanding of resistance as agency is far more appropriate for illuminating the ways in which poor, disenfranchised, powerless groups, who operate outside of power structures, negotiate the world to make their situations tenable. By broadening our definition of resistance in this way, we are able to understand protests which characterize subaltern agency.

Research into the workings of the Poor Law in England highlighted similar strategies of resistance amongst paupers who adopted a range of tactics to negotiate access to relief from their parishes. The agency of paupers has been highlighted in a range of studies of the Poor Law, in particular the ability of individuals to obtain relief through bargaining, asserting their rights, appealing to the humanitarian impulses of Overseers or making reference to traditional entitlements have been highlighted as strategies through which the poor could influence the assistance they received. Pauper letters have provided a particularly rich vein of evidence of the agentive capacity of the English poor, revealing their ability to deploy sophisticated rhetorical tactics to enhance their chances of their petitions being answered favourably.[95] Paupers also made appeals in person, turning up at the door of the overseer or occupying places within the parish community to publicly make their appeals.[96] More recently, work on the sick poor by Steven King has demonstrated the capacity of this subset of the English poor to exercise agency. They secured financial assistance during times of financial difficulty occasioned by ill-health through writing letters to overseers which

[95] Thomas Sokoll, *Essex Pauper Letters 1731-1837* (Oxford, 2001); James Taylor, 'Voices in the Crowd: The Kirkby Lonsdale Township Letters, 1809-1836', in Tim Hitchcock, Peter King and Pamela Sharpe (eds.), *Chronicling Poverty: The Voices and Strategies of the English Poor, 1640-1840* (Basingstoke, 1997), pp. 109-26; Steven King, Thomas Nutt and Allanah Tomkins, *Narratives of the Poor in Eighteenth Century Britain* (London, 2006).
[96] Steven King and Peter Jones, 'Testifying for the Poor: Epistolary Advocates and the Negotiation of Parochial Relief in England, 1800-1834', *Journal of Social History*, 49(4) (2016), 784-807; Steve Hindle, 'Destitution, Liminality and Belonging: The Church Porch and the Politics of Settlement in English Rural Communities, c.1590-1660', in Christopher Dyer (ed.), *The Self-Contained Village? The Social History of Rural Communities, 1250-1900* (Hatfield, 2006), pp. 46-71.

appealed for assistance with living costs, funeral costs, treatment costs and so on through a range of rhetorical strategies.[97]

Despite the utility of this work on the labouring poor in moving scholarship beyond narrow definitions of what actions constitute resistance, such work has not addressed whether types of action other than resistance might also constitute agency in relation to marginalized groups. Such scholarship maintains a dichotomy of domination and resistance which has been critiqued by scholars who, 'regard its dualistic structure as a limited product of modernist, essentialist, masculinist, or Eurocentric thought'.[98] Such conceptualizations of power relations have also been criticized for their assumption of power as static and reactive, rather than dynamically practised by particular people, in particular societies, at specific times in history.[99] Ahearn suggests that this tendency towards framing agency and protest as one and the same thing can be explained with reference to the social and political implications of scholarship which tells the histories of oppressed, minority groups. Such work aims to establish the seriousness and pervasiveness of the systems keeping subaltern groups oppressed, whilst also seeking to inspire such groups to activism.[100] Consequently, in the work of some scholars, 'instead of a balance between these two countervailing tendencies, there is an overemphasis on resistance'.[101] Often, this results in scholars, 'romanticizing resistance'.[102] This equation of agency and opposition shoe-horns historical actors into two categories: they either resist, or they are victims. This dichotomy ignores the complexities of agency, which, as Arlene MacLeod points out, can manifest as resistance, protest, accommodation, retreat or acceptance, or often a combination of these strategies at the same time.[103]

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[97] Steven King, *Sickness, Medical Welfare and the English Poor, 1750-1834* (Manchester, 2018).
[98] Eleanor Conlin Casella, *The Archaeology of Institutional Confinement* (Gainesville, 2007), p. 72.
[99] Lu Ann De Cunzo, 'Reform, Respite, Ritual: An Archaeology of Institutions: the Magdalen Society of Philadelphia, 1800-1850', *Historical Archaeology*, 29(3) (1995), 1-168; Conlin Casella, *The Archaeology of Institutional Confinement,* p. 72.
[100] Ahearn, 'Language and Agency', pp. 115-16.
[101] Ahearn, 'Language and Agency', p. 115.
[102] Lila Abu-Lughod, 'The Romance of Resistance: Tracing Transformations of Power through Bedouin Women', *American Ethnologist*, 17(1), 41-55.
[103] Arlene MacLeod, 'Hegemonic Relations and Gender Resistance: The New Veiling as Accommodating Protest in Cairo', *Signs*, 17(3) (1992), 533-57.

Mary Jo Maynes points out that theories that homogenize agency and resistance are inadequate for understanding the role of subaltern groups in historical processes. In relation to her study of girls, which seeks to understand the roles of female children as historical actors, Maynes found that the usual understandings of agency and power simply did not apply. The conflation of agency and resistance, in Mayne's view, stems from the inadequacies of common understandings and assumptions about historical agency: 'Thinking about girls as historical agents goes right to the heart of the contradictions in modern conceptualizations of individual agency as epitomized by rational choice models'.[104] We must, argues Mayne, broaden our understanding of what it is we mean by agency. If we only understand the agency of groups external to societal power structures through big, public moments of protest and resistance, then we cannot possibly understand the agency of groups such as children, women and, indeed, asylum patients. This thesis, therefore, seeks to build on these theorizations of human agency in order to provide an account of the agency of asylum inmates that moves beyond the dichotomy of domination and resistance.

2.5 The Agentive Turn in Institutional Histories

Interest in the ability of patients to influence their experience of asylum life has its roots in earlier work which responded to Porter's call to write a history of insanity from the point of view of the mad.[105] Ascertaining patients' feelings and experiences of the asylum and of madness presented considerable challenges due to the sparse volume of patient accounts of their experience.[106] Some historians overcame this by building a profile of the asylum patient by compiling information about admission, discharge, treatment and diagnoses in particular institutions.[107] Others were more concerned with subjective experiences and therefore turned to the accounts provided by patients of their time in asylums. Such accounts paid particular attention to the subjective experiences of madness that individuals expressed in their writings, often taking a biographical approach to this issue.[108] Others have worked with the

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[104] Mary Jo Maynes, 'Age as a Category of Historical Analysis: History, Agency and Narratives of Childhood', *Journal of the History of Childhood and Youth,* 1(1) (2008), p. 116.
[105] Porter, 'The Patient's View'.
[106] Joseph Melling and Bill Forsythe (eds.), *The Politics of Madness: The State, Insanity and Society in England 1845-1914* (London and New York, 2006).
[107] Melling and Forsythe (eds.), *The Politics of Madness.*
[108] Stanley W. Jackson, *Melancholia and Depression: From Hippocratic Times to Modern Times* (New Haven, CT and London, 1986); Michael MacDonald, 'The "Fearefull Estate" of

autobiographical writings of individuals who had been patients in asylums in order to explore their perspectives.[109] Such work provided key insight into the ways in which asylumdom and madness was experienced by individuals from the upper strata of society. As discussed above, historians concerned to consider the experience of the lower classes, who populated county asylums, turned to casebooks and letters in order to understand how insanity and asylum care was experienced by non-elites, who left behind little in the way of autobiography.[110] Material culture and archaeological studies have been employed by some scholars to gain insight into patient experiences of institutional life.[111] Using this wide range of sources, scholars have moved beyond the idea of patients as passive recipients of asylum treatment, and instead have begun to take seriously the role of the patient in shaping the medical encounter and institutional environment in which they were confined.

Several historians have explored patient agency in the asylum, however, very few studies have moved beyond equating agency with resistance. Such studies provide valuable insight into how patient agency operated in opposition to medical authority, and this thesis seeks to build on these works in order to provide a comprehensive picture of the relationship between agency and authority in the asylum. Louise Hide has argued that patients were able to exercise agency in relation to certain areas of asylum life. Hide identifies refusals to work, non-attendance at Church services, verbal expressions of resistance, and patient petitions in Claybury Asylum as evidence of patient agency.[112] Work by Katherine Rawling has sought to interrogate the degree to which asylum photography, a tool which has previously been understood as a technology of control, could be a mechanism for patient agency.[113] She

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Francis Spira: Narrative, Identity and Emotion in Early Modern England', *Journal of British Studies*, 31(3) (1992), 32- 62; Roy Porter, '"The Hunger of Imagination": Approaching Samuel Johnson's Melancholy', in Bynum, Porter and Shepherd (eds.), *The Anatomy of Madness*, Vol. 2 (London, 1985), pp. 62-88.

[109] Porter, *A Social History of Madness*; Helen Nicolson, 'Introduction', in Roy Porter, Helen Nicolson, and Bridget Bennett (eds.), *Women, Madness and Spiritualism,* 2 Vols (London and New York, 2003), pp. 139-56; Herman Merivale, *My Experiences in a Lunatic Asylum by a Sane Patient* (London, 1879).

[110] Andrews, 'Case Notes, Case Histories'; Beveridge, 'Life in the Asylum'; Coleborne, 'Families, Patients and Emotions'; Wannell, 'Patients' Relatives and Psychiatric Disorders'; Smith, '''Your Very Thankful Inmate'".

[111] Suzanna M. Spencer Wood and Sherene Baugher, 'Introduction and Historical Context for the Archaeology of Institutions of Reform. Part I: Asylums', *International Journal of Historical Archaeology,* 5(1) (2001), 3-17.

[112] Hide, *Gender and Class*.

[113] For discussion of photography as a technology of control and classification see, Sander Gilman, *The Face of Madness: Hugh W. Diamond and the Origin of Psychiatric*

argues that through the adoption of poses, smiling or even refusing to sit for a photograph, patients were able to exercise agency in this particular area of asylum life. Rawling highlights that patient agency was as evident in decisions to actively participate in the photographic encounter, as in instances where patients refused to be photographed.[114] Hamlett and Hoskins draw on the material culture of the asylum to investigate patient agency. Examination of patient clothing reflected how patient agency could be expressed through the customization of asylum uniforms.[115] In a further work, which focuses on asylums, schools, and hostels, Hamlet explores how the material worlds of these institutions could facilitate or limit the agency of those living within them. The ways in which residents could adapt, customize, or repurpose the physical world of these facilities is explored to assess the degree to which it was possible to find a sense of home in such institutions.[116]

Archaeological approaches to institutional studies have been particularly influential in suggesting potential methods of recovering the agency of the incarcerated. Eleanor Conlin Casella has used archaeological evidence from nineteenth- and twentieth-century American institutions including prisons, almshouses, Magdalen asylums and prisoner of war camps to understand how inmates used objects to engage in small acts of self-management or resistance in the institution.[117] Other archaeological studies have also concerned themselves with understanding the agency of inmates through the material remains of carceral institutions. Lu Ann De Cunzo's study of Magdalen Asylums in Philadelphia explores the ways in which the materiality of the institution was used in ritualistic ways to reform wayward women. De Cunzo highlights the strategies with which women resisted internalizing the idealized version of nineteenth-century womanhood which the institution sought to inculcate in them.[118] Several studies of prisons have highlighted the significance of material culture to inmates' coping strategies, particularly in relation to the existence of illicit trading networks which allowed inmates to form social bonds, cement social groupings, and access items to make their imprisonment more comfortable.[119] Investigations of concentration

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Photography (New York, 1976); John Tagg, *The Burden of Representation: Essays on Photographies and Histories* (Basingstoke, 1988).

[114] Katherine Rawling, 'Visualising Mental Illness: Gender, Medicine and Visual Media, c.1850–1910' (Unpublished PhD Thesis, University of London, 2011).

[115] Hamlett and Hoskins, 'Comfort in Small Things?', 93-114.

[116] Hamlet, *At Home.*

[117] Conlin Casella, *The Archaeology of Institutional Confinement*.

[118] De Cunzo, 'Reform, Respite, Ritual', 1-168.

[119] For examples of studies of inmate subcultures see, Vergil L. Williams and Mary Fish, *Convicts, Codes, and Contraband: The Prison Life of Men and Women* (Cambridge, 1974);

camps have similarly demonstrated the importance of material culture to inmate coping strategies, and maintenance of a sense of personhood.[120]

Increased attention to inmate agency can also be seen in historical studies of nineteenth and twentieth century institutions other than the asylum. David Green has investigated the ways in which London workhouse inmates resisted the institution through a range of tactics. Green highlights the significance of inmate actions which damaged property, and also the importance of appeals made by paupers through official channels to complain about aspects of institutional life.[121] Anna Clark has investigated the strategies adopted by female paupers to resist elements of workhouse life in nineteenth-century Ireland.[122] Tamara Myers and Joan Sangster have investigated twentieth-century girls reformatory schools in Canada to explore how the girls who were sent there could resist these institutions. From refusing to behave as expected during the court hearings that would decide whether they would be sent to such schools, rioting and running away, female pupils of reform schools had a range of tactics with which to resist institutional agendas.[123] Again, much of the work which has sought to investigate agency draws attention to important elements of inmate resistance, but stops short of investigating other manifestations of agency.

David R. Bush, 'Interpreting the Latrines of the Johnson's Island Civil War Military Prison', *Historical Archaeology,* 34(1) (2000), 62-78; Eleanor Conlin Casella, '"Doing Trade": A Sexual Economy of Nineteenth-century Australian Convict Prisons", *World Archaeology,* 32(2) (2000), 209-21.

[120] Adrian T Myers, 'Between Memory and Materiality: An Archaeological Approach to Studying the Nazi Concentration Camps', *Journal of Conflict Archaeology,* 4(1-2) (2008), 231-45; Myers, 'The Things of Auschwitz', in Adrian Myers and Gabriel Moshenska (eds.), *Archaeologies of Internment* (New York, 2011), pp. 75-88; Johanna Bergqvist Rydén, 'When Bereaved of Everything: Objects from the Concentration Camp of Ravensbrück as Expressions of Resistance, Memory, and Identity', *International Journal of Historical Archaeology,* 22(3) (2017), 1-20.

[121] David Green, 'Pauper Protests: Power and Resistance in Early Nineteenth-century London Workhouses', *Social History,* 31(2) (2006), 137-59.

[122] Anna Clark, 'Wild Workhouse Girls and the Liberal Imperial State in Mid-Nineteenth Century Ireland', *Journal of Social History,* 39(2) (2005), 389-409.

[123] Tamara Myers and Joan Sangster, 'Retorts, Runaways and Riots: Patterns of Resistance in Canadian Reform Schools for Girls, 1930-60', *Journal of Social History,* 34(3) (2001), 669-97.

2.6 Conclusion

This thesis seeks to establish a broader framework through which to approach patient agency to explore the role of asylum patients in medical history. Resistance will be explored as one particular mode of agency, alongside analysis of other agentive mechanisms. The first chapter deals with patient protests, the second with the adoption of coping mechanisms by patients, and the third examines strategies adopted by patients to actively engage with institutional life. These three categories of agency allow for a more comprehensive understanding of the responses of institutional populations to their confinement, however, they are not exhaustive. These categories often overlapped in patient strategies, and individuals frequently demonstrated all three 'types' of agency in particular combinations, or at different points in their institutional 'career', in response to different circumstances that arose. As Ortner points out, motivations are always complex and contradictory, and the idiosyncrasies of patient agency are addressed throughout this thesis.[124] The final two chapters of this thesis address the complex nature of patient agency through an exploration of the relationship between the material world of the institution and patient agency. The ways in which categories of agency overlapped in patient strategies for negotiating the asylum are highlighted through a discussion of space and material culture.

Through understanding more fully how patients exercised agency in the institution, this thesis also seeks to explore how patient agency influenced the development of the asylum. Returning to the idea of a dialectical relationship between agency and structure, this thesis will attempt to show that the interaction of patient agency with asylum authority produced changes in institutional structures. The efforts of the asylum authorities to respond to or cope with expressions of individual agency in a large institution had important implications for the development of the institution. Institutional regulations and practices were not just shaped by the personalities of asylum doctors and staff, psychiatric theory, or the influence of local or national policy makers. Rather, many policies adopted 'on the ground' were responses to issues that arose from the day-to-day practicalities of managing a group of highly problematic individuals in a large, ill-funded institution. Through understanding how patients exercised agency in the asylum, not only will patient responses to institutional life be better understood, but through examining the relationship between patient

[124] Sherry B. Ortner, 'Resistance and the Problem of Ethnographic Refusal', *Comparative Studies in Society and History*, 37(1) (1995), 173-93.

agency and asylum authority, the strategies employed to manage patients will also be further illuminated.

3. Methodology

3.1 Categories of Agency

In the previous chapter, the limitations of social control theory as an explanatory schema for the development of asylum treatment were set out, and the potential of the agentive turn in adding to understandings of Victorian asylums was highlighted.[1] The caveat to this was that the nature of the agency of subaltern groups, including asylum patients, must be carefully defined if it is to provide a useful analytical lens. It was suggested that scholarship which narrowly defines agency as synonymous with resistance is limited in its ability to account for the agency of marginalized social groups.[2] Indeed, the agency of such groups is more complex than this binary model allows for.[3] Instead, it is suggested that a model of agency which includes resistance, coping mechanisms, and assent is more appropriate, and effective, in exploring the agency of asylum patients. These three 'categories' of agency form the framework through which this thesis explores the relationship between agency and authority in Lancaster Asylum.

These categories of agency are central to the methodology of this thesis, and as such it is necessary to explore each more thoroughly to provide necessary context for the remainder of this chapter. Though I have set out to move away from conflating agency with protest, it is still important to consider acts of resistance as agency alongside these other types of behaviour. Actions characteristic of resistance are those which deliberately or knowingly contravene the rules of the institution. Resistance might include actions such as refusing to work, refusing to submit to medical examinations or attempting to run away.[4] Coping

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[1] Edwin R. Wallace, 'Historiography, Philosophy and Methodology or History, with Special Emphasis on Medicine and Psychiatry; and an Appendix on "Historiography" as the History of History', in Edwin R. Wallace and John Gach (eds.), *History of Psychiatry and Medical Psychology: With an Epilogue on Psychiatry and the Mind-Body Relation* (New York, 2008), pp. 3-16.

[2] There is a great deal of discussion of resistance as agency in institutions e.g., Green, 'Pauper Protests'; Clark, 'Wild Workhouse Girls'; Myers and Sangster, 'Retorts, Runaways and Riots'.

[3] Scott, *Weapons of the weak*; Pruyn, *Discourse Wars*; for a critique of equating agency with resistance see, Ahearn, 'Language and Agency', pp. 115-16.

[4] Work in other areas of social history highlight the broad range of actions constitutive of the protests of marginal groups, see for example, R. C. Cobb, *The Police and the People: French*

mechanisms are defined as actions which were undertaken by the patient to feel more comfortable within the asylum.[5] They are actions which were tolerated, if not necessarily encouraged, by the asylum authorities. They usually endeavoured to make the patients' life more comfortable, or confinement easier, and might include behaviours such as forming relationships, requesting a particular work assignment, or customizing clothing. Actively engaging with the regime looked rather different than undertaking coping mechanisms. Examples of this include refusing to leave the asylum, asking for medication or a particular type of treatment, or endeavouring to uphold the rules of the institution by reporting another patient's misbehaviour.[6]

These categories of patient agency are, of course, an artificial device which provide a framework through which a broader understanding of patient agency can be reached. As will be apparent throughout this thesis, these categories often overlapped, and many patients employed more than one mechanism of agency during their stay in the institution. The type of agency pursued by patients depended on a range of factors including their mental state, how long they had been in the asylum, the state of their relationships within the institution, recent events including receiving visitors, letters, or a medical examination, or any given patient's personal preferences, tolerances, and beliefs. For example, Thomas P., a patient admitted to Lancaster Asylum for the second time in 1870 due to the recurrence of his melancholia, began his time in the institution assenting to his treatment. In fact, Thomas himself had sought readmission to the institution when he noticed that his melancholic symptoms had returned.[7] After a little over a month in the asylum, Thomas commenced a number of unsuccessful escape attempts when his requests to be discharged were not met.[8] This case demonstrates that one patient could exercise agency through assent, and through resistance at different points in his asylum career. Even individual behaviours may not clearly fit neatly

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Popular Protest, 1789-1820 (London and New York, 1970); Michael Adas, 'From Avoidance to Conscription: Peasant Protest in Precolonial and Colonial Southeast Asia', *Comparative Studies in Society and History*, 23(2) (1981), 217-47; Scott, *Weapons of the Weak*; Green, 'Pauper Protests'.

[5] E. Gallo and V. Ruggiero, 'The Immaterial Prison: Custody as a Factory for the Manufacture of Handicaps', *International Journal for the Sociology of Law*, 19 (1991), 273-91; Alison Liebling, 'Prison Suicide and Prisoner Coping', *Crime and Justice*, 26 (1999), 283-359.

[6] Susan A. Miller, 'Assent as Agency in the Early Years of the Children of the American Revolution', *Journal of Childhood and Youth*, 9(1) (2016), 48-65.

[7] LA, HRL/4/12/2/4, 21 Jul 1868-8 Dec 1870, p. 223.

[8] LA, HRL/4/12/2/4, 21 Jul 1868-8 Dec 1870, p. 223.

into one category of agency. For example, in an incident in which a patient chiselled the back of a door, we might understand this behaviour as resistance, or as a coping mechanism.[9] This action might be considered a manifestation of resistance since it damaged the fabric of the asylum, causing cost to the institution. On the other hand, it might be considered a coping mechanism, a means of expressing individuality or personalizing surroundings.[10]

If these categories are so artificial, why employ such a framework at all? Firstly, without moving towards a broader definition of agency, scholarship concerned with relationships between dominant and marginalized social groups will remain limited. Marginal groups frequently exercise agency in ways which do not directly challenge hegemonic powers, rather they adopt low-key strategies which allow them to survive in the existing framework, rather than overthrowing it entirely.[11] Secondly, the three categories of agency set out in this thesis encompass different types of action, that were employed for different reasons. As such, examining different categories facilitates insight into why particular strategies were selected. This approach allows a better integration of analysis of agency and structure, avoiding the pitfalls of an interactionist approach.[12] This approach also provides an opportunity to understand how asylum authorities responded to different types of agency. As will be demonstrated, asylum authorities saw some manifestations of agency as positive, or tolerable, whilst others were viewed as subversive. To understand how the interaction between asylum authority and patient agency shaped the practice of treating insanity, it is important to understand how the medical profession reacted to different patient behaviours. Finally, the categories of agency suggested here potentially provide a framework with which agency and authority can be approached in a variety of settings. The theoretical issues in current scholarship on the agency of marginalized groups are not unique to institutional studies.[13] As such, beginning a discussion about an analytical framework through which to understand responses of marginalized groups to dominant powers has broader applications in social history.

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[9] For example, Thomas C. W.'s case notes record that 'the door of his single bedroom…bore marks of having been cut with some sort of knife…', LA, HRL/4/12/2/2, 12 Apr 1865-2 Feb 1867, p. 61.
[10] Nicholas Saunders, *Trench Art: Materialities and Memories of War* (Oxford, 2003).
[11] Scott, *Weapons of the Weak*.
[12] For a critique of micro-sociological approaches see, Ortner, *Anthropology and Social Theory*, p. 2.
[13] Feminist scholarship has long dealt with questions of agency, see for example, Patricia S. Mann, *Micro-politics: Agency in a Postfeminist Era* (Minneapolis, MN and London, 1994).

3.2 Methodological Challenges of Asylum Casebooks

While some asylum patients wrote diaries and letters, generally the histories of poor asylum patients can rarely be approached through sources written by the patients themselves.[14] Instead, we encounter them through medical records written *about* them – casebooks. Jonathan Andrews suggests that casebooks 'provide the surest basis we have for understanding the changing nature of the experience of the insane in asylums since 1800'.[15] Indeed, studies such as Allan Beveridge and Michael Barfoot's investigation of the Royal Edinburgh Asylum demonstrate the potential of casebooks to paint rich pictures of the interior life of these institutions. However, despite their utility, case records present significant challenge to historians seeking to write medical history 'from below'. These difficulties are two-fold: 1) casebooks present significant challenges for recovering patient voice through documents that were not written by them; and, 2) casebooks constitute a significant undertaking for the historian to analyse in terms of their volume.

Several scholars, most notably Michel Foucault, have stressed that case notes leave out important components of the clinical encounter.[16] When writing case notes, doctors chose what to include and exclude, and as studies of Freudian case histories have demonstrated, such selectivity is distorting.[17] Discrepancies between published and unpublished case records of Anna O. have demonstrated the degree of physician selectivity involved in the production of medical histories.[18] Kerry Davies argues that very little of patient speech would have been recorded in casebooks, leading her to a pessimistic conclusion as to the utility of case notes in approaching patients' perspectives on the asylum.[19] Andrews points out that the accuracy of case histories may be also be questionable due to inaccuracies caused by medical

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[14] Porter, 'The Patient's View', 175-98; Porter, *Mind-Forg'd Manacles*; Porter, *A Social History of Madness*; Dale Peterson (ed.), *A Mad People's History of Madness* (Pittsburgh PA, 1982).
[15] Andrews, 'Case Notes,' p. 255.
[16] Michel Foucault, *Discipline and Punish: The Birth of the Prison* (trans.), Alan Sheridan (London, 1979); Arthur Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition* (New York, 1988)*;* Brian Hurwitz, 'Form and Representation in Clinical Case Reports', *Literature and Medicine,* 25 (2006), 216-40.
[17] Frank J. Sulloway, 'Reassessing Freud's Case Histories. The Social Construction of Psychoanalysis', *Isis,* 82(312) (1991), 245-75.
[18] Mark S. Micale, 'Henri F. Ellenberger: The History of Psychiatry as the History of the Unconscious', in Micale and Porter (eds.), *Discovering the History of Psychiatry,* pp. 112-34.
[19] Kerry Davies, '"Silent and Censured Travellers"'? Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine,* 14(2) (2001), 267-92.

incompetence, or the reluctance of families or patients to be forthcoming with doctors.[20] Scholars have expressed concern that casebooks may tell us more about psychiatric preoccupations, or the development of asylum medicine, than patient experiences. On the other hand, the presence of both patients' case histories and medical preoccupations in one document has proved valuable for some scholars, who have used case notes to trace power relations in the asylum.[21] As Andrew Scull points out, despite their limitations, case notes enable historians to research the practice of psychiatric treatment in the asylum rather than dealing in the ideals, claims, and theory of published literature.[22] Indeed, case notes have been used to create richly detailed accounts of the day-to-day regimes of institutional worlds.[23]

We must also bear in mind that casebooks were written for external, as well as internal, audiences. This may have led to censorship and selectivity of recording to cast the asylum in a positive light. However, it may also make casebooks more reliable in some ways. Case notes were intended to provide protection for the asylum and its staff from law suits and they had to be available to external government bodies such as the Commissioners in Lunacy.[24] This means that we can be reasonably well assured that the testimony, behaviour and actions of patients is an accurate record. The main problem with casebooks centres on selectivity, whether that selectivity was what families told doctors, what patients revealed, and what doctors chose to write down. Due to this selectivity, it is imperative to read casebooks in light of contemporary medical beliefs and practices regarding insanity, as well as contemporary popular beliefs, given the importance of patients and family members in constructing case histories. With these precautions in mind, casebooks remain a vital tool for understanding patients' lives in the asylum.[25]

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[20] Andrews, 'Case Notes', p. 263.
[21] Guenter B. Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5(2) (1992), 183-205; Hazel Morrison, 'Unearthing the "Clinical Encounter": Gartnavel Mental Hospital, 1921-32' (Unpublished PhD Thesis, University of Glasgow, 2014).
[22] Scull, *The Insanity of Place/The Place of Insanity*, p. 137.
[23] E.g., Carol Berkenkotter, *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia SC, 2008).
[24] Andrews, 'Case Notes', p. 267.
[25] Donald P. Spence, 'Narrative Smoothing and Clinical Wisdom', in Theodore R. Sarbin (ed.), *Narrative Psychology, the Storied Nature of Human Conduct* (New York, 1986), pp. 211-32.

Casebooks also present a particularly challenging source base due to the sheer volume of information they contain. Many casebooks contain several hundred patients, a fact perhaps unsurprising given that by 1880 Lancaster Asylum had a population of over 1,000.[26] They also contain information on a wide range of aspects of asylum life, including details about the symptoms of mental illnesses, treatment, the types of drugs used, the frequency of solitary confinement, the use of mechanical restraint, the work done by patients, escape attempts, and many more subjects.[27] Not only are multiple areas covered, but a huge amount of data is available on each of them.[28] For instance, the casebooks for 1880 contain records of 407 patients admitted in that year.[29] If one were interested in the history of drug use in asylums, and wished to use case notes to ascertain the frequency of drug treatment, the types of drugs used, or to identify types of illness treated with drugs, the amount of information available even for one year would be significant. Even if only half of all patients admitted to Lancaster in 1880 were treated with drugs, one would first have to go through all of the casebooks to identify those that were relevant, and then have c. 200 to work through in greater detail. Thus, even with a narrow focus, the amount of information to process from casebooks is significant.[30]

This perhaps explains why studies which have utilised casebooks have often focussed on either a relatively short period of time,[31] a specific group of patients,[32] or on particular diagnostic categories.[33] These studies each take a particular element of asylum treatment which allows a narrowing of focus within a large, unwieldy source base. The problem of

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[26] See Appendix I, p. 240.
[27] Angela McCarthy, Catharine Coleborne, Maree O'Connor, Espeth Knewstubb, 'Lives in the Asylum Record, 1864 to 1910: Utilising Large Data Collection for Histories of Psychiatry and Mental Health', *Medical History*, 61(3) (2017), 358-79.
[28] Davis, *The Cruel Madness of Love": Sex, Syphilis and Psychiatry in Scotland, 1880-1930* (Amsterdam and New York, 2008), p. 23; Andrews, 'Case notes', p. 256.
[29] See, LA, HRL/4/12/2/9, 4 Feb 1879-13 May 1880; LA, HRL/4/12/2/10, 18 May 1880-30 Nov 1881; LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881.
[30] Juliet D. Hurn, 'The History of General Paralysis of the Insane in Britain, 1830 to 1950' (Unpublished PhD Thesis, University of London, 1998); Catherine Cox and Hilary Marland, '"A Burden on the County"', 263-87; Marland, 'Dangerous Motherhood'; Davis, *The Cruel Madness of Love*.
[31] See, Morrison, 'Unearthing the "Clinical Encounter"', which focuses on 60 patients admitted to Gartnaval Mental Hospital.
[32] Cox and Marland, '"A Burden on the County"', 263-87.
[33] Hurn, 'The History of General Paralysis of the Insane in Britain'; Marland, 'Dangerous Motherhood'.

casebooks as 'big data'[34] has also been addressed by analytical techniques made available by new technologies and digital humanities approaches.[35] Several studies have shown the value of using sampling methods, digital tools, or, in many cases, teams of researchers. [36] As has been pointed out by McCarthy et al., many historians have discussed the relevance of case records and the difficulties they present to the researcher, however few have 'talked openly about their own strategies in sorting, storing, analysing and making sense of large data sets'.[37] Such methodological discussions could only assist in the development of more effective ways of approaching casebooks. Taking inspiration from the transparency of discussion of research methods in the works of Andrews[38], McCarthy et al.[39], and Cox and Marland[40], the subsequent section of this chapter will be devoted to a discussion of the ways in which this study has approached the challenges presented by the scale of information presented by casebooks. It is hoped that this discussion of methodology will add to conversations surrounding how 'big data' might be utilized in studies of medical history.[41]

3.3 Sampling Lancaster Asylum's Casebooks

Many of the approaches to dealing with the problem of volume when working with casebooks rely on adopting a narrow focus of inquiry. An investigation of patient agency, however, does not provide a focus that is particularly narrow. To identify patient agency, each patient's case notes must be read carefully, combing through each line of scrawled doctors' handwriting to identify incidents in which patients behaved in a manner constitutive of agency as defined in this thesis. Consequently, this thesis draws on a sample of Lancaster Asylum's casebooks within the period 1840-1915. This allows the in-depth analysis and close-reading 'against the grain' necessary to identify patient agency to be undertaken by a

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[34] Jeffrey S. Reznick and Frederick W. Gibbs, 'Teaching and Researching the History of Medicine in the Era of (Big) Data: Reflections', *Medical History,* 61(4) (2017), 609-14.
[35] McCarthy, et. al., 'Lives in the Asylum Record'; Reznick and Gibbs, 'Teaching and Researching the History of Medicine in the Era of (Big) Data', 609-14; 'The Casebooks Project', http://www.magicandmedicine.hps.cam.ac.uk/ [accessed 12/01/2016].
[36] Cox and Marland, '"A Burden on the County"', 263-87; McCarthy et al., 'Lives in the Asylum Record', 358-79; 'The Casebooks Project'.
[37] McCarthy et al., 'Lives in the Asylum Record', p. 359.
[38] Andrews, 'Case Notes'.
[39] McCarthy et. al., 'Lives in the Asylum Record'.
[40] Cox and Marland, '"A Burden on the County"'.
[41] E.g., Sean Morey Smith, 'Digitizing Doctors: Methodologies for Creating a Database from Historical Directories of Physicians', *Medical History,* 61(4) (2017), 611-14.

single researcher. The sample has been taken by consulting casebooks of patients admitted in two years out of each decade of the period of study. The casebooks used were for patients admitted in the first year of each decade (1840, 50, 60 etc.) and the fifth (1845, 55, 65. etc.).[42] This limits the amount of data in such a way as to make it manageable, whilst retaining a broad time coverage. The case notes of each patient were kept in the casebook that started in the year of their admission and their notes remained in that book until their death or discharge. As such the case histories of each patient cover a time span beyond the year of admission. This means that even in a sample taken in the way described above, examples of patient behaviour from each year within the period are obtained. The sample included a total of 4,747 patients, of whom 3,190 demonstrated some form of agency.

One significant way in which the scale of casebooks has been addressed is through the focus on a single institution. Focusing on one asylum also has other advantages, in particular, the *longue durée* view of the asylum's development. This facilitates consideration of how the institution responded to patient agency across the period, and how far patient agency influenced practices in the care and custody of the insane. Contemporary medical journals and books can provide insight into theories of insanity and its treatment in asylums. However, such sources only offer a perspective on theories about how to treat the insane.[43] Examining everyday practice in institutions like Lancaster Asylum allows an understanding of how the treatment of the insane developed 'on the ground'. The realities of everyday practice also provide a window on to asylum treatment that considers the role of practical, managerial concerns in shaping it. Working with the casebooks of just one institution also allows a greater familiarity with the format of case notes, given the lack of standardization across institutions for much of the period covered.[44]

This lack of uniformity in record keeping necessitates some discussion of the composition of casebooks from Lancaster Asylum. From 1865, the casebooks were divided

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[42] This is the case for each decade apart from the 1870s and 1910s where 1876, 1909 and 1914 are taken as the sample years. This is due to damage in the case of the 1875 and 1910 casebooks. In relation to the 1915 casebook this is due to the face that patients admitted in 1915 had their case notes kept in the same book as patients admitted up to 1918 and consequently this book was not accessible under the 100-year rule as it applied when this research began.

[43] Michel Borch-Jacobsen, *Making Minds and Madness: From Hysteria to Depression* (Cambridge, 2009), pp. 8-9.

[44] Wright, 'Getting out of the Asylum', 146-9.

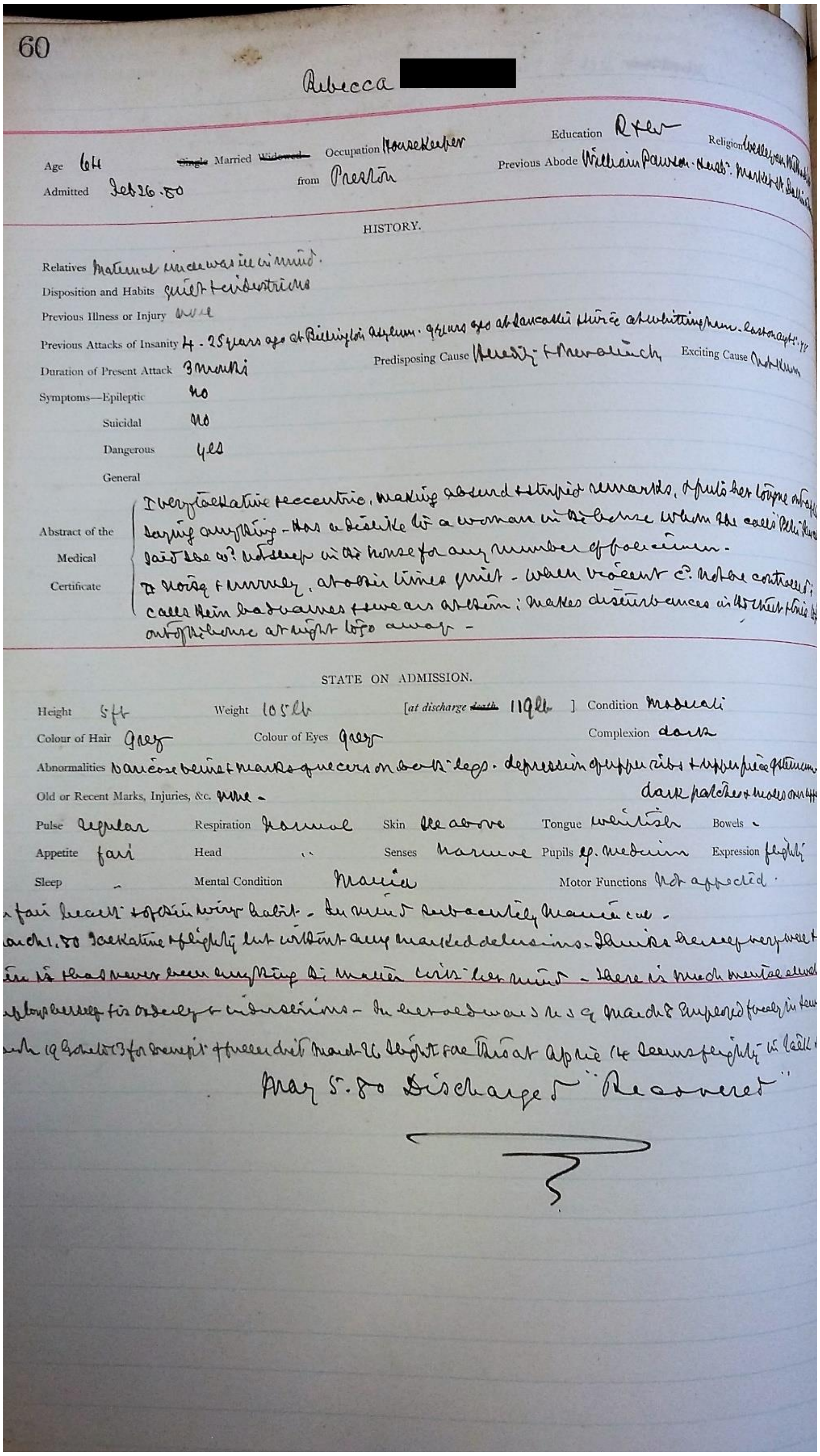
by sex, with male and female patients being recorded in separate books.[45] This is possibly the result of the increase in the number of patients admitted over the period studied, but was also undoubtedly due in part to the increased emphasis placed on the separation of the genders in the institution as theories of the heredity of insanity became increasingly influential.[46] Prior to this, male and female records were kept in the same book. Every year a new casebook was started containing all patients who were admitted in that year. Patients' case notes remained in the casebook of the year of their admission for the duration of their stay. For example, a patient admitted in 1880 and discharged in 1910 would have had all of their case notes kept in the 1880 casebook.

Due to the lack of standardization of case records prior to 1870, patient information could be collected in a haphazard manner. As such, casebooks from the earlier part of this period do not always have the same information available as those from after the 1870s when more standard mechanisms of collecting information were introduced. These took the form of a pro forma placed at the top of the page, which was standardized throughout the entire run of casebooks, ensuring that the same information was gathered on every patient (Fig. 1).[47] It took details of the patients' age, marital status, occupation, level of education, religion, admission date and previous address. The pro forma then set out a 'medical history section', which was usually taken using a questionnaire completed with information provided by a family member which would often, though not always, be inserted into the book. This section contained information on the patient's history relating to areas including any family history of insanity, their dispositions and habits, previous illness or injury, previous attacks of insanity, duration of present attack, predisposing cause, 'exciting' cause, and whether the patient was suicidal, epileptic or dangerous. The medical history section also included space for an abstract of the medical certificate where evidence of the patient's insanity could be transcribed. There was also a section about patients' physical conditions on admission to the asylum which included categories for height, weight, condition, hair colour, eye colour, complexion, 'abnormalities', old or recent marks and injuries, pulse, respiration, skin, tongue, bowels, appetite, head, senses, pupils, expression, sleep, mental condition and motor

[45] See, LA, HRL/4/12/2/2 and LA, HRL/4/12/3/2 for the beginning of separate records for male and female patients.
[46] Shorter, A *History of Psychiatry*.
[47] This reflected wider trends apparent in the latter half of the nineteenth century which sought to introduce standardized scientific methods into hospital treatment, McCarthy et al., 'Lives in the Asylum Record', pp. 365-66, 370.

functions.[48] Following the pro forma section of the casebook, there are dated entries made about the progress and condition of the patient.

[48] The pro forma for patient histories were introduced in Lancaster Asylum from the middle of 1865, which was also the point at which male and female case notes were separated reflecting the trend towards increased efforts to introduce rigorous categorization which was considered to promote scientific rigour and objectivity. For examples of the introduction of this pro forma see LA, HRL/4/12/2/2 and LA, HRL/4/12/3/2.


60

Rebecca [redacted]

~~Single~~ Married ~~Widowed~~ Occupation Housekeeper Education R + W Religion Wesleyan Methodist

Age 64

Admitted Feb 26. 80 from Preston Previous Abode [illegible]

HISTORY.

Relatives Maternal uncle was ill in mind.

Disposition and Habits quiet & industrious

Previous Illness or Injury none

Previous Attacks of Insanity 4 - [illegible]

Duration of Present Attack 3 months Predisposing Cause Heredity & [illegible] Exciting Cause [illegible]

Symptoms—Epileptic no

Suicidal no

Dangerous yes

General

Abstract of the Medical Certificate [illegible]

STATE ON ADMISSION.

Height 5 ft Weight 105 lb [at discharge ~~death~~ 119 lb] Condition moderate

Colour of Hair grey Colour of Eyes grey Complexion dark

Abnormalities [illegible]

Old or Recent Marks, Injuries, &c. none

Pulse regular Respiration normal Skin as above Tongue whitish Bowels

Appetite fair Head Senses normal Pupils eq. medium Expression flighty

Sleep Mental Condition Mania Motor Functions not affected

[illegible]

May 5. 80 Discharged "Recovered"

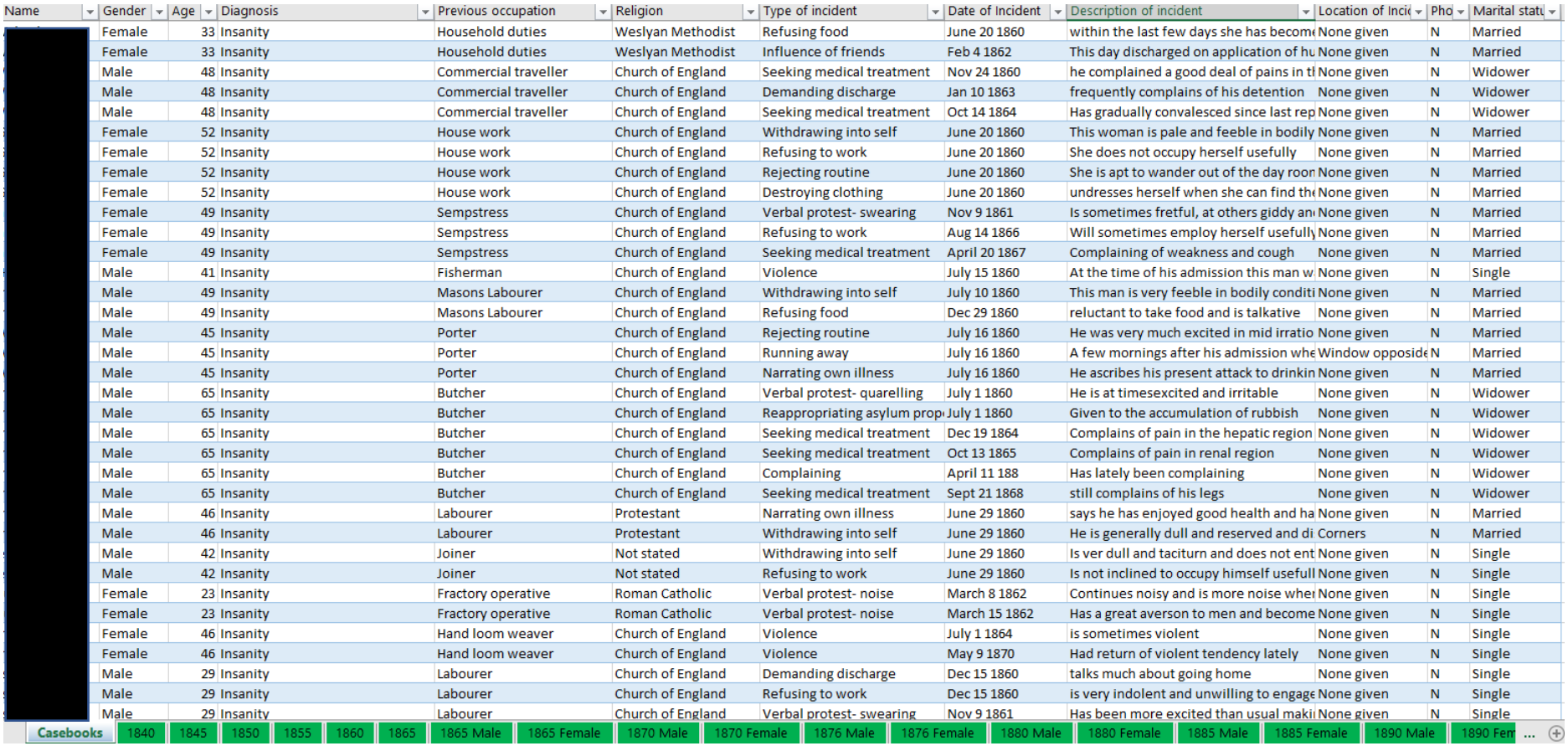
Figure 1. Example of a Patient's Case Notes, LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 60.

The information collected during the analysis of casebooks was organized into a datasheet created using the form function on Microsoft Excel (Fig. 2). The form allowed for the collection of data which could be analysed from a mainly qualitative perspective but was capable of permitting some quantitative insights where appropriate. Sections in the form were created for the following categories of information in relation to patients: name, gender, age, diagnosis, previous occupation, religion, marital status, and whether a photograph was attached to their case record. Further sections recorded information about incidents of patient agency gleaned from a close reading of the case notes, which included what 'type' of incident it was, the date on which the incident occurred, a transcription of the description of the incident from the casebook, and the location of the incident. The 'types' of incident were generated through close reading of the asylum casebooks and were determined based on the language used to describe incidents in the casebook. For example, when the casebooks described incidents in which patients used violence and identified other patients as the targets of that violence these incidents would be assigned to the 'attacks on patients' type. Incidents in which patients were described as using violence against staff would be designated as 'violence to staff' type of incidents. Where there was no clear target of patient violence, such incidents would simply be classified as 'violence'. Other incident 'types' included attempts by patients to run away, which were designated as 'running away'; attempts to alter uniforms would be designated as 'altering clothing'; when patients asked doctors, attendants or nurses if they could move to another ward this would be considered in the type 'requests to move wards' and so on. Others were property damage, making friends, making requests, providing illness narratives, and several others which will be discussed in subsequent chapters.

These 'types' were employed to codify the qualitative data recorded in the data sheet. Creating these themes enabled me to analyse similar kinds of patient behaviours together, which allowed me to explore how specific behaviours changed over time, interacted with asylum power, and to consider how common certain behaviours were. Furthermore, identifying different 'types' of behaviour facilitated thinking around the ways in which different behaviours constituted different kinds of agency. The types of patient behaviour identified through the casebooks of Lancaster Asylum can be thought of as having fallen into one (or more) of the categories of agency discussed at the beginning of this chapter – resistance, coping mechanisms, and active engagement. Organising qualitative casebook data in this way thus facilitated the development of the framework for approaching agency which

addresses the shortcomings of theories of agency in previous scholarship that were discussed in Chapter Two.

Figure 2. Excel Datasheet



Name	Gender	Age	Diagnosis	Previous occupation	Religion	Type of incident	Date of Incident	Description of incident	Location of Inci	Pho	Marital statu
[redacted]	Female	33	Insanity	Household duties	Weslyan Methodist	Refusing food	June 20 1860	within the last few days she has become	None given	N	Married
	Female	33	Insanity	Household duties	Weslyan Methodist	Influence of friends	Feb 4 1862	This day discharged on application of hu	None given	N	Married
	Male	48	Insanity	Commercial traveller	Church of England	Seeking medical treatment	Nov 24 1860	he complained a good deal of pains in th	None given	N	Widower
	Male	48	Insanity	Commercial traveller	Church of England	Demanding discharge	Jan 10 1863	frequently complains of his detention	None given	N	Widower
	Male	48	Insanity	Commercial traveller	Church of England	Seeking medical treatment	Oct 14 1864	Has gradually convalesced since last rep	None given	N	Widower
	Female	52	Insanity	House work	Church of England	Withdrawing into self	June 20 1860	This woman is pale and feeble in bodily	None given	N	Married
	Female	52	Insanity	House work	Church of England	Refusing to work	June 20 1860	She does not occupy herself usefully	None given	N	Married
	Female	52	Insanity	House work	Church of England	Rejecting routine	June 20 1860	She is apt to wander out of the day roon	None given	N	Married
	Female	52	Insanity	House work	Church of England	Destroying clothing	June 20 1860	undresses herself when she can find the	None given	N	Married
	Female	49	Insanity	Sempstress	Church of England	Verbal protest- swearing	Nov 9 1861	Is sometimes fretful, at others giddy an	None given	N	Married
	Female	49	Insanity	Sempstress	Church of England	Refusing to work	Aug 14 1866	Will sometimes employ herself usefully	None given	N	Married
	Female	49	Insanity	Sempstress	Church of England	Seeking medical treatment	April 20 1867	Complaining of weakness and cough	None given	N	Married
	Male	41	Insanity	Fisherman	Church of England	Violence	July 15 1860	At the time of his admission this man w	None given	N	Single
	Male	49	Insanity	Masons Labourer	Church of England	Withdrawing into self	July 10 1860	This man is very feeble in bodily conditi	None given	N	Married
	Male	49	Insanity	Masons Labourer	Church of England	Refusing food	Dec 29 1860	reluctant to take food and is talkative	None given	N	Married
	Male	45	Insanity	Porter	Church of England	Rejecting routine	July 16 1860	He was very much excited in mid irratio	None given	N	Married
	Male	45	Insanity	Porter	Church of England	Running away	July 16 1860	A few mornings after his admission whe	Window opposide	N	Married
	Male	45	Insanity	Porter	Church of England	Narrating own illness	July 16 1860	He ascribes his present attack to drinkin	None given	N	Married
	Male	65	Insanity	Butcher	Church of England	Verbal protest- quarelling	July 1 1860	He is at timesexcited and irritable	None given	N	Widower
	Male	65	Insanity	Butcher	Church of England	Reappropriating asylum prop	July 1 1860	Given to the accumulation of rubbish	None given	N	Widower
	Male	65	Insanity	Butcher	Church of England	Seeking medical treatment	Dec 19 1864	Complains of pain in the hepatic region	None given	N	Widower
	Male	65	Insanity	Butcher	Church of England	Seeking medical treatment	Oct 13 1865	Complains of pain in renal region	None given	N	Widower
	Male	65	Insanity	Butcher	Church of England	Complaining	April 11 188	Has lately been complaining	None given	N	Widower
	Male	65	Insanity	Butcher	Church of England	Seeking medical treatment	Sept 21 1868	still complains of his legs	None given	N	Widower
	Male	46	Insanity	Labourer	Protestant	Narrating own illness	June 29 1860	says he has enjoyed good health and ha	None given	N	Married
	Male	46	Insanity	Labourer	Protestant	Withdrawing into self	June 29 1860	He is generally dull and reserved and di	Corners	N	Married
	Male	42	Insanity	Joiner	Not stated	Withdrawing into self	June 29 1860	Is ver dull and taciturn and does not ent	None given	N	Single
	Male	42	Insanity	Joiner	Not stated	Refusing to work	June 29 1860	Is not inclined to occupy himself usefull	None given	N	Single
	Female	23	Insanity	Fractory operative	Roman Catholic	Verbal protest- noise	March 8 1862	Continues noisy and is more noise whe	None given	N	Single
	Female	23	Insanity	Fractory operative	Roman Catholic	Verbal protest- noise	March 15 1862	Has a great averson to men and become	None given	N	Single
	Female	46	Insanity	Hand loom weaver	Church of England	Violence	July 1 1864	is sometimes violent	None given	N	Single
	Female	46	Insanity	Hand loom weaver	Church of England	Violence	May 9 1870	Had return of violent tendency lately	None given	N	Single
	Male	29	Insanity	Labourer	Church of England	Demanding discharge	Dec 15 1860	talks much about going home	None given	N	Single
	Male	29	Insanity	Labourer	Church of England	Refusing to work	Dec 15 1860	is very indolent and unwilling to engage	None given	N	Single
	Male	29	Insanity	Labourer	Church of England	Verbal protest- swearing	Nov 9 1861	Has been more excited than usual maki	None given	N	Single

Casebooks | 1840 | 1845 | 1850 | 1855 | 1860 | 1865 | 1865 Male | 1865 Female | 1870 Male | 1870 Female | 1876 Male | 1876 Female | 1880 Male | 1880 Female | 1885 Male | 1885 Female | 1890 Male | 1890 Fem ...

It is recognized that classification of incidents in this manner risks an imposition of categories not unlike the modes of classification adopted by the nineteenth-century medical profession to render their patients visible to the clinical gaze, and constitute scientific knowledge and power.[49] However, in dealing with such a large collection of data, the introduction of specific categories facilitates meaningful analysis.[50] These 'types' were also included in order to permit the analysis of similar kinds of incidents together, to allow for comparisons, assess their frequency, and to establish common locations. This approach allows for an analysis of specific manifestations of patient agency. For example, running away can be interrogated in depth, its meaning to patients can be examined and analysed, the frequency of such behaviours over time can be assessed, and the types of patients most likely to escape can be established. By including a section in the data sheet to reflect the location of incidents of agency, it has also been possible to analyse the impact that the built world of the institution had on patient agency, and vice versa. The methods used to capture the data which this thesis draws on are thus essential to the types of analysis that have been possible.

3.4 Material Culture Approaches to Patient Agency

Casebooks form the backbone of this study. However, they are utilized alongside another significant source: material culture. Many scholars engaged in recovering the histories of subaltern groups recognise that material culture provides invaluable insights into their lives.[51] Patients did not write their casebooks, nor did the pauper patients of county asylums leave behind many letters or memoirs.[52] However, patients had direct contact with the material world of the asylum, and as such we might see objects as having a more direct relation to the patient perspective than the case notes produced by asylum doctors. As has been discussed, many historians have argued that casebooks were a document which was constructed *about*

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[49] Ian Hacking, 'Making up people', in Thomas C. Heller, Morton Sosna and David E. Wellbery (eds.), *Reconstructing Individualism: Autonomy, Individuality, and the Self in Western Thought* (Stanford, CA, 1986), pp. 161-71.
[50] McCarthy et al., 'Lives in the Asylum' pp. 370-75.
[51] Daniel Miller (ed.), *Acknowledging Consumption: A Review of New Studies* (London and New York, 1995), p. 1.
[52] For discussion of how patients could shape their case notes see Hazel Morrison, 'Constructing Patient Stories: "Dynamic" Case Notes and Clinical Encounters at Glasgow's Gartnavel Mental Hospital, 1921-32', *Medical History*, 60(1) (2016), 67-86; Sarah Chaney, '"No 'Sane' Person Would Have Any Idea": Patients' Involvement in Late Nineteenth-century British Asylum Psychiatry', *Medical History*, 60(1) (2016), 37-53.

the patient by the medical profession, which patients had little influence over.[53] As such, it is suggested that, as well as using casebooks and 'against the grain'[54] approaches to them, researchers interested in accessing patient voice, patient experiences, or patient agency, must supplement the written medical record with alternative sources.

Though the material worlds of carceral institutions were intended to control inhabitants, several studies demonstrate that patients found ways to turn institutional objects to their own uses, appropriating them to assert control over their lives.[55] Similarly, the built world of the asylum might be subverted by the patient. Though constructed to control movement and allow surveillance, the architecture of the asylum could be manipulated by patients to assist in behaviours which subverted the expectations of the institution.[56] Drawing on the work of Erving Goffman, this thesis will explore the idea of 'free space' in the institution. Goffman argued that patients in St. Elizabeth's Hospital in Washington D.C. made use of areas of the institution which were not kept under effective surveillance by staff, or areas in which staff deliberately did not impose hospital regulations, to engage in behaviours which were against hospital rules. Goffman identified these free spaces through conducting fieldwork in the hospital, and interviewing staff and patients.[57] This thesis aims to perform a similar analysis of space to that which Goffman achieved through his interviews with patients in St. Elizabeth's Hospital, to assess whether any 'free spaces' existed in Lancaster Asylum. The approach used will emphasize analysis of patients' uses of space in practice, rather than focussing purely on plans or maps.[58] Casebooks will be used to identify

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[53] Foucault, *Discipline and Punish*.
[54] The idea of reading against the grain comes from the Subaltern School, see, Ranajit Guha, 'The Prose of Counter-Insurgency', in Ranajit Guha (ed.), *Subaltern Studies II: Writings on South Asian History and Society* (Delhi, 1983), pp. 1-42.
[55] Hamlett & Hoskins, 'Comfort in Small Things?'; Rebecca Wynter, '"Good in All Respects"'; Hamlett, *At Home*; Hamlett, Hoskins, Preston, (eds.), *Residential Institutions*; Conlin Casella, *The Archaeology of Institutional Confinement*; Peter Davies, Penny Crook and Tim Murray, *An Archaeology of Institutional Confinement, The Hyde Park Barracks, 1848-1886* (Sydney NSW, 2013).
[56] Erving Goffman, *Asylums*.
[57] Goffman, *Asylums.*
[58] The importance of patients' uses and understandings of space has been highlighted in several studies: Coleborne, 'Families, Patients and Emotions', Chris Philo, 'Madness, Memory, Time and Space: The Eminent Psychological Physician and the Unnamed Artist – Patient', *Environment and Planning D: Society and Space* 24(6) (2006), 891-917; Kerry Davies, '"A Small Corner that's for Myself" Space, Place, and Patients' Experiences of Mental Health Care, 1948-98', in Leslie Topp, James E. Moran and Jonathan Andrews (eds.), *Madness, Architecture and the Built Environment* (London and New York, 2007), pp. 305-20.

patients' understandings and uses of asylum space in order to explore the effects that patients' uses (and misuses) of asylum space had on its development over time.

The objects that surrounded patients in the asylum – i.e. the movable elements of asylum material culture – will be examined to assess how they were used to facilitate agency. The objects analysed in this chapter are drawn from a museum collection from Lancaster Asylum held by Lancashire Museums Services, Preston. This collection is subject to the same limitations that surround most, if not all, collections focussed on psychiatric history. Museums encourage the public to remember a particular version of the past, often one which ties in with our understandings of the present. As such, provision for the insane in the Victorian period is often presented as a barbaric predecessor to modern day medical psychiatry, with collections demonstrating progress from mechanical restraints to occupational therapy, thereby validating contemporary psychiatric practice. Often psychiatric collections focus on 'hard' material culture, centring on medical paraphernalia rather than the soft 'curtains and cushions' domestic material culture that would have shaped many patients' day-to-day experiences.[59] This is, to a great extent, true of the Lancaster Asylum collection. There are many medical objects included such as the paraphernalia used to make house medicines, items surgically removed from patients' stomachs after being ingested, and a significant number of articles used for restraint.[60] These objects of 'hard' material culture form a significant proportion of the collection. There are, however, a significant number of inclusions of items of domestic material culture.

Understanding the origins of the collection from Lancaster Asylum goes some way towards explaining its high proportion of domestic objects. The collection was put together in the late-twentieth century (exact date unknown) by a member of staff in the asylum, most likely an attendant.[61] The collection was originally housed in an on-site museum and was, to a significant extent, concerned with demonstrating the progress of the hospital from its founding in 1816 up to the time of the exhibition. The fact that the collection was gathered by an attendant, rather than a doctor, is perhaps significant in explaining the proliferation of everyday domestic items such as locks, keys, crockery, and sewing samples. The view of

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[59] Dolly MacKinnon and Catharine Coleborne, 'Seeing and Not Seeing Psychiatry', in Catharine Coleborne and Dolly MacKinnon (eds.), *Exhibiting Madness in Museums: Remembering Psychiatry through Collections and Display* (London, 2011), pp. 3-13.
[60] Museum of Lancashire, Preston, Lancaster Moor Hospital Collection (LMH).
[61] Lancaster City Museum, Lancaster, Susan Ashworth, Exhibition notes for 'Institutional Eyes' (1986).

nursing staff would necessarily entail a consciousness of medical developments, particularly of items they or their forebears used in their own practice, hence the prevalence of items of restraint. At the same time, nursing staff would also have been cognisant of ward routines and the day-to-day stuff of institutional life. The greater weight given to domestic items in the Lancashire Museum collection is thus most likely explicable by the collection priorities of the original 'curator'. Unfortunately, many of the domestic items are from the latter part of the institution's life, after it had become Lancaster Moor Hospital. Some items do date, however, from the nineteenth and early twentieth-centuries, albeit a relatively small proportion, and these objects are the focus of this study.

Understanding the life of the collection of objects from Lancaster Asylum helps to shed some light on issues faced in working with material culture. Just as case notes reflect the concerns and agendas of the medical profession, the objects collected to display in the in-house hospital museum reflect the preoccupations of the collector. The objects available to work with share the major problem presented to us by the casebooks, they are put together by the medical profession, not by the patient. It is impossible to know whether the objects that were collected reflect the items that were the most significant parts of patients' experiences of asylum life. Nor do all of the objects in the collection 'speak' for themselves about how patients responded to them (although as we shall see there are some that do). Some scholars have questioned whether any objects are capable of telling us about the past without reference to other sources. Richard Grassby has called for historians to move away from emphasis on the symbolic characteristics of objects, and to test inferences made from objects against written documents.[62] The methodology of this thesis remains committed to taking seriously the objects with which patients interacted, whilst also acknowledging the need for the provision of context, or, more accurately, contexts, for those items. This context is provided through descriptions of objects and of patients' uses of them as described in case notes, and through depictions in photographs, again, demonstrating the value of incorporating the textual and the material in tandem.

[62] Richard Grassby, 'Material Culture and Cultural History', *Journal of Interdisciplinary History,* 35(4) (2005), 591-604.

3.5 Structure of Thesis

The methodology discussed in this chapter will permit a careful examination of casebooks, artefacts, photographs, and architecture to understand how patients were able to exercise agency within the institution. Discussion in this chapter and Chapter Two has highlighted the problems of equating agency and resistance. However, ignoring resistance as an importance and valid mechanism of patient agency would be equally problematic. Whilst this thesis will in no way equate agency and protest, it will not ignore resistance as an important manifestation of agency. As such, Chapter Four will discuss resistance as a manifestation of patient agency. This chapter will not focus purely on 'big moments' of resistance, rather, subtle acts of subterfuge will also be considered.[63] The acts of resistance undertaken by patients will be set within the structures of authority in Lancaster Asylum, as well as structures of medical knowledge, and the socio-economic backgrounds from which patients came. Acts of resistance or protest will be understood, not only as having been undertaken in response to and within particular structural constraints, but also as having created impacts on those structures, particularly those of the asylum.

Chapter Five will focus on coping mechanisms adopted by patients, analysing the ways in which Lancaster Asylum patients sought to make their time in the institution bearable. This chapter will suggest that several acts, which have been characterized by some studies as efforts to quietly undermine powerful regimes, may be better understood as coping mechanisms, particularly in an institutional context. The distinction between resistance and coping mechanisms will be demonstrated to be significant in endeavours to understand the agency of marginalized social groups, as it facilitates a move beyond simplistic dichotomies of power and resistance in analysing relationships between the powerful and the subaltern.[64]

Patients who chose to actively engage with the asylum regime, or aspects of it, will be considered in Chapter Six. Rather than viewing patients who did not resist confinement as passive, this chapter will seek to read incidents of compliance more critically and assess why

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[63] Scott, *Weapons of the Weak*; James Scott, *Domination and the Arts of Resistance: Hidden Transcripts* (New Haven, CT, 1990).

[64] Sarah Tarlow, 'Excavating Utopia: Why Archaeologists Should Study "Ideal" Communities of the Nineteenth Century', *International Journal of Historical Archaeology,* 6(4) (2002), 299-23; Joan M. Gero, 'Troubled Travels in Agency and Feminism', in Marcia-Anne Dobres and John Robb (eds.), *Agency in Archaeology* (London, 2000), pp. 34-9; Lynn Meskell, 'The Somatization of Archaeology: Institutions, Discourses, Corporeality', *Norwegian Archaeological Review*, 29(1), 1-16.

patients made decisions to engage with life in the asylum. It will be suggested that patients' understandings of their illness experiences, their quality of life prior to their admission, and opportunities available to asylum patients for employment, food, and shelter, may have motivated some patients to engage with asylum life. By approaching case notes as documents which contain patient narratives of their illness experiences, this chapter will establish how and why some patients may have preferred life in the asylum to their lives outside of its walls.

Chapter Seven will draw on casebooks, architectural plans, maps, and photographs to situate incidents of agency within their spatial contexts. This chapter will highlight locations where patients may have been more likely to exercise agency. The characteristics of these spaces will be examined to determine whether areas with higher proportions of incidents of agency may have possessed physical traits which encouraged patients to target them in this way. Casebooks will also be drawn on to investigate patients' perceptions of and responses to institutional space.

Chapter Eight discusses moveable items of material culture, to explore the ways in which the asylum deployed objects to cure and control patients, and how patients could subvert institutional technologies of control in order to use objects to facilitate their exercise of agency. Drawing on casebooks, photographs, and objects from the asylum, this chapter will explore the centrality of material culture to both asylum authority and patient agency. The material world will be highlighted as a particularly useful arena through which to explore the ways in which power dynamics between patients and asylum authorities produced and altered institutional spaces and material practices.

Throughout this thesis, we will see that patients were not powerless, silent, or incomprehensible, but were individuals who adopted a range of strategies to resist, cope with and engage with life in the institution. They did not merely exist within the strictures of institutional life, passively acquiescing to treatments imposed upon them by an omnipotent medical profession. Rather, they engaged in a range of behaviours which allowed them to negotiate their confinement in Lancaster Asylum. Nor were the structures of authority and regulation in Lancaster Asylum static and unchanging in relation to how patients behaved in the institution. Changes to medical practice in the treatment of insanity were not born solely out of publications in medical journals, rather, they were developed in the asylum; at the

'coalface' of nineteenth-century psychiatric medicine.[65] The relationship between agency and authority in Lancaster Asylum will be highlighted as a dynamic, symbiotic exchange. The effects of patient agency, and the asylum's responses to it, will be shown to have been significant in shaping how the asylum approached patient management, and the treatment of insanity in this period.

[65] McCarthy et al., 'Lives in the Asylum Record', p. 368.

4. Patient Resistance to Asylum Authority

4.1 Introduction

Work on asylums has examined patient perspectives, patient experiences, and, more recently, the question of patient agency has started to be addressed.[1] Scholarship has considered the strategies of the family and friends of the insane, but limited consideration has been given to the strategies employed by the insane themselves.[2] In contrast, strategies of resistance of inmates in comparable carceral institutions and patient resistance in other medical settings have been well-documented.[3] Patient defiance of asylum authority has been interpreted as involuntary, undertaken because of patients' mental states; defiance has been analysed as a symptom of insanity.[4] Unlike inmates of workhouses or reformatory schools, or hospital patients, the insane are doubly silenced by the historical record. Not only are they extraneous to record production, but their designation as 'insane' also continues to permeate our readings of their actions.

Yet, other examples of popular protest, even when they have incorporated spontaneous activities like violence, have been framed in terms of the rational pursuit of self- and collective interest in histories of the poor.[5] Rioting, violence, strikes etc. have been framed as methods of effecting change. Workhouse riots are explained as attempts to redress unfair conditions,[6] popular violence in protests against the Anatomy Act has been considered a correspondingly visceral response to legislation attacking the bodies of the poor,[7] and

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[1] Bacopoulos-Viau and Fauvel, 'The Patient's Turn', 1-18.
[2] Coleborne, 'Families, Patients and Emotions', 425-42; Suzuki, *Madness in the Home*.
[3] Green, 'Pauper Protests', 137-59 ; Clark, 'Wild workhouse girls', 389-409; Myers and Sangster, 'Retorts, Runaways and Riots', 669-97; Conlin Casella, *The Archaeology of Institutional Confinement*; Elizabeth Roberts, 'Oral history investigations of disease and its management by the Lancashire Working Class 1890-1939', in J. V. Pickstone (ed.), *Health, Disease and Medicine in Lancashire 1750-1950: Four Papers on Sources, Problems and Methods* (Manchester, 1980), pp. 33-51; Beier, *For Their Own Good.*
[4] Refusals to work and violence, for example, are discussed as evidence of insanity in medical texts such as John Haslam, *Considerations on the Moral Management of Insane Persons* (London, 1817); John Connolly, *Construction and Government of Lunatic Asylums.*
[5] E. P. Thompson, 'The Moral Economy of the English Crowd in the Eighteenth Century', *Past and Present,* 50(1) (1971), 76-136.
[6] Virginia Crossman, 'The New Ross Workhouse Riot of 1887: Nationalism, Class and the Irish Poor Laws', *Past and Present,* 179 (2008), pp. 135-58.
[7] Katrina Navickas, *Protest and the Politics of Space and Place, 1789-1858* (Manchester, 2016).

popular agitations from the Captain Swing riots to campaigns for female suffrage have been analysed as a mechanism of enfranchisement.[8] Yet, the resistance, struggles and violence of patients in asylums have been interpreted using the same analytical framework applied by Victorian doctors.

This chapter will suggest that by situating patient resistance within the wider context of popular protest in nineteenth-century society, it becomes apparent that pauper patients were drawing on strategies and discourses with which they were already familiar.[9] It will be suggested that patient grievances were not only shaped by the circumstances they encountered in the asylum, but also by wider societal concerns including the limits of the power of the state, the encroachment of medical authority, and the rights of workers. The types of resistance considered in this chapter range from significant moments of public resistance[10] to patients' 'everyday' acts of defiance.[11] This approach draws on James Scott's analysis of resistance, which he defines as:

> *any* acts by members of a subordinate class that is or are *intended* [author's own emphasis] either to mitigate or deny claims (for example, rents, taxes, prestige) made on that class by superordinate classes (for example, landlords, large farmers, the state) or to advance its own claims (for example, work, land, charity, respect) vis-a-vis those superordinate classes.[12]

In the context of the asylum, resistance did not just take place in the context of a class struggle – although the social classes of doctors, attendants and patients undoubtedly affected power relations therein.[13] Other factors also shaped the nature of power and resistance. The claims made on patients were not rents or taxes, but were claims upon their liberty, their bodily autonomy, and their freedom of choice over day-to-day activities. These claims also

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[8] Hobsbawm and Rudé, *Captain Swing* (London, 1969); John Rule, *The Labouring Classes in Early Industrial England, 1750-1850* (London and New York, 1986); John Belchem, *Industrialization and the Working Class: The English Experience* (Aldershot, 1990); John K. Walton, *Chartism* (London and New York, 1999)
[9] Hitchcock, King and Sharpe (eds.), *Chronicling Poverty.*
[10] Scott, *Domination and the Arts of Resistance*.
[11] This approach is influence by the approaches of practice theorists in works such as Scott, *Weapons of the Weak*; Michel de Certeau, *The Practice of Everyday Life,* (trans.), Steven Rendall (Berkeley CA, 1984); Andrew Turton, 'Patrolling the Middle-Ground: Methodological Perspectives on "Everyday Peasant Resistance"', *Journal of Peasant Studies,* 13(2) (1986), 36-48; Ortner, *Anthropology and Social Theory*.
[12] Scott, *Weapons of the Weak,* p. 290.
[13] Hide, *Gender and Class*.

operated on individuals outside the asylum; throughout the nineteenth century the body[14] and aspects of daily routines such as the working day, holidays, leisure etc,[15] were points of tension. However, they took on a particularly fraught nature in the asylum where the walls of the institution magnified the strength of these claims. The 'superordinate' classes who sought to impose those claims also differed within the institution – landlords and factory owners were largely irrelevant, and instead doctors, Poor Law Guardians, nurses and attendants were the superordinate groups who advanced claims over patients, and who thus became the targets of resistance.

Resistance in the asylum took a number of forms that will be explored throughout this chapter. Patient complaints will be explored as a means by which patients appealed to authorities to address their grievances. Patients made appeals to asylum authorities. However, they also went over their heads to make complaints, seeking out the adjudication of external bodies or invoking the court of public opinion. Patients also withdrew their compliance from physical examinations and medical interviews to reclaim control over their bodies. Patients' refusals to work will be discussed as a strategy of resistance influenced by both asylum life and patients' previous experiences of labour relations. Patient escapes and violence will also be considered as ways in which patients were able to resist asylum authority. Influenced by Foucault's challenge to see power as a productive, rather than a purely repressive force, this chapter will examine the relationship between asylum authority and patient resistance. Foucault argued that although power produces resistance, resistance can never be in a position of exteriority to power.[16] The strategies adopted by patients to resist asylum authority were thus inextricably linked to ways in which the asylum exercised power. Not only did asylum power shape patient resistance, but patient resistance also had significant impacts on the ways in which the asylum authorities exercised power.

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[14] Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge, 1980); Leonore Davidoff, 'Class and Gender in Victorian England', in Judith L. Newton, Mary P. Ryan, and Judith R. Walkowitz (eds.), *Sex and Class in Women's History* (London, 1983), pp. 17-71; Sonya O. Rose, *Limited Livelihoods: Gender and Class in Nineteenth Century England* (Berkeley CA, 1982); Ruth Richardson, *Death, Dissection and the Destitute,* 2nd Edition, (Chicago, IL, 2000); Ellen Ross, *Love and Toil: Motherhood in Outcast London, 1870-1918* (Oxford, 1993).

[15] Peter Bailey, *Leisure and Class in Victorian England: Rational Recreation and the Contest for Control, 1830-1885* (London and New York, 1987); Robert Gray, *The Factory Question and Industrial England, 1840-1860* (Cambridge and New York, 1996); John T. Ward, *The Factory Movement, 1830-1855* (London, 1962).

[16] Foucault, *The History of Sexuality*, pp. 95-6.

4.2 Complaints Channels within the Asylum System

Current scholarship on patient complaints tends to emphasize the role of people and organizations surrounding the patient in registering grievances and bringing about changes in the treatment of the insane and of insanity. The role of the patient has only been considered in relation to upper- and middle-class individuals, who were able to publish their grievances.[17] This lack of attention to pauper complaints is a significant gap considering that pauper patients made up the bulk of asylum populations. Lack of attention to pauper complaints is also surprising given that the systems which lunacy reformers campaigned to put in place to safeguard their treatment were designed to allow patients *themselves* to raise grievances.[18] Studies of pauper populations in comparable carceral institutions have demonstrated the importance of inmates' use of the complaints channels available to them.[19] Their ability to use these channels demonstrates that paupers knew how the system worked, and understood how to advocate for themselves within it.[20] As we shall see, pauper patients in Lancaster Asylum demonstrated a similar knowledge, and they utilized it to register dissatisfaction with their confinement.

There were several ways in which patients could complain using official channels.[21] Within the institution, patients met with Medical Officers regularly so that their condition could be monitored. Their testimony during these interviews was recorded to aid in the evaluation of patients' mental states and their progress towards recovery.[22] However, patients also used interviews as an opportunity to complain about their treatment. Patients could also use officially designated complaints channels, including making their complaints to the asylum's Visiting Committee which was comprised of two individuals from the Management

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[17] Andrew Scull, 'A Culture of Complaint. Psychiatry and its Critics', in Jonathan Reinarz and Rebecca Wynter (eds.), *Complaints, Controversies and Grievances in Medicine: Historical and Social Science Perspectives* (Abingdon, 2015), pp. 41-47.
[18] D. J. Mellett, 'Bureaucracy and Mental Illness: The Commissioners in Lunacy, 1845-90', *Medical History,* 25 (1981), 221-50.
[19] David Green, *Pauper Capital: London and the Poor Law, 1790-1870* (Farnham, 2010), pp. 157-8.
[20] Peter Mandler, 'Introduction', in Peter Mandler (ed.), *The Uses of Charity: Poor on Relief in the Nineteenth Century Metropolis* (Philadelphia, 1990), pp. 12-23; Tim Hitchcock, *Down and Out in Eighteenth-Century London* (London, 2007), pp. 125-49.
[21] Clive Unsworth, 'Law and Lunacy in Psychiatry's "Golden Age"', *Oxford Journal of Legal Studies,* 13(4) (1993), 479-507.
[22] Andrews, 'Case Notes, Case Histories', pp. 270-8.

Committee of Lancaster Asylum who were selected on an annual basis to inspect the institution.[23] Patients could also complain to the Commissioners in Lunacy, who were responsible for the inspection of all county asylums and private institutions throughout the country.[24]

The most common complaint made by patients in Lancaster Asylum was about their detention. During his interview with one of Lancaster Asylum's doctors, William R., 'Complains of having been brought here against his wish and says he could follow up his employment as a porter'.[25] William's case illustrates how patients tried to ensure that their complaints were taken seriously. He not only complained about his detention but sought to support his demand for discharge by highlighting that he was capable of supporting himself outside the asylum.[26] William's efforts to emphasize his ability to work suggests that he believed that this would increase his chances of being taken seriously when demanding his discharge. His ability to support himself was highlighted as evidence of sanity. A similar tactic was used by female patients who expressed desires to return to their family. Catherine B. was noted to be 'very anxious to get home to her family' during a medical interview.[27] The ability of female patients to return to fulfil their domestic roles was a key marker of sanity.[28] That patients like Catherine emphasized their desire to resume their duties as mothers and wives suggests their awareness of how doctors measured patients' recoveries. That patients emphasized their fitness for discharge by referring to markers of recovery that were employed by asylum doctors suggests that patients were aware of medical frameworks of recovery and sought to employ them to their own advantage when demanding their release. The appropriation of medical frameworks of recovery by patients was undertaken to ensure that their complaints about their continued detention were taken seriously.

The Visiting Committee at Lancaster Asylum recognized the prevalence of patient complaints about detention. During their 1907 inspection, the Committee noted that 'there were no complaints only the *usual* [my own emphasis] ones by a few who think they ought to

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[23] LA, HRL/1/5/1, Visiting Committee Minutes 1845-1856; LA, HRL/1/10/1, Visiting Committee Reports 1906-1938; LA, QAM/5/1-45, *Reports* (1841-1888); LA, CC/LAR/1-2, *Reports* (1889-1890); LA, CC/HBR/1-45, *Reports* (1891-1938).
[24] Mellett, 'Bureaucracy and Mental Illness', 221-50.
[25] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 346.
[26] James Moran, 'Travails of Madness, New Jersey, 1800-70', in Ernst (ed.), *Work, Psychiatry and Society*, pp. 89-91.
[27] LA, HRL/4/12/3/12, 30 June 1885-4 Dec 1886, p. 78.
[28] Marland, *Dangerous Motherhood*, p. 133.

be discharged'.[29] Their description of these complaints as 'usual' underlines their ubiquity. Often, as in the extract above, Visitors found such cases to be 'deluded' and dismissed them out of hand, but on other occasions appeals to the Visiting Committee were successful. A German patient sought an interview with the Visitors to secure his return to his homeland: 'With respect to a patient named Herr [H.] a German we heard his application and complaint, after which we feel justified in recommending the consideration of his deportment to his own Country'.[30] Notably, this patient had not challenged the propriety of his diagnosis, only the propriety of his detention in England. This may well have been a sentiment with which the Visitors agreed, not only for the comfort of the patient, but also as a means of relieving Lancashire rate-payers of their responsibility for foreign patients.[31] Complaints about detention were more likely to be upheld in cases where patients sought to modify their detention, rather than have it overturned altogether.

Asylum food was also frequently a source of complaint. Despite claims made by asylum doctors that a good diet was essential for patients' recoveries, many patients did not appreciate the diet provided.[32] Account statements suggest that patients received a diet that was plentiful and contained a variety of fresh fruit and vegetables, as well as meat, poultry, fish and dairy.[33] Records of food served to patients contained in the asylum's 'Dietary Book' and in tables contained in Annual Reports corroborate this impression.[34] Inspectors and asylum doctors tended to evaluate asylum diet positively, focusing on its quantity and nutritional content. These attitudes reflect the 'Malthusian abstraction of the poor into "machines that eat"' and drew on different criteria for evaluating food than the standards applied by patients.[35] Preoccupation with assessing asylum diet in terms of nutritional content is mirrored in much scholarship on asylum food.[36]

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[29] LA, HRL/1/10/1 Visiting Committee Report, July 21 1906.
[30] LA, HRL/1/10/1 Visiting Committee Report, July 20 1907.
[31] Catherine Cox and Hilary Marland, '"A Burden on the County"', 268-9.
[32] George Man Burrow, *Commentaries on the Causes, Forms, Symptoms, and Treatment, Moral and Medical, of Insanity* (London, 1828) pp. 664-65.
[33] LA, HRL/1/1/1-7, Management Committee Minutes.
[34] LA, QAM/1/33/10, Asylum Dietary Book, 1883-9; LA, QAM/5/1-45, *Reports* (1841-1888); CC/LAR/1-2, *Reports* (1889-1890); LA, CC/HBR/1-45, *Reports* (1891-1938).
[35] Nadja Durbach, 'Roast Beef, the New Poor Law, and the British Nation, 1834-63', *Journal of British Studies*, 52 (2013), p. 964.
[36] Digby, *Madness, Morality and Medicine*, pp. 130-3.

Whether being provided with 'sufficient' food nutritionally equated to being provided with enjoyable food is cast into doubt by patients' opinions on asylum meals.[37] The case notes of Margaret M. record that she had an 'Enormous appetite but always complaining of the food not being enough and not nourishing her'.[38] Andrew M. was also displeased: 'Says he requires nourishing food such as beef and that he does not get half enough to eat'.[39] The appeals made by patients to the lack of 'nourishment' they received invoked medical language to complain about their diets. The food received by patients like Margaret and Andrew was, in terms of contemporary medical opinion, sufficient to ensure they received the nutrition they required. However, the complaints of both of these patients suggested that their issues with asylum food were based on their belief that it was not nutritionally adequate. While this could indicate a divergence in medical and lay opinions on nutrition, it also reflects an appropriation of medical language by patients seeking to have their complaints taken seriously.

Andrew M.'s case in particular is suggestive of patients' manipulations of medical vocabulary. Andrew's request specifically identified the lack of beef in the asylum diet as evidence of its insufficiency. In the nineteenth century, beef was a luxury food, and although meat was considered essential to health[40] and was a component of the diets of all social classes, beef was not a large part of pauper diets.[41] Rather, it was associated with celebratory meals, such as Christmas roast beef and plum pudding – a privilege often denied to those in Poor Law institutions.[42] Unlike workhouses, asylums were not subject to the dictum of less eligibility.[43] However, they were still a Poor Law institution and, as such, provisions of luxury items to patients were controversial. This explains perhaps the necessity of their justification of 'luxury' foodstuffs, such as beef, with reference to medical rationales. This can also be seen in relation to alcohol, a commodity that was excluded from other Poor Law institutions due, in part, to its status as a luxury item.[44] In asylums, alcohol was provided to

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[37] Complaints about food were also recorded by the Visiting Committee e.g., LA, HRL/1/10/1, Visiting Committee Report, Dec 20 1906.
[38] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 90.
[39] LA, HRL/4/12/2/10, 18 May 1880-30 Nov 1881, p. 101.
[40] James Gregory, *Of Victorians and Vegetarians: The Vegetarian Movement in Nineteenth-Century Britain* (London, 2007), p. 82.
[41] Chris Otter, 'The British Nutrition Transition and its Histories', *History Compass,* 10(11) (2012), 812-25.
[42] Durbach, 'Roast Beef', pp. 966-7.
[43] Durbach, 'Roast Beef', pp. 970-6.
[44] Durbach, 'Roast Beef', p. 966.

patients to alleviate mental distress, particularly to patients who could not sleep, were malnourished, or agitated.[45] Patients' tendency to frame requests for additional, or luxury, foodstuffs in terms of nourishment, therefore, appealed to a medical framework which permitted luxury items for reasons of medical necessity.

This tactic was not always successful – neither Margaret or Andrew obtained the food that they wanted, perhaps because medical discourse held that the asylum food provided was 'sufficient'. Complaints about food couched in medical language, therefore, could be readily quashed.[46] However, some complaints about food were successful. Sarah S. was to be 'Allowed an egg daily at her own request'[47] and a Jewish patient, Esther L., was allowed access to kosher food products.[48] Both of these complaints were resolved in favour of the patients because they were connected to ensuring that they were receiving 'sufficient' food. Sarah S. was noted to be malnourished, so her request for additional food aligned with asylum doctors' plan for her treatment. Allowing Jewish patients to keep kosher was also in line with promoting a 'sufficient' diet for patients - if religious beliefs prevented a patient eating, they would certainly not be consuming a sufficient amount of food. The success or failure of patient complaints about food thus depended on their alignment with medical beliefs on the role of food in curing insanity.[49]

A further area of patient complaints related to their treatment by staff. The asylum had a duty of care to its patients[50] and scandals of mistreatment attracted negative publicity.[51] As such, patient complaints about mistreatment were always taken seriously. Complaints were initially investigated through a physical examination of the complainant. If proof of injury was found then the complaint would be investigated further, through interviews with

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[45] Edward B. Renvoize and Allan W. Beveridge, 'Mental Illness and the Late Victorians: A Study of Patients Admitted to Three Asylums in York, 1880-1884', *Psychological Medicine*, 19 (1989), pp. 21-3, 26.
[46] LA, QAM/5/4, *Annual Report*, 1854.
[47] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 45.
[48] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 35.
[49] The overlap between lay and medical understandings of illness and its treatment has been discussed elsewhere. See Charles E. Rosenberg, 'The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America,' in Charles Rosenberg and Morris Vogel (eds.), *The Therapeutic Revolution: Essays in the Social History of American Medicine* (Philadelphia, PA, 1979), pp. 3-26.
[50] Sarah Hayley York, 'Suicide, Lunacy and the Asylum in Nineteenth-Century England' (Unpublished PhD Thesis, University of Birmingham, 2009), p. 128.
[51] Jennifer Wallis, *Investigating the Body in the Victorian Asylum* (Basingstoke, 2017), pp. 102-3.

witnesses including members of staff or other patients. Usually the statements of staff were given more weight, meaning that even when there was proof of injury, often no further action was taken. However, some investigations did result in staff being reprimanded. Robert Martin M. was injured by an attendant who was subsequently cautioned for his behaviour.[52] Even when complaints were not upheld, many patients did secure investigations, suggesting that patients did have a degree of agency in this situation.[53] Some patients clearly took advantage of this, threatening staff with feigned complaints to obtain leverage over them. William S., for example, was said to have been 'making complaints about the attendants which are groundless. Says "he will get them all sacked".'[54]

Making complaints within the channels available through the asylum thus afforded patients a measure of agency. In cases where the asylum authorities were not persuaded by the language used to express patient grievances, patients' complaints were investigated but ultimately dismissed. Even in such instances, however, patients' ability to secure investigations still represents agency. Patients' ability to secure investigations into the behaviour of staff members was empowering, with some patients going so far as to use the threat of complaining to gain leverage over staff. At the very least, patient complaints encouraged a high level of scrutiny of Lancaster Asylum by the authorities responsible for its management. Internal channels, however, were not the only option available to patients, and some individuals preferred to go over the heads of Lancaster Asylum authorities and complain to external audiences.

4.3 Complaining in Public

As with their middle-class counterparts, [55] county asylum patients made use of forums outside the asylum to express their dissatisfaction with life in the institution using letter writing and public appeals. Lancaster's patients were not oblivious to the power of the press and the threat that public airings of their grievances might pose to the institution's reputation. The

[52] LA, HRL/4/12/2/13, 25 Mar 1884-20 Dec 1886, p. 347.
[53] For example, LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23527.
[54] LA, HRL/4/12/2/20, 27 June 1898-6 July 1902, p. 178.
[55] For example, Louisa Lowe, *The Bastilles of England; or, The Lunacy Laws at Work* (London, 1883).

publicity surrounding the wrongful confinement scandals of the 1850s and 60s,[56] the circulation of autobiographies of disgruntled ex-asylum patients, as well as fictional accounts of wrongful detention in popular literature, alerted patients to the level of public interest in such scandals.[57] It was clear, therefore, that doctors preferred to keep complaints within the asylum, and patients often threatened to go to the press as a way of gaining leverage. Elizabeth S., for example made several complaints in this manner: 'Threatening to publish the matters in newspapers'.[58] Although there were not any first-hand accounts of the mistreatment of patients in Lancaster Asylum published in the local press, newspapers did report on scandals of mistreatment.[59] Elizabeth's threat to go to the press, therefore, demonstrated her knowledge of the fact that there was press interest in such matters, and that the publication of such incidents was detrimental to the Asylum's reputation.

Letter writing as a mechanism of complaint for patients' relatives has been highlighted by Louise Wannell. However, the casebooks of Lancaster Asylum suggest that patients themselves also used letters to make complaints.[60] Sarah Ann G. undertook a letter-writing campaign in regard to her detention. Her case notes state: 'Writes numerous letters to Master of Rolls – Masters in Lunacy – legal personage etc asking them to enquire into her case'.[61] Sarah Ann was a private patient and given her social class, she had more options available to voice her complaints. This was not only due to her education and literacy, but also because private patients were able to complain to authorities other than the Commissioners in Lunacy.[62] Her letters had some success, securing a visit from 'James C. Brown'.[63] Given Sarah's private patient status (and although his name is misspelled in the casebook) her visitor appears to have been Sir James Crighton-Browne, the Lord

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[56] McCandless, 'Liberty and Lunacy: The Victorians and Wrongful Confinement', *Journal of Social History*, 11(3) (1978), 366-86.
[57] For example, Charles Reade, *Hard Cash* (London, 1868).
[58] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 198.
[59] E.g., 'Conviction of Asylum Keepers', in *Examiner,* 19 March 1870; 'Cruel Treatment of a Lunatic', in *Manchester Courier and Lancashire General Advertiser,* September 13, 1888; 'Nurses Punishment', in *Manchester Courier and Lancashire General Advertiser,* 1 March 1907.
[60] Wannell, 'Patients' Relatives and Psychiatric Doctors', 297-313.
[61] LA, HRL/4/12/3/33, 21 Mar 1908-3 Sept 1909, p. 149.
[62] Chancery lunatics were found insane at trial by jury, a legal proceeding undertaken to protect the family and property of the lunatic. This meant that Chancery lunatics were upper or middle-class individuals and therefore kept as private patients. See Mellet, 'Bureaucracy and Mental Illness', p. 243, n130.
[63] LA, HRL/4/12/3/33, 21 Mar 1908-3 Sept 1909, p. 149.

Chancellor's Visitor in Lunacy.[64] Although she was not discharged, Sarah Ann was given the option to move to another institution. Her case highlights the role that a patient's social class could play in facilitating agency. That is not to suggest, however, that pauper patients were not able to express their complaints in writing. Thomas B., a labourer admitted as a pauper patient, wrote a letter to the Home Office complaining about his treatment in Lancaster Asylum. Consequently, the Commissioners in Lunacy requested that the asylum provide them with a full report on the allegations.[65] When he had initially made his complaint during a medical interview on 4 June 1908, no further action had been taken; however, by writing a letter to external authorities, Thomas secured an investigation.[66]

Several patients sought to make complaints more effective by asking relatives to forward them on their behalf. Henry M. wrote to his friends instructing them to ask for his discharge: 'I have spoken to the Doctor in reference to [my] discharge, and he informed me that my Friends should write to the Medical Superintendent'.[67] This strategy was ostensibly sensible, given that friends and family could have a significant input into the treatment of patients in asylums.[68] Patients could be discharged at the request of friends and relatives even when the asylum doctors judged that they were not fully cured. Thomas P., for example, made several escape attempts during which he returned to his family who lived near to Lancaster. After being returned to the asylum by his relatives on all three occasions, he was finally discharged into their custody, and although his condition was said to have been 'relieved', he was not discharged 'cured'.[69] Soliciting support from relatives could clearly add weight to patients' complaints.

Complaining through external channels was, on balance, more effective than using internal complaints mechanisms. The influence of the press, external regulators, and relatives was significant in lending weight to patient complaints. In all the instances of complaint discussed in the previous sections it is apparent that whether complaining through internal channels, or in external forums, patients were more likely to have been able to alter the ways in which they were treated *within* Lancaster Asylum than to obtain their discharge. As such,

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[64] Michael Neve and Trevor Turner, 'What the Doctor Thought and Did: Sir James Crichton-Browne (1840-1938)', *Medical History*, 39 (1995), 399-432.
[65] LA, HRL/4/12/2/29, 17 Aug 1908-18 May 1910, no. 23513.
[66] LA, HRL/4/12/2/29, 17 Aug 1908-18 May 1910, no. 23513.
[67] LA, HRL/4/12/2/24 17 Feb 1905-21 Dec 1905, letter attached to p. 249.
[68] Wannell, 'Patients' Relatives', pp. 305-6.
[69] LA, HRL/4/12/2/4, 21 Jul 1868-8 Dec 1870, p. 223.

for the many patients for whom detention itself was their issue, complaining was not effective in obtaining their desired outcomes and they found other ways to resist their confinement.

4.4 Rejecting Medical Authority

As we have seen, making use of asylum-sanctioned procedures afforded patients a degree of agency, however, operating within these systems meant the tacit acceptance of medical authority. As such, some patients made use of other means of resistance. For some, this took the form of a rejection of asylum doctors' claims to medical expertise. Regardless of whether patients agreed with their designation as 'insane', they did not necessarily accept the asylum was the right venue for their recovery. Often, this disagreement was made apparent from the outset in patients' resistance to admission. Admission to Lancaster Asylum began with patients being bathed by nurses on arrival prior to their physical and mental examination by doctors. Each stage in this process presented discontented patients with an opportunity to resist institutional authority. Patients like Frances L., resisted admission at every stage: 'Would not get out of cab on arrival and several attendants carried her into waiting room where she was held by about ½ doz nurses and thence taken to bath and held whilst examined'.[70]

Francis' resistance, however, did not prevent the asylum authorities from ensuring that the admissions procedure was followed. Francis' use of her body to resist detention - refusing to move from the cab, and then struggling against being held – corresponded with the physical means used by the asylum to quash that resistance, carrying her inside and holding her still. The methods used to resist and reassert medical authority reflect competition between patient and practitioner for control of the body. The nature of asylum power was thus productive of the particular type of resistance to it, and vice versa.[71] It was not just during admissions that patients resisted medical control over their bodies; some patients refused to cooperate with physical examinations.[72] Michael F., for example, made physical examination difficult by keeping 'his general muscular system in a state of tension, holds his breath as long as he can and examination is thus very difficult'.[73] Although it has been argued

[70] LA, HRL/4/12/3/8 11 Oct 1879-9 Mar 1881, p. 103.
[71] This interpretation is influenced by Foucault's discussion of power and resistance in Foucault, *The History of Sexuality*, pp. 95-6.
[72] Edward Shorter, *Doctors and their Patients: A Social History* (New Brunswick, NJ, 1991).
[73] LA, HRL/4/12/2/9, 4 Feb 1879-13 May 1880, p. 246.

that patients' bodies were constituted as objects of scientific knowledge by nineteenth-century medical professionals, and thereby subjects of control,[74] we see in cases like those of Francis L. and Michael F., that patients used their bodies to resist medical authority. The doctor's power over the patient rests on their respect of medical authority, and allowance of the physical examination. As has been pointed out elsewhere, if the patient withdraws their cooperation then the medical encounter cannot take place.[75]

The outcome of patients' resistance to medical examinations may have been to deprive asylum doctors of knowledge of their bodies and/or minds, however, this was not necessarily their aim. Many incidents of resistance to the physical examination appear to have been connected with mistrust or fear, especially in examinations involving medical equipment. Agnes R. was reluctant to allow the use of an ophthalmoscope: 'considerable opthalmia [sic] but a view of her fundus [retina] with the opthalmascope [sic] is impossible owing to patient keeping her eyes firmly closed'.[76] Reticence in examinations involving medical instruments is not surprising given the propensity of patients to be wary of new medical technologies.[77] Distrust of the medical profession, shaped by preferences for self-help amongst the English working-classes during the nineteenth-century, probably carried over into the institution. [78] Patient resistance to medical examinations can thus be situated alongside broader trends within working-class health culture.

This mistrust of medical authority can be seen in many interactions between doctors and patients in the asylum. Some patients refused to speak to doctors altogether; Annie T. physically turned her back to medical officers whenever they spoke to her.[79] This rejection of the right of the asylum doctors to know anything about patients was a common response. As

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[74] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (trans.), Allan Sheridan (London, 1976).
[75] M. E. Fissell 'The disappearance of the patient's narrative and the invention of hospital medicine', in Roger French and Andrew Wear (eds.), *British Medicine in an Age of Reform* (London and New York, 1991).
[76] LA, HRL/4/12/3/25 9 Jan 1900-8 Mar 1901, p. 63.
[77] Joel D. Howell, *Technology in the Hospital. Transforming Patient Care in the Early Twentieth Century* (Baltimore, MA and London, 1995), pp. 136-57; Roy Porter, 'The Rise of Physical Examination', in W. F. Bynum and Roy Porter (eds.), *Medicine and the Five Senses* (Cambridge, 1993), p. 180; Peter John Brownlee, 'Ophthalmology, Popular Physiology, and the Market Revolution in Vision, 1800-1850', *Journal of the Early Republic,* 28(2) (2008), p. 613.
[78] Beier, *For Their Own Good.*
[79] LA, HRL/4/12/3/25 9 Jan 1900-8 Mar 1901, p. 92.

Porter points out, the doctor's 'right' to 'ask intimate questions' could be construed as 'unusual, embarrassing, intrusive or offensive' in the absence of the patient's consent.[80] Given that asylum patients were detained without consent, it is not surprising that patients like Annie found medical questioning offensive. Patients were particularly reluctant to supply the doctors with evidence of insanity, lest it interfere with their discharge. John E. summed up this reluctance: 'When asked for his evidence [for his delusions] says that being in asylums so long has made him think that silence is golden'.[81]

Some issues, however, were too apparent for patients to conceal from doctors. Certain physical ailments, which were visible to the naked eye, or symptoms of acute mental distress that patients were unable or unconcerned to hide, were easy to observe within the institutional setting. However, even where such symptoms were plainly visible, doctors still could not treat them if patients refused to cooperate. Some patients refused to accept pills, potions and prescriptions that were recommended by asylum doctors. There was a notable desire amongst patients to avoid taking opiates or sedatives. Jane A. refused chloral hydrate, a common sedative, and her resistance was successful.[82] It was not just opiates that patients objected to, many individuals were simply reluctant to take medicines at all. Betsy E. refused cod liver oil[83] and Margaret W. refused all medicines.[84]

The resistance of patients to medical control over their bodies can be situated in relation to wider public resistance to medical control during the nineteenth century. Popular resistance to medical authority coalesced around the Anatomy Act (1832), the Compulsory Vaccination Act (1853) and the Contagious Diseases Acts (1864, 1866 and 1869).[85] The Anatomy Act provoked rioting outside Parliament whilst its passage was being debated, and resistance was particularly marked amongst the poor for whom the dissection issue highlighted their place in the class-structure of Victorian society.[86] Opposition to the Contagious Diseases Acts and Compulsory Vaccination Act was motivated by concerns over

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[80] Porter, 'The Rise of Physical Examination', pp. 179-80.
[81] LA, HRL/4/12/2/23, 25 Feb 1904-15 Feb 1905, p. 242.
[82] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 151.
[83] LA, HRL/4/12/1/22, 11 June 1860-14 Dec 1861, p. 32.
[84] LA, HRL/4/12/3/4, 31 Dec 1869-3 May 1872, p. 27.
[85] Nadja Durbach, *Bodily Matters: The Anti-Vaccination Movement in England, 1853-1907* (Durham and London, 2005).
[86] Richardson, *Death, Dissection and the Destitute,* p. 275.

individual liberty and resistance to 'medical despotism'.[87] The existence of an alternative working-class health culture produced deep-rooted resistance to medical expertise and medical control of the body.[88] Resistance to the aforementioned Acts, and the persistence of working-class health culture was particularly marked amongst the poor, and especially prevalent in Lancashire.[89] The pauper population of Lancaster Asylum was, thus, drawn from a socio-economic section of English society amongst whom opposition to medical authority was particularly prevalent.

The challenges made by these patients to medical authority in the asylum did not go unanswered by asylum doctors. Just as patient resistance was influenced by contemporary issues over the encroachment of professional medicine into the lives of the working classes, asylum doctors' assertion of their authority was also influenced by contemporary issues in nineteenth-century medical practice wherein doctors were seeking to assert their expertise and consolidate professional authority.[90] Asylum doctors reasserted their right to apply their expertise to the bodies of asylum patients through physical, often violent, mechanisms. Patients were forced to participate in medical treatment by being held down during physical examinations or force-fed drugs. These mechanisms did little to promote patient trust of asylum doctors, thus fuelling a perpetual cycle of domination and resistance, which characterised much of the relationship between patient agency and asylum authority throughout the period.

4.5 Refusing to Work

Asylum treatment was not constituted solely by medical interventions, and as such patient resistance was not solely targeted towards medicine. Work, in many ways, was the backbone of moral treatment, being employed to restore patients' self-control and to distract

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[87] F. B. Smith, 'The Contagious Diseases Acts Reconsidered', *Social History of Medicine,* 3(2) (1990), p. 200.
[88] Beier, *For Their Own Good.*
[89] Sean Burrell and Geoffrey Gill, 'The Liverpool Cholera Epidemic of 1832 and Anatomical Dissection – Medical Mistrust and Civil Unrest', *Journal of the History of Medicine and Allied Sciences,* 60(4) (2005), 478-98; Durbach, *Bodily Matters,* pp. 38-41; Beier, *For Their Own Good*.
[90] Anne Hardy, *Health and Medicine in Britain Since 1860* (Basingstoke, 2001).

their minds from morbid thoughts.[91] Work in the asylum was also important to the economy of the institution, offsetting running costs.[92] Consequently, patient labour has been considered as exploitative, and as a means through which the Victorian middle-class work ethic was cultivated in patients.[93] Such negative assessments of the ways in which patient labour was used in asylums have usefully been subject to refinements in more recent scholarship on the topic.[94] In line with this more nuanced view of work in the asylum, evidence from Lancaster Asylum suggests that work was an area of life over which patients could exercise a significant degree of agency. Case notes suggest that patients only engaged in work if they wanted to. In fact, contemporary medical opinion, expressed in treatises on moral treatment, was clear that patients should not be forced to work against their will.[95]

Engaging in work was seen as a key marker of patient recovery; a sign that they were capable of being a useful citizen and therefore ready for discharge.[96] As such, patients' refusals to work were recorded diligently in casebooks.[97] Lancaster Asylum doctors distinguished between patients who were *unable* to work, and those who refused.[98] This is apparent in the language from case notes, and in the categories used to collect statistics on the number of patients employed per year.[99] The case notes of many patients only recorded that they refused to work, providing no record of any reasons given by the patient for not taking

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[91] Samuel Tuke, *Description*, pp. 133, 139; Haslam, *Considerations on The Moral Management of Insane Persons*, p. 73.
[92] LA, QAM/5/1-45, *Reports* (1841-1888); LA, CC/LAR/1-2, *Reports* (1889-1890); LA, CC/HBR/1-45, *Reports* (1891-1938).
[93] Shawn N. Phillips, '"Just Can't Work Them Hard Enough": A Historical Bioarchaeological Study of the Inmate Experience at the Oneida County Asylum", in Knowles and Trowbridge (eds.), *Insanity and the Lunatic Asylum*, pp. 71-84.
[94] Digby, 'Moral Treatment at the Retreat, 1796-1846', in Bynum, Porter and Shepherd (eds.), *The Anatomy of Madness,* Vol. 2, pp. 52-72, 68; Waltraud Ernst, 'Introduction: Therapy and Empowerment, Coercion and Punishment. Historical and Contemporary Perspectives on Work, Psychiatry and Society', in Ernst (ed.), *Work, Psychiatry and Society*, p. 7.
[95] Jane Freebody, 'The Role of Work in Late Eighteenth- and Early Nineteenth-Century Treatises on Moral Treatment in France, Tuscany and Britain', in Ernst (ed.), *Work, Psychiatry and Society*, p. 44.
[96] Chaney, 'Useful Members of Society or Motiveless Malingerers?', pp. 277-97.
[97] Hide, *Gender and Class,* pp. 102-3, 113.
[98] Such debates parallel wider contemporary discourses surrounding unemployability, see, John Welshman, 'The Concept of the Unemployable', *Economic History Review,* 59(3) (2006), 578-606.
[99] LA, QAM/5/1-45, *Reports* (1841-1888); LA, CC/LAR/1-2, *Reports* (1889-1890); LA, CC/HBR/1-45, *Reports* (1891-1938).

up employment, and viewing such individuals either as defiant or lazy.[100] Thomas B. was one such patient, his case notes state simply stating that he was 'very idle, and refuses to work'.[101] For the asylum, refusals to work at best suggested that patients were not improving, and at worst that they were malingerers.[102] However, on some occasions, discussions in casebooks of patients' refusals to work provide more detail as to why they refused, allowing some insight into what refusing to work meant to patients. These incidents indicate that, for some, refusing to work was a mechanism of resisting asylum authority.

Some patients stopped work in the asylum as a protest, refusing to work until a demand was met, or a grievance addressed. Thomas W. ceased employment after he had not received his discharge: 'refused to work yesterday, alleging disappointment at not being discharged'.[103] In the asylum, where patients found themselves in an inherently unequal power relationship, withdrawing their labour was one of the only options available to gain some leverage. The futility of this mechanism of resistance was recognised by some patients, who demonstrated an awareness that unless all patients refused to work, such tactics would have little impact. These patients attempted to incite collective action to give their 'strike' more impact. Charles M., for example, 'Endeavoured to stir up rebellion and to induce men to refuse to work'.[104] His endeavour was not successful in bringing about collective action, however, his attempt to start a strike demonstrates that some patients did see the withdrawal of patient labour as a mechanism of resistance. Patient strikes cannot solely be viewed in the context of asylum life but must be placed within the wider context of labour relations during this period. Lancashire, known as the 'hot bed' of Chartism, saw significant volumes of labour disputes during the nineteenth century. Lancashire workers took part in a number of organized strikes in this period, including the 1878 cotton riots, and strikes from cotton-workers and miners that took place throughout the latter part of the nineteenth century.[105] Pauper patients admitted from the labouring classes of Lancashire were inevitably influenced by the wider socio-cultural milieu of organised labour in the County.[106]

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[100] Hide, *Gender and Class*, p. 113.
[101] LA, HRL/4/12/1/10, 9 Apr 1839-24 Jul 1840, p. 174.
[102] Chaney, 'Useful Members of Society or Motiveless Malingerers?', p. 284.
[103] LA, HRL/4/12/1/21, 22 Jan 1859-8 Jun 1860, p. 201.
[104] LA, HRL/4/12/2/13, 26 Mar 1884-20 Dec 1886, p. 301.
[105] John K. Walton, *Lancashire: A Social History, 1558-1939* (Manchester, 1987), pp. 239-82.
[106] Walton, *Lancashire*, pp. 239-82.

Several patients refused to work because they were not paid. Patients employed in asylums worked as a part of their moral treatment, [107] and to offset the cost of their treatment and accommodation.[108] However, some patients felt that they should receive monetary payment. During the late-nineteenth century, the identity and social status of working-class men was closely connected to their ability to perform their function as the breadwinner.[109] Louise Hide points out, the connection of working-class masculinity with men's capacity as wage-earners meant that male patients' senses of self were shaken by institutionalisation: 'Once in the institution, their most valuable personal assets – their time, skills and labour – would have remained either unused or earned them little more than an extra ounce of two of tobacco and a glass of milk at mealtimes'.[110] In Lancashire, the significance of women as wage-earners within the household economy suggests that these considerations would equally have applied to their experiences of working in the asylum. [111] Ann D's case notes demonstrate this, stating that she, 'will not do much work "because she cannot get wages": says she is a nail maker and could do that if she was paid'.[112] Walton notes that the unusually high level of female employment in the Lancashire area provided scope for the exchange of ideas between women in the workplace and gave female employees experience of labour organisation. The refusal of patients like Ann D. to work, can therefore perhaps be better understood within the context of the social meanings of work amongst the Lancashire working-classes.

Whatever the reasons given, or not given by patients, refusing to work was one of the key areas of asylum life over which patients had ultimate control.[113] The reasons that patients in Lancaster Asylum gave for not working, and the mechanisms of resistance to work that they adopted, illuminate the close connections between attitudes to work in the asylum, and patients' experiences of work and working-class culture outside the institution. While patients were induced and encouraged to work by asylum staff, they could not be forced to take up employment, and as such, they could exercise a significant degree of agency over this area of asylum life. Such behaviour undoubtedly delayed patients' discharge, since asylum doctors

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[107] Ernst, 'Introduction', pp. 5-6.
[108] Cf, Mary Nejedly, 'Earning Their Keep: Child Workers at the Birmingham Asylum for the Infant Poor, 1797-1852', *Family and Community History,* 20(3) (2017), 206-17.
[109] Rose, *Limited Livelihoods,* p. 176.
[110] Hide, *Gender and Class,* p. 114.
[111] Walton, *Lancashire,* pp. 280-81.
[112] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 208.
[113] Hide, *Gender and Class,* p. 113.

saw such refusals as evidence of recalcitrant behaviour. However, some patients, perhaps, were unconcerned with (or unaware of) the effect that refusals to work would have on their chances of being discharged.

4.6 Patient Escapes

For many individuals in Lancaster Asylum, escaping provided an alternative route out of the institution, enabling patients to bypass medical control over their detention. The motives underlying patient escapes varied; some were planned, others were opportunistic; some were reactions to being forcibly detained, others were a reaction to a specific incident in the asylum; some were successful, others were not. In all cases, however, escapes represented a tangible way for patients to regain control over their lives; a literal rejection of the asylum's authority to detain them. A patient who remained uncaptured for 14 days had to be discharged.[114] This quirk of English law has not been considered in current scholarship, however, work which deals more generally with English lunacy legislation in this period suggests that the so-called '14-day rule' reflected contemporary concerns for individual liberty.[115]

Attendants and nurses had significant incentives to guard carefully against patient escapes.[116] They were held responsible when any patient in their charge ran away: 'when any patient escapes through the inattention or carelessness [of a member of staff] the whole or a portion of the expenses of capturing and bringing back such a patient to the Asylum may be deducted from their wages'.[117] Superintendents were also penalized by Commissioners in Lunacy for escapes, risking not only their reputations, but also financial penalties.[118] The authority of the asylum was undermined by escapes; it made staff appear incompetent during a period when asylum doctors were concerned with consolidating professional authority.[119] Prevention of escapes was also connected with concerns for the safety of the wider

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[114] The Lunacy Act, 1890, 54 Victoria, 1113.
[115] Victorian concerns for the threat posed by the compulsory detention of the insane to individual liberty were periodically debated in the press. See, McCandless, 'Liberty and Lunacy', 366-86.
[116] These responsibilities could take a significant toll on asylum staff, Hide, *Gender and Class*, p. 58.
[117] LA, HRL/2/2/1, 'Regulations and Orders', p. 9.
[118] The Lunacy Act, 1890.
[119] Scull, *Museums of Madness*, pp. 164-80.

community; in 1870 the *Lancaster Guardian* reported the 'Escape of Four Lunatics!', warning locals to be on their guard.[120] Such panics in the local press may have reinforced the necessity of the asylum to contain potentially dangerous individuals, however, escapes also highlighted that asylum doctors were failing to fulfil this function of safeguarding the public.[121] Indeed, in his 1885 Report, Superintendent David Cassidy noted that the public were 'apt to be sensitive' when patients escaped.[122] It was mandatory for asylums to report escapes to the Commissioners in Lunacy, so in descriptions of escapes in casebooks and on official forms, asylum authorities used this opportunity to exonerate themselves from blame.[123]

Escaping from the institution was not without difficulty; patients were under constant observation, and the building they inhabited was designed prevent them from leaving. Despite such challenges, escapes were relatively common. Through running away, patients disregarded asylum authority altogether; they rejected the right of the medical profession to detain them against their will.[124] Escape provided a means of circumventing, or disregarding, medical discussions about fitness to leave the asylum, making patients' discharge a question of liberty/captivity rather than cured/uncured. The case notes of Thomas H. reflect this disparity between medical and patient understandings of escape. Thomas's doctor's description of his attempt to break out of the asylum sheds some light on this: 'he became quite excited and struck the window frame violently with a small table saying that he would not stop here and that if he could not get out by the door he would go by the window'.[125] Thomas's speech refers to the door as a legitimate method of leaving the asylum, a metaphor for being allowed to leave legitimately. The window represents the illegitimate method of leaving the asylum – escape. Thomas's explanation of his actions shows how some patients

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[120] *Lancaster Guardian,* 19 March 1870.
[121] David O'Driscoll and Jan Walmsley, 'Absconding from hospitals: a means of resistance?', *British Journal of Learning Disabilities,* 38(2) (2010), 97-102.
[122] LA, QAM/5/34, *Reports* (1885), p. 23.
[123] Escapes were also recorded in a separate book from 1899 as required by the Commissioners in Lunacy, LA, QAM/1/33/12, Records of Escape and Recapture, 1899-1915.
[124] Peter Carpenter, 'Resistance and Control: Mutinies at Brentry', in Duncan Mitchell, Rohhss Chapman, Nigel Ingham, Sue Ledger, Louise Towson and Rannweig Traustadottir (eds.), *Exploring Experiences of Advocacy by People with Learning Disabilities: Testimonies of Resistance* (London and Philadelphia, PA, 2006), pp. 172-8.
[125] LA, HRL/4/12/2/7, 28 Jul 1875-26 Jun 1877, p. 93.

perceived escape; as a viable means of obtaining freedom when they could not obtain their discharge.

Patient escape attempts were often prompted by specific situations or events that occurred while they were in the asylum.[126] That patients had specific drives to escape can be seen in the fact that many attempts were evidently premeditated, with some plans being highly elaborate. William S., for example, recruited a co-conspirator and persuaded him to break the locks on his door and window. He planned his escape to take place at night, making it less likely that he would be spotted in the grounds. William had also considered how he would get safely to the ground, creating a rope from bedsheets to climb down the side of the building.[127] The lengths to which patients went to escape reflects the determination of some individuals to evade medical control.

Other incidents, however, were more opportunistic, and, for men, work presented such opportunities.[128] Richard B., for example, 'Took the opportunity of leaving the workshops during the dinner and was followed as far as Clitheroe where all trace was lost'.[129] The fact that male patients had access to outdoor spaces may go some way toward explaining why they made escape attempts more frequently than their female counterparts. Out of the 400 escape attempts that appear in the casebook sample used in this study, 303 were made by men and 97 by women.[130] Women were more frequently occupied indoors, and being confined to the building meant that they were subject to greater levels of surveillance and physical security obstacles.[131] When female patients did escape they often did so by taking advantage of the limited access they did have to outdoor areas. [132] Women often escaped when they were taking exercise on organised walks, or whilst moving from one building to another within the asylum complex. Indeed, patients making a run for it when moving between buildings became increasingly problematic for staff over time as the asylum buildings multiplied.[133] This was evidently recognised as a problem by the asylum authorities, as in the twentieth century, underground tunnels were added to allow patients to

[126] O'Driscoll and Walmsley, 'Absconding from Hospital', pp. 101-2.
[127] LA, HRL/4/12/2/20, 27 Jun 1898-6 Jul 1902, p. 178.
[128] Hide, *Gender and Class*, p. 164.
[129] LA, HRL/4/12/1/14, 12 Jun 1845-24 Jul 1847, p. 51.
[130] For discussion of sample size see Chapter Three, pp. 55-63.
[131] Hide, *Gender and Class*, p. 164.
[132] For example, LA, HRL/4/12/3/25, 9 Jan 1900-8 Mar 1901, p. 203.
[133] Watts-Tobin, 'A History of Lancaster Moor Hospital', 71-4.

move between buildings without going outside.[134] In this way the building itself was adapted to reassert institutional authority over the bodies of patients.[135]

Patient escapes highlight the tension between control and cure that was inherent within moral treatment in nineteenth-century asylums. Patients were to be allowed outside to take exercise, and to be allowed in the workshops and farms at the asylum to undertake active employment. These aspects of asylum life were essential to restoring patients' capacity for 'self-control'; their capacity for agency. Yet, at the same time, these activities were what allowed patients to make escapes. When these elements of asylum life were part of attempts to run away, asylum authority was reasserted by prohibiting patients' access to them. Ultimately, the custodial elements of the institution were emphasised over the asylums' curative functions. Patient agency as manifested in escapes, therefore, can be seen as having produced a particular mode of medical power in the asylum that was far more authoritarian than the rhetoric of moral treatment would imply.

4.7 Violence

All of the tactics discussed thus far sought, in some way, to resolve patients' grievances, to bring about change through resistance. Violent behaviour, whether directed against other patients or against staff, did not seek to resolve grievances in the same way. Violence in the asylum was used by patients to express frustration with elements of institutional life, to resolve interpersonal conflicts and sometimes in situations where there was no clear motive. It was often, though not always, a spur-of-the-moment response, and in most cases was employed to resolve a specific and immediate situation. In some cases, violence was employed to express dissatisfaction with elements of institutional life. However, through examining the frequency and direction of patient violence in Lancaster Asylum, it is suggested here that violence was more important as a spontaneous expression of frustration than a calculated response to institutional oppression.

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[134] Personal Correspondence with Dr Steve Dealler, Independent Scholar, Lancaster.
[135] See Chapter Seven, pp. 149-55.

	Violence Against Staff	Violence Against Patients	Undirected Violence	TOTAL
Violence by Male Patients	170	510	266	946
Violence by Female Patients	151	345	334	830
TOTAL	321	855	600	**1776**

Table 1. Incidents of Violence in Lancaster Asylum by Gender and Target based on the Casebook Sample used in this Thesis

The direction of patient violence suggests that it was not primarily a means of resisting the institution, given that staff were targeted far less frequently than other patients. That violence was the result of patient frustrations caused by life in the asylum is apparent from some of the violent encounters described in case notes. For example, William K. continually shouted to 'unseen' people, presumably owing to his delusions, which was undoubtedly disturbing to other patients. Another patient became extremely frustrated with William and this frustration was expressed through violence: '[William] Got a bad blow on the face from another patient some weeks ago which cut his nose pretty deeply…The cause of this accident appears to have been a sudden fit of anger on the part of another patient roused by [K.'s] habit of shouting to unseen people'.[136]

On other occasions, patient violence resulted from interpersonal conflicts. In an institution like Lancaster Asylum, a whole host of personalities from various backgrounds were thrown together. Not only were people in Lancaster Asylum faced with the challenges of communal living, but these difficulties were compounded by the fact that individuals were there against their will and living amongst people suffering from mental illnesses of varying severities. Some attacks must be understood in this context. On 1 October 1880, Eliza F.'s

[136] LA, HRL/4/12/2/10, 18 May 1880-30 Nov 1881, p. 35.

case notes record that she got into a fight with another patient: 'Slapped J [I.'s] face who struck her twice in the face'.[137] Another patient, Isabella M. 'Struck another harmless old woman with her elbow because she was talking'.[138] When interpreting these 'unprovoked' acts of violence we must understand them in the context of the experience of asylum life. The buildings of Lancaster Asylum were crowded,[139] many patients were noisy, and patients were often there against their will. Such an environment was, undoubtedly, a uniquely emotional and challenging setting. Indeed, the history of emotions, especially work on anger, may offer a useful explanatory schema for patient violence in the asylum.[140]

The language used by asylum doctors to report incidents of violence reflects such contemporary understandings of emotions. In each case discussed above, an explanation was provided for patients' violent propensities which situated them as apparently rational responses. William K. was attacked because he was creating a disturbance, Eliza F. slapped another patient because that patient had previously attacked her, and Isabella M. was said to have been annoyed by another patient 'talking'. The language used in these cases emphasized the apparent rationality of the patients' uses of violence. By explaining incidents of violence in these terms, asylum doctors potentially sought to exonerate themselves from any blame in regard to poor patient management, or a failure to instil their patients with self-control. Instead, inter-patient violence was framed in language that drew on contemporary understandings of permissible expressions of anger.[141]

Not all violence was spontaneous; some was planned and clearly demonstrated strategies of resistance. Indeed, violence has formed a key part of the resistance strategies of many marginalized social groups at various times and in various places.[142] The use of

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[137] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 158.
[138] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 176.
[139] See Appendix I for institutional population figures, p. 240.
[140] Peter N. Stearns, *American Cool: Constructing a Twentieth Century Emotional Style* (New York, 1994), pp. 29-31; William M. Reddy, *The Navigation of Feeling: A Framework for the History of Emotions* (Cambridge, 2001); Jamison Kantor, 'Burke, Godwin, and the Politics of Honor', *SEL Studies in English Literature 1500-1900*, 54(3) (2014), 675-96.
[141] For a comprehensive discussion of the naturalisation of anger in Victorian society see, Peter Gay, *The Cultivation of Hatred: The Bourgeois Experience Victoria to Freud* (New York, 1993).
[142] Katherine D. Watson (ed.), *Assaulting the Past: Violence and Civilisation in Historical Context* (Newcastle, 2007); Clark, 'Wild Workhouse Girls'; Green, 'Pauper Protest'; Crossman, 'The New Ross Workhouse Riot', 135-58; Navickas, *Protest and the Politics of Space and Place.*

violence to resist institutional authority can be seen in the case of Peter L., who reacted violently when an attendant put pressure on him to do work at a time when Peter was especially insistent upon his discharge. His case notes record that 'he became importunate about his discharge and in a fit of passion struck the attendant who was asking him to do his accustomed work'.[143] Peter's case notes suggest that he reacted violently because the attendant was asking him to employ himself. The case notes are silent on the issue of Peter having wanted to discuss his discharge. On closer reading, it seems more likely that Peter's frustration stemmed, not only from being detained in the asylum against his will but was also due to the attendant's decision to ignore these concerns. As discussed above, informal channels of complaint such as airing grievances with medical staff could provide a vent for patient protests but in this instance, Peter was deprived of such an outlet. The case notes couch the incident in terms of a refusal to work, emphasizing the patient's lack of conformity with asylum rules, and ignore the role that staff might have played in causing or perpetuating patient frustrations.[144]

Violence as resistance can also be seen in the correlation of patient violence with certain points in the institutional timetable; being required to wake up, work, and go to bed at set times of day was something to which several patients objected. As such, attacks on staff were often associated with these times of day. William Henry F. 'became much excited at bedtime and struggled with the attendants when being put to bed'.[145] Isabella M. attacked the nurse who was attempting to wake her up one morning.[146] The nurse and attendant attacked in these incidents were representatives of institutional authority; it was through them that the asylum was able to exercise control over patients.[147] In this light it is unsurprising that violence was at times directed against these representatives.

What is more striking is the low frequency with which nurses and attendants were targeted: just 18.1 per cent of violent incidents in the sample were targeted at staff. As such we might infer that nurses and attendants were very rarely held 'responsible' by patients for

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[143] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 293.
[144] Cf. staff roles in defusing potential violent incidents in modern psychiatric facilities in Marnie Rice, Grant T. Harris, George W. Vancey and Vernon L. Quincey, *Violence in Institutions: Understanding, Prevention and Control* (Toronto, 1989).
[145] LA, HRL/4/12/2/7, 28 Jul 1875-26 Jun 1877, p. 154.
[146] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 176.
[147] Claire Chatterton, '"Always Bear in Mind That You Are in Your Senses": Insanity and the Lunatic Asylum in the Nineteenth Century- From Keeper to Attendant to Nurse', in Knowles and Trowbridge (eds.), *Insanity and the Lunatic Asylum*, pp. 85-97.

their dissatisfactions. Loyalties did not always lie along a simplistic binary of patients versus staff; the situation was more complex. Perhaps this was due to attendants and nurses being of a similar social background to patients. Many patients and their families knew attendants prior to entering the asylum. This is evidence in casebooks, for example, when William Henry T. escaped from the asylum to his friends' house, his friends contacted an attendant they already knew when William showed up at their house.[148] There may also have been a sense of camaraderie between nursing staff and patients due to shared living conditions.[149]

Casebook evidence gives little direct indication of collusion between patients and staff. Subtle traces of this run through some casebook reports, for example, in some incidents of attacks against staff, other patients intervened to protect nurses or attendants.[150] One incident discussed in an annual report mentions suspected collusion between a patient and a woman employed as a laundry maid in the asylum in contriving an escape attempt and stealing some clothes.[151] These traces inevitably do not give us the whole picture, but they do suggest that patients' relationships with nurses and attendants could be collegial. If collaboration or collusion did occur between patients, and their nurses and attendants it would only appear in casebooks if they were caught. It is unlikely that patients would give up nurses and attendants even if they were caught breaking rules.[152] Official records may therefore mask the complexities of relationships been patients and their nurses and attendants.

Violence represented a challenge to the authority of the institution, one that took place in front of other patients and members of staff, which necessitated the visible reassertion of asylum authority i.e. the punishment of patients. Violent patients were moved to different wards or galleries, away from whomever they had been violent towards. This not only served the practical purpose of separating antagonistic patients, but also punished patients.[153] Removing patients from their ward could also mean moving them to a single room – placing them in seclusion. Ostensibly this was done for patients' own safety, and that of the people around them. However, seclusion was also a punishment. It has a strong association with

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[148] LA, HRL/4/12/2/29, 17 Aug 1901- 16 May 1910, no. 23427.
[149] Robert Dingwall, Anne Marie Rafferty and Charles Webster, *An Introduction to the Social History of Nursing* (London, 1988), p. 127.
[150] E.g., LA, HRL/4/12/3/8, 11 Oct 1879-9 March 1881, p. 176.
[151] LA, CC/HBR/4, *Reports* (1896), p. 19.
[152] Cf. Bill Forsythe, 'Loneliness and Cellular Confinement in English Prisons 1878-1921', *British Journal of Criminology,* 44 (2004), p. 764.
[153] Digby, *Madness, Morality and Medicine*, p. 71.

prisons, particularly the separate system, where it was intended to force introspection and reflection.[154] Punishments for violent behaviour in the asylum occasionally focussed on patients' bodies with blistering, purgatives, medicines and shower-baths being used. Such treatments occupied an uneasy area between medical intervention and punishment, and as the rhetoric of moral treatment and the non-restraint movement became more influential throughout the nineteenth-century such interventions became less common. Nonetheless, the use of blistering, purgatives, low-diets and the administration of other sedative medicines in cases of violence continued into the 1860s.[155] Even shower-baths, despite their controversial nature, continued to appear in the casebooks as a response to violence in Lancaster Asylum until 1895.[156]

The patients' body was, therefore, a significant site for the reassertion of asylum authority throughout the nineteenth century, either through its removal to different wards, secluded rooms, or through medical interventions which depleted it. Given that patient violence targeted the physical bodies of staff, or of other patients, punishments that focussed on the bodies of violent patients directly corresponded with this particular manifestation of patient agency. Such physical reprisals may well have served as deterrents, especially of violence towards staff, however, they also inevitably heightened the frustrations of patients, and their feelings of powerlessness and desperation. This fuelled a perpetual cycle of institutional violence which highlights that the relationship between agency and authority in the asylum was not simply a dichotomy of power and resistance, but a cycle. This cycle shaped the nature of medical treatment, and patient experiences, in the asylum.

4.8 Conclusion

Despite the variety of mechanisms of resistance explored throughout this chapter, significant common themes emerge from analysis of these strategies of defiance. It is clear that the strategies discussed above were shaped by trends and events in wider society. Paupers'

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[154] Forsythe, 'Loneliness and Cellular Confinement', p. 761.
[155] Blistering fell out of use in English asylums by the mid nineteenth-century, Mary De Young, *Encyclopaedia of Asylum Therapeutics, 1750-1950s* (Jefferson NC, 1959), pp. 30-1. Purging continued to be used, certainly in Lancashire asylums, into the twentieth century, Montagu Lomax, *The Experiences of an Asylum Doctor: With Suggestions for Asylum and Lunacy Law Reform* (London, 1921).
[156] De Young, *Encyclopaedia of Asylum Therapeutics*, pp. 184-5.

struggles against medical authorities for control over their bodies during this period continued after their admission to the asylum. The influence of the mechanisms of popular protest in wider Lancashire society can be seen in patients' uses of strikes to resist employment in the institution. The institutional focus of this thesis prohibits comparison with other institutions, however, findings here suggest that further research into the nature of local popular protest, and its relationship with mechanisms of resistance employed in local institutions would be fruitful. The knowledge that paupers brought into the asylum with them regarding lunacy law and public opinion of asylums also clearly influenced tactics of resistance such as complaining, using the press, letter-writing and even escaping. Even the use of violence in the institution may be situated in the contexts of Victorian understandings of 'righteous anger' in this period.

The other common thread which runs through this exploration of patient resistance to institutional authority in Lancaster Asylum is the relationship of patient agency with asylum authority. Patient agency was limited by the intervention of the asylum to reassert its authority. Although some patients can be said so have evaded asylum control altogether – patients who escaped – the majority of tactics discussed here allowed patients varying degrees of agency. To understand the extent of this agency, it must be situated within its relationship to power in the asylum. The authorities in Lancaster Asylum asserted their power over patients using mechanisms shaped by the ways in which patients defied that power. When patients complained and demanded investigations into their allegations of mistreatment or wrongful detention, the asylum responded by creating highly detailed investigation reports exonerating the institution from blame. When patients resisted physical examinations, or being given medication, the asylum responded by forcing compliance using physical means including restraint and force-feeding, reclaiming medical control of patients' bodies. When patients refused to work, although the asylum's options were limited here, they could prolong patients' detention. When patients attempted to escape, asylum authorities took steps to secure the patients' recapture and subjected recalcitrant escapees to spatial restrictions and careful monitoring. Violent patients were restrained, secluded, or moved to different wards – efforts of control focussing closely on the body. Resistance was not only produced by asylum power, but it in turn produced the particular modes of authority asserted in the asylum. Understanding this cycle of domination and resistance is essential to understanding the ways in which asylum treatment developed over the period.

5. Coping with Confinement

5.1 Introduction

In the previous chapter, we explored the ways in which inmates rejected their detention in Lancaster Asylum. Such acts of overt opposition to institutional authority could afford patients agency, however, they also occasioned significant consequences when the asylum reasserted its authority over the patient. Consequently, some patients did not seek to resist the institution, but to find ways of adjusting to, or coping with, life in Lancaster Asylum. The concept of 'coping strategies' deployed throughout this chapter can be likened to patients' experience of colonization identified in Goffman's *Asylums.* In their experience of colonization, inmates accepted their position in the institution and sought to make their existences therein as comfortable as possible by acquiring privileges through manipulations of the institutional regime.[1] Gallo and Ruggiero define coping mechanisms as strategies aimed at controlling distress *within* institutional settings. Inmates who employed coping behaviours did not wholly reject or accept their confinement, rather, they sought to minimize the anguish of institutionalisation.[2] Similarly, patient coping mechanisms in Lancaster Asylum pushed the limits of institutional rules, without breaking them. Such strategies might be considered 'half-measures', aimed neither entirely at rejecting or endorsing institutional authority.[3] In many ways, this made such behaviour especially problematic for the asylum regime to confront and, consequently, such strategies were often remarkably successful in allowing patients a degree of agency.

This chapter draws on heterarchical models of power to account for the fluidity of power relations in institutional settings.[4] Hierarchical models of power relations, which focus on vertical relationships of domination and subordination, cannot explain institutional life in

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[1] Goffman, *Asylums*, pp. 62-3.
[2] E. Gallo and V. Ruggiero, 'The Immaterial Prison: Custody as a Factory for the Manufacture of Handicaps', *International Journal for the Sociology of Law*, 19 (1991), 273-91.
[3] Liebling, 'Prison Suicide and Prisoner Coping', p. 288.
[4] Mikhail M. Bakhtin, *The Dialogic Imagination* (Austin, TX, 1981); Henrietta Moore, *A Passion for Difference: Essays in Anthropology and Gender* (Bloomington, IN, 1994); Suzanne M. Spencer-Wood, 'Gendering Power', in Tracy. L. Sweely (ed.), *Manifesting Power: Gender and the Interpretation of Power in Archaeology* (London and New York, 1999), pp. 175-83.

Lancaster Asylum.[5] While there were hierarchies in Lancaster Asylum, they existed within a larger, heterarchical structure.[6] Heterarchical power models understand power as operating as 'moments of opportunity', as 'lateral, nested, and plural', rather than emphasizing 'binary conflicts'.[7] Such models enable 'exploration of the situational means by which institutional inhabitants mobilize transient moments of power to negotiate their austere environment'.[8] It is these negotiations, this exploitation of moments of opportunity by patients, with which this chapter is concerned.

As the number of patients in Lancaster Asylum increased over the course of the nineteenth and twentieth centuries, the opportunities for patients to manipulate the asylum regime, and acquire more freedoms within the bounds of the institution, increased.[9] As approaches towards managing asylum populations shifted from moral treatment towards moral management, patients were able to gain a greater degree of power in the institution, both in relation to their own lives in the asylum and over other patients.[10] This heterarchical structure was central to the way in which patients were managed, and through this model the development of the asylum over time can be illuminated. The various coping strategies discussed in this chapter elucidate the mechanisms of this diffusion of power from asylum authorities to patients. Some coping strategies were effective throughout the period, however, in many cases these strategies became increasingly prominent in the latter decades of the nineteenth century. It is suggested that as patient numbers increased, managerial pragmatism came to outweigh therapeutic considerations, and unless patients' coping mechanisms directly challenged institutional authority, such behaviours were ignored or, in some cases, openly sanctioned.

There are a number of behaviours which could be considered as coping mechanisms that have not been discussed in this chapter. Patient suicide and self-injury have not been considered, even though such behaviours have been interpreted as coping mechanisms in

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[5] Wolf's model of power is hierarchical: Eric R. Wolf, 'Distinguished Lecture: Facing Power – Old Insights, New Questions', *American Anthropologist*, 92(3) (1990), 586-96.
[6] Janet E. Levy, 'Gender, Power and Heterarchy in Middle-Level Societies', in Sweely (ed.), *Manifesting Power*, p. 74.
[7] Conlin Casella, *Archaeology of Institutional Confinement*, p. 77.
[8] Conlin Casella, *Archaeology of Institutional Confinement*, p. 77.
[9] For details on the increase of the patient population see, Appendix I, p. 240.
[10] Digby, 'The changing profile of a nineteenth-century asylum', pp. 739-48.

other contexts.[11] The casebooks of Lancaster Asylum do not contain sufficient evidence of the meanings of these actions to patients to permit their discussion as agentive behaviours. The case record erases patient voice from such incidents because, following suicide attempts – even in cases where they were unsuccessful – the patient was not able to give an account of their motives due to physical injury or death. Similarly, in cases of self-injury, casebooks contain little to indicate that patients were asked why they had injured themselves, perhaps due to prevailing medical views of self-injury, which saw such actions as instinctive, undertaken upon animal impulses rather than as products of any rationale which could be offered up as explanation.[12] Yet self-injury was an action that was inherently cultural and personal, highlighting its potential to be employed as a coping mechanism.[13] As such, the use of suicide or self-injury as responses to institutionalisation may be a fruitful avenue of inquiry in future studies should appropriate sources be identified.

This chapter will explore how asylum patients used aspects of the medical encounter to empower themselves, providing illness narratives to influence the construction of their institutional identity. By co-constructing their psychiatric identity, patients were able to influence how they were perceived by the institution and thereby influence how they were treated. Patient requests will also be considered as a strategy that allowed patients to shape their lives in the institution. Patient requests were made in relation to their medical treatment, their access to material items, the wards on which they lived, and the types of employment they undertook in the institution. The final section of this chapter considers 'internal agency': strategies through which patients withdrew from their surroundings and sought refuge in solitary activities to distance themselves from institutional life. Patient coping mechanisms, at times, pushed the limits of institutional regulations so far that patients' expressions of agency were curtailed by the intervention of asylum staff. However, many of the behaviours that will be discussed here coalesced with the objectives of asylum authorities, or at least manipulated medical language to give the impression of doing so. Consequently, many of these strategies were tolerated and were therefore successful in affording patients the benefits that they

[11] Liebling, 'Prison Suicide and Prisoner Coping', 283-359; Myers and Sangster, 'Retorts, Runaways and Riots', p. 684.
[12] Eric Sinclair, 'Case of Persistent Self-Mutilation', *Journal of Mental Science,* 32(137) (1886), 44-50.
[13] Sarah Chaney, *Psyche on the Skin: A History of Self-harm* (London, 2017).

wished to obtain. Although these behaviours might be considered 'half-measures', coping mechanisms could afford patients a considerable degree of agency and power in the asylum.

5.2 Stage-Managing Psychiatric Identity

Foucault's analysis of the fixing of patients' clinical identities by the medical profession through the creation of 'the case', suggests that patients were passively rendered objects of medical science over which medical power could be exercised. [14] However, I will suggest that by communicating their illness narratives to asylum doctors, patients in Lancaster Asylum exercised a significant degree of control over their institutional identities. Alienists, and their psychiatrist descendants, relied (and continue to rely) on patient narratives of their symptoms to diagnose and treat mental health conditions. As such, the agency that Lancaster Asylum patients exercised in the construction of their clinical identities was considerable. This degree of control over the construction of their psychiatric identities may be compared to the active role of the eighteenth-century patient in the medical encounter. Nicholas Jewson argued that eighteenth-century patients had more power within the doctor-patient relationship than their nineteenth-century counterparts because, prior to the development of diagnostic technologies, doctors relied on the patients' descriptions of symptoms to prescribe treatment.[15] This alleged lack of patient power ushered in by improvements in diagnostic techniques has limited application in terms of the development of psychiatric treatment. Even Foucault recognised that patients' disclosures, or 'confessions', were key to the ability of doctors to render patients as 'cases'.[16] Consequently, the notion of the patient as passive in the construction of this identity is limited, particularly in the context of psychiatry. This is a contradiction which Foucault himself confronted in his later works. Influenced by the 'Foucault of power' rather than the 'Foucault of discipline',[17] I have viewed the case record as a site through which clinical identity was co-constructed by doctor and patient. Rather than viewing the asylum patient as an object of a psychiatric 'savoir', I have explored how the information they

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[14] Foucault, *Discipline and Punish*, p. 191.
[15] Nicholas Jewson, 'The Disappearance of the Sick Man from Medical Cosmology 1770-1870', *Sociology,* 10(2) 1976, 225-44.
[16] Michel Foucault and Lawrence D. Kritzman (eds.), *Michel Foucault: Politics, Philosophy, Culture, Interviews and Other Writings 1977-1984* (trans.), Alan Sheridan, (London, 1990), pp. 126-27.
[17] Morrison, 'Unearthing the Clinical Encounter', p. 35; Haslam, *Fitting Sentences*, pp. 10-11.

provided about their inner mental states afforded them an active role in 'stage-managing' how they were perceived by asylum doctors and how this simultaneously empowered them and enabled them to influence their treatment. In this way, the case record is not viewed as presenting the 'truth of a patient, or the doctor's writing as addressed to us, his avid reader',[18] but a site through which the interaction of medical authority and patient agency produced a narrative of the patient in the asylum.

A key means by which patients contributed to their clinical identities was by explaining what they believed had caused their condition.[19] This demonstrated that they were not entirely reliant on, or convinced by, doctors' explanations of their illness. In these accounts, patients articulated their own understandings of insanity, which rationalized their experiences.[20] However, the causes identified by patients did not often present any alternative schema of understanding insanity which might challenge asylum doctors' expertise. As Steven King points out in his study of the sick poor in the late-eighteenth and early-nineteenth centuries, the illness narratives of working-class men and women were shaped by newspapers, access to medical knowledge, and medical advertising.[21] Similarly, patients in Lancaster Asylum presented accounts of their illness that drew on medical models of insanity that they encountered through popular medical culture. This reinforces arguments made by Charles Rosenberg as to the overlap between medical and lay understandings of mental disorder.[22] Although presenting their own accounts of the onset of their insanity may well have empowered patients at an individual level, patients' testimonies during medical interviews corroborated medical theory and thereby reinforced the authority of asylum doctors.

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[18] Sally Swartz, 'Asylum Case Records: Fact and Fiction', *Rethinking History,* 22(3) (2018), p. 297.

[19] Some studies have considered the contributions of private patients to their medical histories, Michael Barfoot and Allan W. Beveridge, 'Madness at the Crossroads: John Home's letters from the Royal Edinburgh Asylum, 1886-87', *Psychological Medicine*, 20(2) (1990), 263–84; Michael Barfoot and Allan W. Beveridge '"Our most notable inmate": John Willis Mason at the Royal Edinburgh Asylum, 1864-1901', *History of Psychiatry,* 4 (1993), 159-208; Chaney, '"No 'Sane' Person"', 37-53.

[20] There are parallels between the ways in which Lancaster Asylum patients framed their illnesses, and the three key frames identified from the oral testimony of psychiatric patients in the late-twentieth century in by Kerry Davies in, Davies, '"Silent and Censured Travellers"?', 267-92.

[21] King, *Sickness, Medical Welfare and the English Poor,* pp. 74, 80.

[22] Rosenberg, 'The Therapeutic Revolution', 3-26.

The role of patient illness narratives in confirming medical models of the causes of insanity can be seen in patients' discussions of the role of alcohol in their condition. Excessive consumption of alcohol was a cause of insanity that asylum doctors had discussed since the eighteenth century, and many patient narratives paralleled contemporary medical understandings of the relationship between alcohol and insanity.[23] For example, Alfred D.'s case notes recorded that he 'Attributes his illness to excessive drinking of spirits to which it appears he has been for years past much addicted'.[24] Admitting to excessive alcohol consumption carried significant implications in relation to the patient's morality, and potentially of the assessment of their character by Victorian, middle-class asylum doctors. [25] However, it also had several advantages that may explain its ubiquity in illness narratives. If a patient's insanity was caused by alcohol, its reversal could be affected by removing alcohol – a feat that could be accomplished outside of the asylum. Indeed, self-help was at the heart of working-class teetotalism, which had several active organisations in Lancashire.[26] Assurances that alcohol had caused their insanity offered asylum patients a way of convincing asylum doctors that they could be discharged from the institution. Referencing alcohol as the cause of insanity also removed patients from pessimistic prognoses and stigma associated with heredity. [27]

Financial worries, domestic discord, romantic disappointment, and grief were also mentioned by patients who grounded their mental distress in the context of past hardships. Explaining insanity in these terms rationalized their condition, anchoring it to tangible misfortunes. Eliza T.'s case notes record her account of the onset of her illness: 'She complains of ill treatment by her husband, says he kept her short of money and that she has suffered much from poverty and frequently has not sufficient to eat when she was suckling'.[28] Eliza's account exemplifies how patients cited several, interrelated factors, providing a narrative of a series of misfortunes that triggered their descent into madness. This narrative structure mirrors a common trope in popular culture of 'descents' in to madness which can be

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[23] Andrew Harper, *A Treatise on the Real Cause and Cure of Insanity* (London, 1789); John Ferriar, *Medical Histories and Reflections,* Vol II (London, 1795) p.199; Thomas Trotter *An Essay, Medical, Philosophical, and Chemical, on Drunkenness, and its Effects on the Human Body* (London, 1804).
[24] LA, HRL/4/12/2/7, 18 Jul 1875-26 Jun 1877, p. 128.
[25] Leonard Smith, *'Cure, Comfort and Safe Custody'*, pp. 108-9.
[26] Lilian Lewis Shiman, *Crusade Against Drink in Victorian England* (Basingstoke, 1988), pp. 29-33, 48.
[27] Ray, 'Models of Madness', pp. 244-5.
[28] LA, HRL/4/12/1/18, 12 Nov 1853-9 Jun 1855, p. 267.

observed, for example, in William Hogarth's *The Rake's Progress* (1732-4) and *A Harlot's Progress* (1731). Eliza's account was not only influenced by contemporary cultural portrayals of insanity, but also referenced causes of insanity that were well established in professional aetiologies of insanity.[29] It was the physical consequences of poverty, malnutrition and lactation that doctors associated with insanity.[30] From the patient's perspective, as with alcohol, such causes could be removed, and even mitigated by the asylum's programme of moral treatment. Anchoring insanity to such issues thereby removed patients from narratives of heredity, maximising their chances of discharge.

Opportunities for patients to 'speak out' in their illness narratives were only permissible because such testimonies often confirmed medical frameworks.[31] Patients' ability to account for their insanity afforded them a degree of determination over their prognosis, whilst also unintentionally acknowledging the expertise of asylum doctors.[32] The coincidences between professional and lay understandings of insanity evident in patients' illness narratives also suggest that patients' testimonies were given in response to doctors' questions. The casebooks from Lancaster Asylum do not contain records of what questions were put to patients during the medical interview, however, it does not seem unreasonable that they would have been similar to questions presented to patients' relatives. It is likely that Eliza would have been responding to the same (or similar) questions that were put to her family. Questionnaires presented to patients' families give some insight into the types of information sought by asylum doctors during medical interviews:

> 10. What do you suppose to be the cause, or causes, of the patients present illness?
>
> 11. Did she suffer from poverty, misfortune, grief, anxiety, family troubles, or unhappiness from any source?
>
> 12. How many children has she had? How many are alive? Are they strong and well in body and mind? Mention what the others died of. What is the age of the youngest child? Were there any miscarriages?[33]

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[29] Marland, *Dangerous Motherhood*, pp. 150-2.
[30] Smith, *'Cure, Comfort and Safe Custody'*, pp. 106-7.
[31] Suzuki, *Madness at Home* p. 39.
[32] Regina Morantz-Sanchez, 'Negotiating Power at the Bedside: Historical Perspectives on Nineteenth-Century Patients and Their Gynaecologists', *Feminist Studies*, 26(2) (2000), p. 301.
[33] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 33 (questionnaire attached in casebook).

The questions asked suggest that information given by patients like Eliza T. was prompted by questions which encouraged information that fit in with medical models of insanity.

However, the patients considered here did not merely answer 'yes' and 'no'; they embedded the causes of their illnesses in detailed narratives.[34] Eliza T. did not just state that she suffered from poverty, family troubles, unhappiness, and that she had experienced difficulty feeding her baby. Rather, she contextualised these experiences in the story of her life, explaining that mistreatment by her husband had caused her poverty, and that this had meant she had struggled to feed herself and her child. The questions asked by doctors prompted patients to focus on particular aspects of their histories, but the narratives were volunteered by patients. Not only does this highlight how patients used the medical interview, but it also demonstrates the nature of the case record as a co-produced entity.[35]

Patients' own views of their experiences could be negated by the ways in which doctors recorded their testimony. Commentaries could be added by doctors, expressing doubts as to the accuracy of patients' accounts. In several cases, the reliability of the patient's narrative was only accepted when it was corroborated by family members or by physical examination.[36] In other cases, doctors only recorded the parts of the patient's history which they believed to be accurate. This can be seen in cases like Mary Ann B.'s, where the patient provided a very detailed and long account of her history, which the doctors recorded selectively: 'gives a rambling account of herself of which the following appears reliable…'.[37] The 'rambling account' is not recorded in full, with only select details being reported by the doctor. Mary Ann's casebook thus only contains aspects of her testimony that her doctor judged to be accurate. Such instances highlight the ways in which, on some occasions, the medical record silenced the patient.[38] Nevertheless, even in cases such as this, in which the assertion of medical authority is apparent, we can still see evidence of Mary Ann's role in constituting her psychiatric identity. The elements of her account that were recorded still leave some trace of her input into the case record.

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[34] For work on illness narratives see, Kleinman, *The Illness Narratives*; Arthur Frank, *The Wounded Storyteller: Body, Illness, Ethic* (Chicago, IL, 1995).
[35] Morrison, 'Unearthing the Clinical Encounter', p. 35.
[36] Suzuki, *Madness at Home*; Andrews, 'Case Notes, Case Histories', 225-81; Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, NJ, and London, 1987).
[37] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 146.
[38] Foucault, *Discipline and Punish*, pp. 185, 189-90.

Patients exercised a considerable degree of power over their institutional identities. Indeed, the medical encounter in the asylum rested on this less coercive facet of psychiatric power. It was advantageous to asylum doctors to empower patients in this way, because it enabled a comprehensive case history to be taken. As Suzanne Spencer-Wood has suggested, while powers such as these have 'traditionally have been considered weak and feminine, the way that they engage willing cooperation is far more powerful than the "power over" type of authority to impose on, control, or command others, which usually generates resistance'.[39] By moving away from a hierarchical model of the doctor-patient relationship, the ways in which patients' clinical identities were constructed, and the role that patients took in their construction, can be explored. Although patients' provision of their illness narratives contributed to the fixing of their psychiatric identity and thereby extended medical authority over them, by giving their own accounts patients could influence how they were perceived by doctors and exercise agency over the ways in which their experiences were understood.

5.3 Managing Medical Treatment

Rather than disengaging with treatment, as resistant patients did, some patients sought to negotiate that treatment – influencing the therapies they received by making requests for specific drugs and therapies. This strategy enabled patients to avoid treatments they did not want or like, and to shape treatment based on their own preferences, affording them a degree of control over their bodies in the institution.[40] In cases where patients sought to negotiate the nature of treatments, rather than totally resist their administration, their ability to exercise agency was greater. Strategies which saw patients request particular medications or accommodate *some* of the doctors' recommendations were arguably more successful.[41]

Patients' ability to influence their treatment depended on how far their preferences cohered with medical models of disease and treatment. In cases where patient requests reflected 'alternative' systems of medicine, not only were such requests denied but the casebook was used to assert the superiority of professional medical expertise. Patients who succeeded in obtaining their desired treatment tended to express preferences that were in line

[39] Spencer-Wood, 'Gendering Power', p. 179.
[40] Gallo and Ruggiero, 'The Immaterial Prison', 273-91.
[41] A useful comparison can be made with the 'immediate, de facto' gains obtained through acts of 'everyday resistance' discussed in, Scott, *Weapons of the Weak*, pp. 32-3.

with what doctors wanted to prescribe. For example, Jonathan B's case notes state that he 'refused the Laudanum he has therefore been taking drops of Morphia every four hours'.[42] Although Jonathan refused to take medication initially, his strategy was not one of flat-out resistance to medication.[43] Rather, Jonathan was aiming to negotiate the treatments that were on offer to him. His preference for morphine can, perhaps, be explained by its relative potency: laudanum was a tincture of morphine, with a high-quality solution containing one grain of morphine per ounce.[44] Jonathan's preference for morphine drops could be connected to the addictive qualities of opiates. Virginia Berridge notes that addiction to opium was common amongst the working classes, and that this dependence was often unknown to the patient and the practitioners who treated them.[45] Jonathan's preferences were also likely to have been shaped by their ubiquity in working-class medicine – this was a familiar substance to asylum patients compared with other commonly used asylum sedatives such as chloral hydrate and hyoscyamine.[46] Jonathan's preferences were accommodated by asylum doctors because, regardless of which form of morphine he was given, Jonathan was still receiving a sedative. From Jonathan's perspective, he secured his drug of choice.

Many Lancaster Asylum patients required treatment for illnesses and injuries, both pre-existing and those developed during their stay.[47] Mary Agnes C.'s case notes record that she experienced digestive issues whilst in the asylum, a fairly common complaint and one which asylum doctors believed was closely connected to insanity.[48] Her casebook stated that she refused any medication apart from castor lozenges: 'Suffers from constipation for which she takes cas. sol. lozenge wd not take any other medicament'.[49] Mary did not altogether reject medical prescriptions for her symptoms, rather, she engaged with them selectively.[50]

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[42] LA, HRL/4/12/1/18, 12 Nov 1853-9 Jun 1855, p. 273.
[43] Cf. Chapter Four, pp. 82-5.
[44] Thomas Dormandy, *Opium: Reality's Dark Dream* (New Haven, CT and London, 2012), pp. 161-2.
[45] Virginia Berridge, *Opium and the People: Opiate Use and Drug Control Policy in Nineteenth and Early Twentieth Century England* (London, 1981), pp. 35-6.
[46] Toine Pieters and Stephen Snelders, 'Mental Ills and the "Hidden History" of Drug Treatment Practices', in Marijke Gijwijt-Hofstra, Harry Oosterhuis, Joost Vijselaar and Hugh Freeman (eds.), *Psychiatric Cultures Compared, Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches* (Amsterdam, 2005), pp. 381-401.
[47] Wallis, *Investigating the Body*, p. 2.
[48] De Young, *Encyclopaedia of Asylum Therapeutics,* pp. 65-7.
[49] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 108.
[50] The ubiquity of castor oil in popular medicine is evident in Whorton's discussion in the context of the advertising campaigns designed by twentieth-century laxative entrepreneurs in

Requests for home remedies such as poultices including ingredients like oats also feature in patients' casebooks.[51] Such items constituted familiar ground for patients in Lancaster Asylum, perhaps explaining patients' preferences.[52] These items could be sanctioned by medical professionals – treatments like castor oil were deemed effective by asylum doctors. The coincidence of patient preferences and doctors' expertise in relation to such substances enabled patients to secure these items for themselves in the institution.

However, in cases where patients made requests for medical treatments that contradicted professional expertise, they were flatly refused. Alternative therapies requested by patients contradicted medical expertise. In such cases the case record was also used to assert the superiority of asylum doctors' medical knowledge. Bernard T. suggested that the doctors in Lancaster Asylum seek the assistance of a 'Quack' doctor he had consulted prior to his admission. Not only do Bernard's case notes record the refusal of his request, they also demonstrate how the case record was used to denigrate patients' preferences when they advocated alternative systems of medicine. Bernard was said to be 'extremely ignorant, credulous and superstitious and appears to have been a victim to the artifices of a "Quack" previously to admission', he was said to have 'unbounded faith in the capabilities of this "herbal doctor" and frequently wishes to send for him here, where he is fully persuaded he would soon cure all the inmates'.[53]

The way in which Bernard framed his request directly challenged the expertise of asylum doctors, claiming that his 'herbal doctors' would be able to succeed where they had failed – in curing not just Bernard, but all of the inmates. The request was, as we might expect, refused. However, the way in which it was recorded did not simply state this refusal but also denigrated the patient as a dupe of Quackery, as unintelligent and superstitious. In fact, the description of Bernard's faith in his 'herbal doctor' borders on pathologizing his behaviour.[54] In response to mention of 'Quack' medicine, professional expertise was promptly re-asserted and patient ignorance was bemoaned in the case record. This can also be seen in Herbert D.'s request for doctors to try 'the salt water cure "for killing the germs"'.[55]

James C. Whorton, *Inner Hygiene: Constipation and the Pursuit of Health in Modern Society* (Oxford, 2000), p. 94.

[51] E.g. LA, HRL/4/12/1/11, 28 Jul 1840-25 May 1842, p. 26.

[52] Beier, *For Their Own Good,* pp. 9-13.

[53] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 303.

[54] Roy Porter, *Health for Sale: Quackery in England, 1660-1850* (Manchester, 1989).

[55] LA, HRL/4/12/4/4, 5 May 1914-1 Dec 1914, no. 1244.

Herbert's advocacy of the 'water cure' contradicted medical expertise on controlling the spread of disease, which was, by the twentieth century, based on germ theory.[56] In cases where patient requests presented such a challenge, they were not only refused, but recorded in casebooks in a manner which apparently pathologized such beliefs.

Making requests to which asylum doctors were receptive enabled patients to negotiate the parameters of their treatment. When compared to strategies which sought to resist treatment entirely, strategies of negotiation were frequently more successful. This was because such strategies were not openly confrontational, so did not warrant the kinds of violent reassertions of medical authority connected to patient refusals to submit to physical examinations or take medication that were discussed in the previous chapter. However, patient preferences were only taken into consideration when they affirmed the expertise of professional medicine.

5.4 Managing Movement

Asylum authorities not only sought to manage patients' bodies through medicine, but also using institutional space. The ward system in Lancaster Asylum, as in other contemporary institutions, was central to systems of medical power/knowledge, and to moral treatment. The ward system provided a way in which to manage patients without physical restraint, using promotion to 'better' wards as an incentive for good behaviour, and inversely demotion to 'worse' wards as punishment.[57] However, in practice, patients exercised greater influence over their movement through the ward system than the rhetoric of moral treatment suggests. Doctors moved patients to different wards depending on their diagnosis, stage of recovery, and because of their behaviour. However, patients sought to move wards due to concerns about personal privacy, the leniency of staff on certain wards, friendships, animosities, and employment opportunities. Patients interpretations of wards and their relative desirability altered the meanings of these spaces in Lancaster Asylum.

Patients' requests to move wards often appealed directly to doctors, explicitly acknowledging the power of asylum doctors over their movement. However, when such

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[56] For more on germ and disease theories in nineteenth-century British medical practice see Michael Worboys, *Spreading Germs: Diseases, Theories, and Medical Practice in Britain, 1865-1900* (Cambridge, 2000).
[57] Digby, *Madness, Morality and Medicine*, pp. 81-3.

requests were granted, doctors implicitly undermined the asylum's authority by sanctioning an alternative rationale for patient movement within the institution. This alternative schema of asylum wards differed from their deployment in systems of medical knowledge and in moral treatment, challenging the expertise of the medical profession and prioritising patients' own opinions on which ward was best for them. By granting such requests, asylum doctors – albeit unwittingly – consented to an erosion to their own authority. Requests from patients to move wards were granted because they were perceived to ensure good behaviour. Patients were clearly aware that doctors and attendants were amenable to granting their requests in return for good behaviour, making requests by bargaining – making promises of good behaviour in exchange for being allowed to move to a different ward. John H. M., 'promised to do better in future if he might be removed from no v.' and indeed he was allowed to relocate based on his promise.[58] In such instances of bargaining, patients manipulated the 'carrot-and-stick' system of moral treatment to secure their removal to a preferred ward.

Requests to move wards were motivated by a variety of factors. Some patients saw benefits to being on wards where staff were less strict, and routines not as rigorously enforced. Elizabeth R. made a ward request based on how closely the staff on her new ward enforced dietary protocols: 'Was always begging to get back to 16 the reason being that she was not made to eat so much there'.[59] Indeed, the strictness of staff, or even how much patients liked particular nurses or attendants, appears to have led them to request to be placed on certain wards. Annie H. wanted to be on Ward 4 with a nurse with whom she was friends, having worked as a nurse in Lancaster Asylum prior to her admission as a patient.[60] Personal relationships could play an important role in determining where patients felt most comfortable. Just as patients like Annie wanted to be on wards with friends, others wanted to move away from patients they did not like.[61] Patients being readmitted often preferred to go back to their 'old ward', reinforcing the idea that patients found certain wards more comfortable.[62]

The accommodation of patient requests to move wards was not guaranteed. As such, in some cases, when patients wanted to move they did not request to do so, but rather

[58] LA, HRL/4/12/2/10, May 1880-30 Nov 1881, p. 135.
[59] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 231.
[60] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 134.
[61] LA, HRL/4/12/3/8, 11 Oct 1879- 9 Mar 1881, p. 130.
[62] E.g. LA, HRL/4/12/3/19, 23 Oct 1894-6 Apr 1896, p. 198.

deliberately engaged in behaviours that they knew would result in their removal to a preferred location. This is reminiscent of the behaviour that Goffman described as 'playing the system'.[63] In such cases, patients deliberately misbehaved to force the asylum to 'punish' them by moving them to another ward. One patient, Patrick O., was moved from a side room to a dormitory because he was observed to have had an epileptic fit by one of the nurses. After he had been moved, he bragged about how he had secured this switch of sleeping arrangements: '…he has been pointing out that he got out of a side room by his fit'.[64] The ability (or in this case inability) of asylum doctors to identify genuine insanity was a marker of their professional competence.[65] By feigning his fits, Patrick led asylum authorities to move him to a dormitory.[66] The ability of patients to manipulate asylum authorities in this way demonstrates their understanding of how the institution was run, an understanding that enabled them to 'work the system'.[67]

Patient requests to move wards afforded them a significant degree of agency. In practical terms, securing their removal to a preferred area of the asylum allowed patients to live where they were most comfortable, mitigating some of the discomforts of confinement.[68] This strategy had further implications for the relationship between patient agency and institutional authority (although this was, it would appear, unintentional). By granting patients' requests to move wards, asylum doctors tacitly sanctioned patients' interpretations of the ward system, thereby implicitly undermining their own. While theories of moral treatment expressed the ideal uses of the ward system – for classification and promotion/demotion – the reality of managing a difficult population meant that, in practice, wards took on different meanings and functions. This reflects the gap between medical theory and practice inherent to the development of psychiatry in the asylum during this period. [69] The practical use of the ward system was shaped significantly by patients themselves, by their interpretations of the purposes of wards, and their preferences for different areas of the institution.

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[63] Goffman, *Asylums*, pp. 189-203.
[64] LA, HRL/4/12/2/24, 17 Feb 1905-21 Dec 1905, p. 202.
[65] The efforts of asylum doctors to prove their expertise in diagnosing insanity are discussed in McCandless, 'Liberty and Lunacy', pp. 367-8.
[66] Preferences for dormitories can be explained by a variety of factors which will be discussed further in Chapter Seven.
[67] Goffman, *Asylums*, p. 191.
[68] Gallo and Ruggiero, 'The Immaterial Prison', 273-91.
[69] McCarthy et al., 'Lives in the Asylum Record', p. 368.

5.5 Managing Separation

Establishing relationships in the asylum enabled patients to cope with separation from friends, family, children, and spouses.[70] Although visits and letters from family members were encouraged,[71] the relatives of many patients lived at some distance from the institution, and of course, they had to continue to work and maintain household responsibilities.[72] The cultivation of new friendships and relationships acted as an alternative support network. In general, asylum authorities allowed, and even encouraged, friendships between patients and cordial relations between patients and asylum staff. When friendships between patients demonstrated 'normal' sociability, this was considered a key marker of patients' progress.[73] However, this sociability was carefully delimited by asylum authorities, and where patients' sociability challenged institutional boundaries, it was swiftly curtailed.

The favourable view of patient friendships taken by doctors in Lancaster Asylum in many cases is unremarkable given the importance of social interactions such as dances, games and sports to moral treatment. Such activities constituted healthy, structured social occasions to fill patients' leisure time.[74] Patient progression was frequently discussed in terms of their inclination to socialise. Edward T. showed progress because he: 'converses freely with the other patients and joins in the amusements'.[75] Inter-patient friendships were also used by the asylum as a mechanism of cure, and a mechanism of management. Their utility for managing patient behaviour lay in allowing well-behaved, or experienced, patients to care for other, more acutely ill individuals. This allowed the Asylum to reduce the burden placed

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[70] The establishment of friendships within institutions as a coping strategy is discussed in Myers and Sangster, 'Retorts, Runaways and Riots', pp. 677-8.
[71] Wannell, 'Patients' Relatives and Psychiatric Doctors', 297-313.
[72] Concern about lack of visits to asylum patients was apparent amongst asylum professionals, see, H. Hawkins, 'Asylums and their Neighbours. Can Neighbours Help?', *Journal of Mental Science,* 23(101) (1877), 10-16.
[73] Comments such as 'readily enters into conversation' accompany analysis of patient improvement in casebooks, both in Lancaster Asylum and in published case histories e.g., R. D. Hotchkis, 'A Case of Mental Stupor: Recovery after Six Years' Duration', *Journal of Mental Science,* 42(178) (1896), p. 589; patients' ability to 'resume their place in society' is also mentioned as a marker of recovery in, J. G. Soutar, 'Recoveries from Mental Disease', *Journal of Mental Science,* 43(182) (1987), 506-17.
[74] Steven Cherry and Roger Munting, '"Exercise is the Thing"? Sport and the Asylum c.1850-1950', *The International Journal of the History of Sport,* 22(1) (2005), 42-58.
[75] LA, HRL/4/12/2/2, 12 April 1865-2 Feb 1867, p. 10.

on attendants by increased patient numbers. However, this system also had a curative rationale; allowing patients to take on responsibility for others provided the asylum with a means by which to cultivate the nurturing capacities of patients which was considered important to recovery – especially for women.[76] Not only would such a system have offered support to nurses in an institution that was perpetually growing, but it was also underpinned by a medical rationale. We can see this in the case notes of Jane C.:

> By use of firm kind and judicious moral treatment she has become quite changed in general conduct and demeanour during the last 9 or 10 months she has gradually acquired great equability of thought feeling and action and has shewn great industry and application as an assistant to her nurse whose efforts to improve her have been most praiseworthy and to whom she became at length most useful in assisting at all indoor work as well as taking charge of unstable or turbulent patients.[77]

From the perspective of asylum doctors, such relationships had a managerial purpose, underwritten by a curative rational. Where patients were able to look after others they provided an important source of support for maintaining order in the institution. However, care-giving relationships between patients in Lancaster Asylum held different meanings for patients than they did for staff. They afforded patients a sense of purpose, and even a degree of power in the institution. The relationship that developed amongst a group of female patients demonstrates this. Ellen O. took charge of a group of female patients suffering from dementia, ensuring that they remained occupied knitting and darning socks throughout the day. Not only did she ensure that they were always occupied but she also supplied them with extra food as a reward and kept them out of trouble. Her case notes stated: 'Very useful looking after the other patients at her table keeping them at work mending and knitting stockings – also feeds them (stuffs some of them) and looks after them carefully'.[78] Ellen took on 'so many responsibilities that she often requested wages.'[79] This role evidently gave Ellen a sense of purpose, and it also gave her a degree of power in the institution – Ellen exercised power over the female patients by keeping them at their work and rewarding them for their labour. Her sense of this power is apparent in her demand for wages, which suggests

[76] Marland, *Dangerous Motherhood*, p. 133.
[77] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 221.
[78] LA, HRL/4/12/3/12, 30 Jun 1885-4 Dec 1886, p. 16.
[79] LA, HRL/4/12/3/12, 30 Jun 1885-4 Dec 1886, p. 16.

that she saw herself as occupying a position in the asylum that was closer to a nurse than a patient.

This acquisition of power and authority by a patient demonstrates the complexity of power dynamics in the institution, and the inadequacy of hierarchical models in elucidating these dynamics. Not only were there power relationships between asylum authorities and patients, but there were also intra-patient power relationships.[80] The power exercised by Ellen disrupted the boundary between patient and staff, undermining the image of hierarchically dispersed power. This is particularly marked when we compare Ellen's role to the responsibilities taken on by Jane C. in 1850. Ellen's responsibilities were spontaneously undertaken at her initiative, whereas Jane was under the direction of a nurse at all times. In Jane's case, her limited degree of power was directly invested in her by a nurse – a representative of institutional authority and was closely overseen and managed. Ellen's role was undertaken at her own initiative, with little apparent supervision, yet it was permitted by the institution – apparently because Ellen's management of the dementia patients relieved staff of a time-consuming element of their duties.

The practice of investing patients with such significant responsibilities appears to have been relatively common and, despite being criticised on a number of occasions during the annual inspections by the Commissioners in Lunacy, it persisted from the 1880s onwards.[81] Indeed, this practice was condemned by the Commissioners precisely because it endowed patients with so much responsibility. However, the pressure of patient numbers and increased difficulties recruiting attendants in the late-nineteenth century compared to the 1850s and 60s, meant that this practice continued. Consequently, Ellen and patients like her were afforded a degree of power unavailable to patients like Jane C.[82] Over the course of the nineteenth-century, heterarchical structures of power thus became even more significant to the institutions' endeavours to manage patients.

Friendships in the asylum were not all built on responsibilities or care-giving roles. Many inter-patient relationships were based on mutual affection. Again, this element of sociability was encouraged by asylum doctors, with patients' ability and inclination to

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[80] Levy, 'Gender, Power and Heterarchy', pp. 62-78.
[81] LA, QAM/5/32, *Reports* (1883), p. 11; LA, CC/HBR/1, *Reports* (1891), p. 12.
[82] The difficulty of recruiting well-trained nurses and attendants is discussed in Walton, 'Pauper Lunatics in Victorian England', pp. 190-1.

socialize considered an indication of recovery.[83] That genuine friendships did emerge between patients can be seen in cases where friendships were halted due to death or discharge. James L. was particularly distressed when a patient he had been close to passed away: 'On the 21. was much affected by the sudden death of another Epileptic boy'.[84] Even after leaving the asylum, patients wrote back to the institution to check on their friends.[85]

However, friendships were only acceptable within defined boundaries. In some cases, patients' friendships or relationships were curtailed if they threatened the order of the institution. Asylum authorities acted to intervene if they believed that patients had a 'bad influence' over one another. This was the case with three patients, Edward L, Joseph F. and Hindle M., who had known each other prior to their admission. The three friends attempted to escape together, and following this, Joseph's case notes discuss the decision to separate them:

> Escaped with Edward [L.] as described p. 279 q.v. This man instigated the attempt and has undoubtedly had a bad influence upon [L.] and Hindle [M.] all hailing from the same place and having been neighbours and friends before admission. They are now kept apart to their several advantage.[86]

This case highlights the disparity between institutional understandings of 'healthy' sociability, and patients' understandings of friendship. Edward L.'s case notes described the same incident, noting that the patients had escaped to go to the local pub together, where they were found by attendants a few hours later.[87] The fact that the patients' 'escape' only saw them attempt to reach a pub three miles away from the asylum suggests that absconding in this instance was not a means of circumventing medical authority, but was geared towards having a break from the institution.[88] The choice to visit a pub is also interesting, given the importance of pubs to working-class male leisure in this period.[89] For the asylum, however, the fact that the patients left the institution without permission constituted a highly visible

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[83] Soutar, 'Recoveries from Mental Disease', 506-17.
[84] LA, HRL/4/12/1/13, 27 Jul 1843-7 Apr 1845, p. 289.
[85] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 135.
[86] LA, HRL/4/12/2/16, 25 Jul 1888-31 Mar 1891, p. 290.
[87] LA, HRL/4/12/2/16, 25 Jul 1888-31 Mar 1891, p. 279.
[88] Goffman, *Asylums*, p. 194.
[89] The pub was an important leisure institution for workers throughout the eighteenth and nineteenth century, Robert W. Malcolmson, *Popular Recreations in English Society 1700-1850* (Cambridge, 1973), pp. 71-4; despite attacks on pubs by middle-class reformers, the pub remained important to workers throughout the nineteenth-century, Stedman Jones, 'Class Expression Versus Social Control?', p. 170.

challenge to medical authority, regardless of what their motivations were.[90] In such cases the asylum reasserted its authority by ending associations between patients.

Sexual relationships transgressed 'healthy' sociability entirely. This was partly due to theories of the hereditary nature of insanity,[91] and partly connected with the asylum's responsibilities to patients *in loco parentis*.[92] Interaction between men and women was strictly governed, and was only allowed to occur in carefully supervised settings.[93] It is particularly challenging to assess how successful asylum policy was in this regard – if any patients were successful in engaging in sexual acts with patients of the opposite sex, their success would be predicated on having been undetected. One incident from the case notes of Thomas K. contain evidence of an unsuccessful attempt: 'Was found attempting familiarities with a female patient'.[94] This suggests that illicit sexual relations were at least attempted, however, it is difficult to learn of their extent from the sources available.

Homosexual relationships appear to have been more prolific than heterosexual encounters – or at least were more frequently discovered.[95] Policing same sex relationships was difficult because most patients slept in dormitories. When patients were discovered to have engaged in homosexual activity, their behaviour was medicalized and framed as symptomatic of mental disturbance.[96] Patrick O. was noted to 'attempt sodomy from time to time', and his casebook recorded that such behaviour was evidence of 'perverted sexual inclinations'.[97] However, for patients, same-sex sexual relationships could have held a number of meanings. In work on prisons, scholars have noted that same-sex relations were a way of coping with the absence of heterosexual relationships.[98] Alternatively, same-sex

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[90] See Ch. 4, pp. 89-92.
[91] Clark 'The Rejection of Psychological Approaches to Mental Disorder', pp. 292-3.
[92] Gittins, *Madness in its Place,* p. 105.
[93] Hide, *Gender and Class,* p. 117.
[94] LA, HRL/4/12/2/10, 18 May 1880-30 Nov 1881, p. 120.
[95] Cf. Clare Anderson, 'Fashioning Identities: Convict Dress in Colonial South and Southeast Asia', *History Workshop Journal,* 52 (2001), 152-74; Gresham M. Sykes, *The Society of Captives: A Study of A Maximum Security Prison* (Princeton, NJ, 1958), pp. 70-2.
[96] Ivan Crozier, 'Nineteenth-Century British Psychiatric Writing about Homosexuality before Havelock Ellis: The Missing Story', *Journal of the History of Medicine and Allied Sciences,* 63(1) (2008), 65-102.
[97] LA, HRL/4/12/2/24, 17 Feb 1905-21 Dec 1905, p. 202.
[98] Stanley Cohen and Laurie Taylor, *Psychological Survival: The Experiment of Long-Term Imprisonment,* (Harmondsworth, 1972), p. 82.

relationships could simply be due to patients' sexual orientations.[99] Diane Gittins notes that for gay women, asylum nursing afforded opportunities for same-sex relationships that were not available in wider society; there is no reason this would not also apply to the patient populations of the same institutions.[100]

Staff-patient relationships could also be a key mechanism of coping with institutional life. Given that asylum nurses and attendants were drawn from the same social class, and often the same neighbourhoods, as patients it is not surprising that loyalties and affections developed between them.[101] We saw evidence of such affectionate relationships in the case of Annie H. who had previously been a nurse at Lancaster Asylum (Section 5.4). Annie was friends with one of the nurses in the institution, so when she was admitted as a patient she requested to be placed on the ward where her friend worked.[102] Utilizing pre-existing relationships between patients and staff was one way in which the asylum managed patients' transition to institutional life. When Robert H. was admitted he was placed in the charge of an attendant he already knew: 'he was very low and desponding, and had a most dejected appearance, but after being here a few hours, and being placed with Smith the Attendant who is an old friend of his, he became quite cheerful'.[103] Robert's case demonstrates how important friendships could be to asylum patients as a source of comfort and familiarity.

Within the framework of moral treatment, it was considered desirable that relationships between patients and their attendants were amicable. Patient, caring, but firm treatment by nurses and attendants of good moral character had been a key component of moral treatment since its use at the York Retreat in the early decades of the nineteenth century.[104] However, there were clear boundaries surrounding staff-patient relationships, and expectations that asylum nurses and attendants would conduct themselves 'properly'.[105] Patients who attempted to form relationships of a romantic or sexual nature with staff

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[99] Cf. Caroline Agboola, 'Consensual Same-Sex Sexual Relationships in South African Female Prisons', *Gender & Behaviour*, 13(2) (2015), 6658-67; Angela Pardue, Bruce A. Arrigo and Daniel S. Murphy, 'Sex and Sexuality in Women's Prisons: A Preliminary Typological Investigation', *The Prison Journal*, 91(3) (2011), 279-304; Goffman, *Asylums*, p. 195.
[100] Gittins, *Madness in its Place*, pp. 105-6.
[101] Dingwall, Rafferty and Webster, *An Introduction to the Social History of Nursing*, p. 127.
[102] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 134.
[103] LA, HRL/4/12/1/19, 15 Jun 1855-27 May 1857, p. 110.
[104] Digby, *Madness, Morality and Medicine*, pp. 144-8.
[105] LA, QAM/4/7, Printed Rules for the Government of Lancaster Asylum, 1846.

members were promptly disciplined. Frances William T. was: 'Transferred to North Side to-day as he makes unseemly overtures to the nurses in charge.[106] The boundaries to staff-patient relationships were very firmly drawn in relation to sexual or romantic relationships.

Relationships in the asylum were pursued to alleviate the discomforts of institutional life; they provided a source of comfort and support in the institution. These relationships were perceived differently by patients and institutional authorities. Asylum authorities considered them to be evidence of recovery when patients socialized within acceptable boundaries, or as evidence of recalcitrance when patients' relationships transgressed asylum rules. When patient relationships were seen in positive terms by the institution, they were permitted; they served different but non-oppositional purposes for asylum and patient. 'Healthy' patient friendships were essential to the maintenance of order in the institution, reflecting the importance of lateral relationships to the structure of asylum power.[107] However, in cases where patient relationships threatened to disrupt asylum authority they were quickly and decisively ended. By separating patients engaged in such relationships, asylum authorities asserted their definition of acceptable sociability over patients' own understandings.

5.6 Managing Work

As discussed in the previous chapter, work was a significant area of asylum life over which patients could exercise control. Moral treatment models of managing the insane advocated that patients were encouraged to work, but not forced.[108] Although patients could (and did) refuse to work, others consented to do so but on their own terms, selectively engaging in work assignments. Goffman points out that asylum patients, who knew the institution well, requested certain assignments because of associated privileges.[109] This can be seen in the attitudes of several patients in Lancaster Asylum towards work. Some types of work were more popular than others, and patients sought out occupations which they saw as more desirable. This allowed patients to 'work the system' – maximising the benefits they could derive from the institution. In Lancaster Asylum, certain occupations provided perks that

[106] LA, HRL/4/12/2/24, 17 Feb 1905-21 Dec 1905, p. 13.
[107] Conlin Casella, *The Archaeology of Institutional Confinement*, p. 77.
[108] Hide, *Gender and Class*, p. 113.
[109] Goffman, *Asylums*, pp. 197-203.

were not intended by asylum authorities. Patients who sought out particular jobs did so because they identified these benefits. Patient requests were frequently successful in securing them their employment of choice because such requests suggested that patients were keen to work – a key marker of recovery.[110] It will become apparent, however, that although patients' requests for certain jobs made use of medical rhetoric, the benefits that patients derived from those occupations were not perceived by institutional authorities.

Many patients wanted to continue to pursue their trade within the asylum. Asylum authorities were happy to grant such requests, especially for patients who had been tailors, joiners, builders etc. prior to their admission. This practice went against the advice of some prominent alienists, who held that such continuities could be detrimental to recovery. It was noted by John Connolly that continuing in their former occupation was particularly damaging for tailors, shoemakers, weavers, or dressmakers.[111] That the requests of patients to continue in these occupations in Lancaster Asylum were granted points to the value of patient labour to the economy of the institution.[112] Although this bears out Scull's argument regarding the function of asylums in cultivating habits of productivity in patients, as Hide points out, work in the asylum could also allow patients a sense of accomplishment and identity.[113]

Patients who continued in their trades could retain a connection to their pre-institutional selves. This can be seen in the case of George C. who had been a tailor prior to admission: 'Was sent today to the Tailors shop for half a day on his own entreaty- It was with difficulty that he could be got to leave off working'.[114] For the asylum, George's request fulfilled two functions; his eagerness to take up skilled work contributed to the institutional economy, and also reinforced the efficacy of moral treatment. However, while his request may have been granted because it could be accommodated within the framework of moral treatment, the benefits that George derived from this employment were unintended. Taking up the same job that they had done prior to admission allowed patients to maintain a connection to their lives and identities outside of the institution.[115] For working-class patients

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[110] Hide, *Gender and Class,* p. 102.
[111] Conolly, *The Construction and Government of Lunatic Asylums,* p. 79.
[112] Scull, *Museums of Madness,* p. 201.
[113] Hide, *Gender and Class,* p. 102.
[114] LA, HRL/4/12/2/13, 26 Mar 1884-20 Dec 1886, p. 177.
[115] Monika Ankele, 'The Patient's View of Work Therapy: The Mental Hospital Hamburg-Langenhorn During the Weimar Republic', in Ernst (ed.), *Work, Psychiatry and Society,* p. 251.

– the majority of individuals in Lancaster Asylum – occupation was closely tied to identity.[116] Although patient requests to follow their previous occupations were clearly accommodated due to their overlap with medical priorities, they also held additional meanings and benefits to patients.

Patient requests for particular types of employment had strong connections with where certain occupations were located within the asylum, with many requests made for outdoor occupation. Such requests could be associated with acts of resistance, with some patients requesting to work outside to make escape attempts.[117] However, some patients made requests to work outdoors because they preferred working outside and preferred the types of occupation available in outdoor areas. [118] Such requests, again, were readily accommodated by medical frameworks, coinciding with the value attached to outdoor, active employment in moral treatment.[119] Patients' requests for certain occupations were also connected to the nature of the work involved in particular occupations.[120] This can be seen in patients' requests to work in the laundry which, despite its association with endeavours to reform 'fallen' women in other nineteenth-century institutions, was remarkably popular in Lancaster Asylum.[121] Several patients saw the active nature of laundry work as particularly desirable.[122] Bridget C.'s case notes provide some insight, noting that she had been 'Asking to go to laundry as active work wd she thinks occupy her attention and thoughts'.[123] The idea of active work as being a distraction from morbid or distressing thoughts fit in well with asylum doctors' understandings of the benefits of employment, perhaps explaining why such requests were granted.

Requesting and securing a particular work assignment in the asylum allowed patients to cope with institutional life through occupying their time, retaining their sense of self, and maximising benefits they could obtain within the institution. Patients' success in securing requests was determined by how far they appealed to medical ideals about work in the moral

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[116] Rose, *Limited Livelihoods*, p. 176; Colin Creighton, 'The Rise of the Male Breadwinner Family: A Reappraisal', *Comparative Studies in Society and History,* 38(2) (1996), p. 232.
[117] See Ch. 4, pp. 89-92.
[118] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 234.
[119] Conolly, *The Construction and Government of Lunatic Asylums*, pp. 78-9.
[120] Goffman, *Asylums,* pp. 189-97.
[121] Walkowitz, *Prostitution and Victorian Society*, p. 221.
[122] Patricia Malcolmson, *English Laundresses: A Social History, 1850-1930* (Urbana IL, 1986).
[123] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 226.

treatment of insanity. Where patient desires and medical aims coincided, patients were able to pursue their chosen occupation. Given the centrality of work to the aims of the asylum, patients' willing participation in employment provided affirmation of asylum doctors' expertise as well as making significant contributions to the economy of the institution. For patients, pursuing a favoured occupation enabled them to exercise determination over the structure and content of their day-to-day lives and obtain perks. Although work was important to medical aims of asylum treatment and to the control of patient behaviour, many patients were able to utilise the work life of the institution to suit their own needs.

5.7 Internal Strategies for Managing Distress

Many casebooks from Lancaster Asylum refer to patients who sat quietly all day, refused to speak to others, and appeared drawn off into their own internal world. Goffman identified this behaviour in his study of St. Elizabeth's psychiatric hospital, and described it as 'situational withdrawal': 'The inmate withdraws apparent attention from everything except events immediately around his body and sees these in a perspective not employed by others present'.[124] It is difficult to assess the meanings or causes of situational withdrawal based on any source that was not written by the individual who employed this behaviour. In the context of the prison, the internment camp, and the concentration camp this behaviour has been interpreted as a coping strategy, as a mechanism employed to disassociate from the reality in which inmates found themselves.[125] However, it has also been a behaviour interpreted pathologically; in twentieth-century psychiatric institutions it was labelled 'regression', and in prisons it has been termed 'prison psychosis'.[126] The disentanglement of situational withdrawal as a coping mechanism and as a symptom of mental illness is especially problematic in the context of the nineteenth-century asylum for a number of reasons that will be discussed below. Whilst not denying that states of withdrawal could be associated with patients' mental states, the possibility that withdrawal could also have functioned as a coping mechanism is worthy of consideration.

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[124] Goffman, *Asylums,* p. 61.
[125] Frank J. Porporino and Edward Zamble, 'Coping, Imprisonment, and Rehabilitation: Some Data and their Implications', *Criminal Justice and Behavior,* 17(1) (1990), 53-70.
[126] Goffman, *Asylums,* p. 61.

There are some examples from the case notes of Lancaster Asylum in which withdrawing was clearly a mechanism by which patients distanced themselves from asylum life. The case notes of some patients demonstrate that refraining from entering into conversations, interactions and friendships was a way of coping with confinement. Thomas B. was one patient who clearly explained that his refusal to socialize with other patients in such terms: 'Says he cannot associate with the other pats. Here- "he is not insane"'.[127] Withdrawing from social interactions with other patients could thus be a mechanism by which patients rejected the propriety of their designation as insane; it was a means by which patients like Thomas sought to distance themselves from the stigma of asylumdom. Mary W.'s lack of social interaction was fuelled by her dislike of spending time with others: 'avoids society of others and tries to get away by herself'.[128] If this isolation was intruded on, her casebook records that she became violent.[129] Others also appear to have enjoyed solitary activities, Charles P. M. preferred writing in isolation: 'Keeps very much to himself- spends many hours writing on manuscript'.[130] The use of writing as an escape has parallels with coping strategies adopted in other carceral settings.[131] Such pursuits in the asylum offered an opportunity to journey inward; solitude in the asylum could be a reprieve from the noise and chaos of institutional life.[132]

The complexity of interpreting the meaning of patient withdrawal can be seen in the case of Annie H, the ex-nurse who sought out the company of her former colleague when she was admitted to the asylum. Despite her initial strategy of seeking out familiar company, Annie later became very withdrawn, appearing totally removed from the goings on of the ward and refusing to see her friends: 'sits in chair all day with her head bent down and eyes shut but walks well enough when meal time comes'.[133] The observation that she was able to move when she wanted to, i.e. to go to the dining hall for a meal, demonstrates that her illness did not render her incapable of movement. As such, we might see withdrawal as a means by

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[127] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23513.
[128] LA, HRL/4/12/3/30, 4 Aug 1904-12 Jan 1906, p. 180.
[129] LA, HRL/4/12/3/30, 4 Aug 1904-12 Jan 1906, p. 180.
[130] LA, HRL/4/12/2/24, 17 Feb 1905-21 Dec 1905, p. 164.
[131] Vladimir Bukovsky, *To Build A Castle: My Life as a Dissenter* (trans. Michael Scammell) (London, 1978); Anatoly Sharansky, *Fear No Evil* (trans.), Stefani Hoffman (New York, 1988); Haslam, *Fitting Sentences*; Maja Suderland, *Inside Concentration Camps: Social Life at the Extremes* (trans.), Jessica Spengler (Cambridge, 2013), pp. 132-8.
[132] Katherine Fennelly, 'Out of Sound, Out of Mind: Noise Control in Early Nineteenth-Century Lunatic Asylums in England and Ireland', *World Archaeology*, 46(3) (2014), 416-30.
[133] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 134.

which she dissociated from her environment. This strategy was only temporary in Annie's case, and in later years her behaviour became more resistant, being violent on several occasions. This reflects that strategies of withdrawal were remarkably hard to sustain in institutional environments; Goffman notes such strategies undoubtedly entailed considerable internal effort.[134] It also highlights how patients' responses to asylum life changed over time, and how in response to changing circumstances, patients deployed various mechanisms of agency at different points in their asylum career.

It would be problematic to argue that every case in which a patient did not speak or refused to socialize was a mechanism of agency. To do so would be to adopt the stance of the libertarian critiques made by famous anti-psychiatrists like Thomas Szasz, and I do not suggest that mental illness was 'manufactured' by the nascent psychiatric profession.[135] The withdrawal of some patients into themselves in some cases was unambiguously the result of their mental condition. Melancholic and catatonic patients are obvious examples of cases in which nineteenth-century asylum doctors would have understood silence as evidence of insanity. Indeed, it would be difficult to make a case that patients suffering from the final stages of General Paralysis of the Insane were anything other than unable to speak. However, the cases discussed above suggest that we should, at the very least, acknowledge the possibility that patients who were withdrawn were so disposed as part of a deliberate coping strategy. Not to acknowledge this would be to ignore the complexities of patient responses to asylum life.

It is difficult to assess how 'successful' strategies of withdrawal were given that their subjective meaning is only accessible through individual testimony in sources such as memoirs, autobiography and interviews. If we are to measure the success of patient agency in terms of its capacity to challenge asylum authority, however, such behaviour was extremely difficult to prevent. Goffman notes that countering such behaviour was essentially impossible: 'Given the pressures required to dislodge an inmate from this status, as well as the currently limited facilities for doing so, this line of adaptation is often effectively irreversible'.[136] Although it is difficult to say with any degree of certainty whether mentally retreating from asylum life enabled patients to forget about the institutional world

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[134] Goffman, *Asylums,* pp. 61-2.
[135] Thomas Szasz, *The Manufacture of Madness: A Comparative Study of the Inquisition and Mental Health Movement* (London, 1971).
[136] Goffman, *Asylums,* pp. 61-2.

surrounding them, it is clear that such behaviours were almost impossible for the institution to prevent. Coaxing patients out of withdrawn states would have been even more challenging from the 1870s as the asylum struggled to recruit and retain sufficient, competent attendants.[137] Patients in withdrawn states did not work, would not speak to doctors to provide them with medical information, and would not engage with any aspect of asylum life. As such, we may conclude that such strategies were successful insofar as they enabled patients to disengage with the asylum regime in a manner that could not be prevented by asylum authorities.

5.8 Conclusion

Coping mechanisms were adopted by patients in Lancaster Asylum to make their confinement more comfortable, to maximize the benefits and privileges they might acquire within institutional strictures without directly or intentionally challenging asylum authority. These strategies were 'half-measures' – they did not resist the institutional regime, however, they did not entirely accept it either. They were behaviours which sought to modify the terms of patients' confinement, rather than challenge the fact of their detention or indeed any aspect of the institutional routine. The fact that many of the behaviours discussed in this chapter could be accommodated by medical frameworks meant that they allowed patients to considerably alter their lives in the institution. In many ways this meant that coping strategies afforded patients a greater degree of agency over their day-to-day lives than strategies which overtly resisted institutional authority.

The coping strategies adopted by patients in Lancaster Asylum demonstrate their knowledge of the institutional systems governing their behaviour and highlight their capacity to manipulate those systems to their own advantage. This system was heterarchical, and it was the presence of this plurality of power relationships which afforded patients the opportunity to accrue power for themselves, thereby enabling them to make institutional life more bearable. Opportunities to engage in such behaviour were afforded by the fact that the asylum required, not only acquiescence from patients, but their taking on roles and responsibilities that promoted and maintained institutional order. For the asylum to effectively manage patients it was essential that a degree of power was invested in them. Due

[137] Walton, 'Pauper Lunatics in Victorian England', pp. 190-1.

to their necessity for the smooth-running of the institution, coping strategies afforded patients a greater degree of agency over their day-to-day lives than strategies which were overtly resistant. By exploiting these cracks in institutional authority, patients were able to carve out niches for themselves which enabled them to derive perks, privileges and even power.

6. Engaging with Asylum Life

6.1 Introduction

Throughout this thesis, I have argued that patient agency occupied a continuum ranging from resistance to assent.[1] In the previous two chapters, we have examined resistance and strategies of coping, or negotiation. In this chapter, the assent end of this spectrum will be explored by examining how patients engaged with the asylum. These strategies did not see patients merely comply with asylum treatment – they were not dupes of a false-consciousness inculcated by a professional medical hegemony.[2] Patient decisions to engage with the treatments available in Lancaster Asylum were far more complex.[3] For a variety of reasons, which this chapter will explore, some patients very actively engaged with the asylum regime, and these individuals played a pivotal role in upholding institutional authority. In seeking out medical expertise and specialist asylum treatment patients promoted the self-confidence of doctors in Lancaster Asylum.[4]

The role of the patient in promoting medical authority has not received a great deal of attention in histories of psychiatry. However, this has been more thoroughly considered in histories of non-psychiatric medicine. Several researchers have argued that English medical practice in the nineteenth century was a 'marketplace', in which doctors had to compete for business by accommodating patients' requests, preferences and beliefs.[5] The doctor-patient relationship was, therefore, a negotiated entity in which patient decisions played an important

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[1] Ahearn, 'Language and Agency', pp. 115-6.
[2] Hoare and Nowell Smith, *Selections from the Prison Notebooks.*
[3] This reading of consent is influenced by broader interpretations of Gramsci's ideas, such as Joseph Femia, 'Hegemony and Consciousness in the Thought of Antonio Gramsci', *Political Studies*, 23(1) (1975), 29-48; Nicholas Abercrombie, Stephan Hill and Bryan S. Turner, *The Dominant Ideology Thesis* (London, 1980); Anne Showstack Sassoon (ed.), *Approaches to Gramsci* (London, 1982); MacLeod, 'Hegemonic Relations', 533-57.
[4] This approach to agency draws on practice theory to understand the reciprocal relationship between actors and social structures, Ortner, *Anthropology and Social Theory,* pp. 1-18.
[5] Digby, *Making a Medical Living;* Elizabeth Hurren and Steven King, 'Public and Private Healthcare for the Poor, 1650s to 1960s, in Paul Weindling (ed.), *Healthcare in Private and Public from the Early Modern to 2000* (London, 2014) pp. 36-57.

role in shaping medical practice.[6] Such studies challenged the idea that doctors' authority over patients was absolute and stressed the importance of the agency of patients in shaping the history of medicine. However, relatively little attention has been paid to the roles played by patients in shaping medical encounters focussed on healing the mind.[7]

Considering patient engagement as a mechanism of agency not only facilitates a better understanding of the development of psychiatric medicine, but also furthers our understanding of historical agency. The importance of engagement as agency has been discussed in the work of Susan Miller on American youth movements. Miller examines children's experiences of membership of the youth movement, Children of the American Revolution. The roles, responsibilities and projects that children took on within this organisation demonstrated very active engagement with the society. Miller argues that, 'we should be attentive to the ways in which children willingly conform to adult agendas, not necessarily because youth acquiesce to power, but because their interests often align with those promoted by adults'.[8] Miller has pointed out that we should not be surprised that many of the child members of this organisation identified their interests as aligning with adults belonging to the same categories of race, ethnicity and social class, especially when membership of these identities conferred enormous social privilege.[9]

Miller's argument centres on the idea that the engagement of marginal groups with dominant regimes was pursued out of self-interest. However, the relationship between the pursuit of self-interest and agency is, perhaps, more complex than this. Some scholars take a cautious approach to incorporating 'intentionality' as an integral component of definitions of

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[6] Morantz-Sanchez, 'Negotiating Power at the Bedside', 287-309; Nancy M. Theriot, 'Negotiating Illness: Doctors, Patients, and Families in the Nineteenth Century', *Journal of the History of the Behavioural Sciences,* 37(4) (2001), 349-68; Kathleen Powderly, 'Patient Consent and Negotiation in the Brooklyn Gynaecological Practice of Alexander J. C. Skene: 1863-1900', *Journal of Medicine and Philosophy,* 25(1) (2000), 12-27; Sally Wilde, 'Truth, Trust and Confidence in Surgery, 1890-1910: Patient Autonomy, Communication and Consent', *Bulletin of the History of Medicine,* 83(2) (2009), 302-30.

[7] There are some important exceptions to this, including Barfoot and Beveridge, 'Madness at the Crossroads', 263–284; Barfoot and Beveridge '"Our most notable inmate"', 159-208; Chaney, '"No Sane Person"', 37-53; Katherine Rawling, '"She Sits All Day in the Attitude Depicted in the Photo": Photography and the Psychiatric Patient in the Late Nineteenth Century', *Medical Humanities,* 43(2) (2017), pp. 107-9.

[8] Miller 'Assent as Agency', 48-65.

[9] Miller, 'Assent as Agency', p. 49.

agency.[10] Others have considered it central to making a distinction between 'routine practices' and 'intentionalized action'.[11] Another view of intentionality and agency, suggested by scholars such as Anthony Giddens, shapes the approach taken throughout this chapter in considering active engagement as agency in Lancaster Asylum.[12] Giddens recognises the intentionality of human agency, while also leaving room for the 'unconscious' in shaping how actors behave.[13] This understanding of intentionality allows for a consideration of the ways in which social structures can shape intentions, often in ways of which actors themselves were not consciously aware. This is particularly significant in relation to understanding why patients identified their interests as having been served by the medical profession in the asylum, given that such beliefs were shaped by wider social and cultural currents. Furthermore, as we shall see throughout this chapter, patients' engagement with the asylum often had consequences which they did not intend, and this further highlights the pitfalls of definitions of agency which hinge entirely on intentionality.[14]

Patients engaged with asylum life for a variety of reasons and, by contextualising these strategies within wider changes and phenomena in working-class society and culture, this chapter will explore the factors which drove engagement. For some individuals, the perceived benefits of asylum treatment were medical; they subscribed to psychiatric theories explaining their experiences and believed that asylum doctors possessed the necessary expertise to relieve their suffering.[15] Others identified the expertise of asylum doctors in relation to their knowledge of medicine and sought out treatment for physical illnesses during their confinement. The benefits perceived by some were connected to the quality of life available to them in the asylum, and they saw the institution as offering a reprieve from poverty. This chapter will also highlight the implications of patient engagement for the development of the institution. Patients' decisions to seek treatment and to engage with

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[10] Jean Comaroff and John Comaroff, *Ethnography and the Historical Imagination* (Boulder CO, 1992); Ahearn, 'Language and Agency', p. 112; Alessandro Duranti, 'Intentionality', in Alessandro Duranti (ed.), *Key Terms in Language and Culture* (Malden, MASS, 2001), pp. 451-73;

[11] Charles Taylor, 'The Concept of a Person', in Charles Taylor (ed.), *Human Agency and Language* (Cambridge, 1985); William H. Sewell, 'A Theory of Structure: Duality, Agency, and Transformation', *American Journal of Sociology,* 98(1) (1992), 1-29.

[12] Ortner, *Anthropology and Social Theory*, p. 135.

[13] Giddens, *Central Problems in Social Theory*.

[14] Comaroff and Comaroff, *Ethnography and the Historical Imagination,* p. 36.

[15] The congruence of medical and lay understandings of disease in non-asylum contexts see Rosenberg, 'The Therapeutic Revolution', pp. 3-26.

asylum life reinforced the self-confidence of Lancaster Asylum doctors in their ability to treat insanity. Moreover, the motivations which underpinned patient engagement led to changes in how the asylum functioned. Patient engagement not only afforded patients agency in relation to their lives and experiences in the institution, but also over the development of the asylum and the treatment of insanity within it.

6.2 Seeking Refuge in the Asylum

That patients actively sought out or preferred life in the asylum is frequently overlooked in current literature. It is well-documented that asylums were one of the 'options' available to the families of the insane in the 'mixed economy of care'.[16] These institutions were used selectively to suit the needs of individual families depending on a variety of factors including economic fluctuations, attitudes towards the propriety of asylum care, and emotional ties to insane relatives.[17] The role of the patient in deciding if and when to access these institutions, however, remains obscure, particularly in county asylums. This is due to the ways in which admissions were governed prior to the introduction of the category of 'voluntary patient' under the 1930 Mental Treatment Act.[18] Prior to this it was impossible for a patient to enter a county asylum without being certified insane, meaning that legally all pauper patients were detained against their will.[19]

However, concentrating solely on the legal framework for admission to a county asylum does not consider how such a procedure operated in cases where certification coincided with pauper patients' own desire to be admitted to the asylum. Case notes indicate that many patients understood how admissions procedures worked,[20] and how to ensure that they were allowed to enter, or to stay in, the asylum rather than living 'in the community' or in another Poor Law institution. As Peter Bartlett has pointed out, 'poor people may well

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[16] Wright, 'Getting out of the Asylum', 137–55; Marland, *Dangerous Motherhood*; Suzuki, *Madness at Home*; Wannell, 'Patients' Relatives and Psychiatric Doctors', 297–313.
[17] Bartlett, *The Poor Law of Lunacy,* p. 4; Coleborne, 'Families, Patients and Emotions', p. 431.
[18] Chaney, '"No 'Sane' Person Would Have Any Idea", p. 39.
[19] The situation in private asylums was different, see Chaney '"No 'Sane' Person Would Have Any Idea", 37-53; Digby, *Madness, Morality and Medicine,* p. 206, n. 9.
[20] This knowledge of institutional procedures within the Poor Law system may be likened to the ways in which paupers used their knowledge of administrative systems to exit and enter the workhouse according to their needs, Green, 'Pauper Protest', p. 139.

have been at least occasionally manipulating the system to their own advantage'.[21] Although Bartlett was mainly referring to the families of insane paupers, this view equally applies to paupers themselves. Although voluntary patient status was not enshrined in law until 1930, it will be suggested that the Mental Treatment Act was not creating a new category of patient, as has previously been suggested, but legitimizing a long-established practice.[22]

Throughout the nineteenth century, Lancaster Asylum doctors allowed several patients to remain in the institution even though they no longer considered them insane. Such decisions were made due to concerns about the economic situations, health, or home environments of patients. This contrasts with the sentiments published by doctors in professional journals and official reports, which bemoaned the effects of allowing the sick, impoverished, and incurably insane into county asylums, leading to the 'silting up' of chronic cases.[23] Recommendations for separate institutions for incurable cases were made by the Metropolitan Commissioners in Lunacy as early as 1844, which cited Lancaster Asylum as an example of the negative effects that chronic patients could have on rates of cure.[24] Despite this rhetoric, in practice decisions were sometimes made to allow patients to stay in the asylum beyond their 'recovery', often at patients' own requests. Case notes suggest that this 'rule-bending' was appreciated by patients who preferred life in the asylum due to the relative security it offered. The case notes of Hugh S. illustrate this use of the asylum as a refuge from poverty:

> Has slight paralytic weakness and aphasia, and is mentally weak, but seems free from delusions and undue excitement or depression and is therefore sane. He is not physically robust and would probably be unable to do any hard work, so that his temporary detention is a kindness, which he himself admits.[25]

Both Hugh and his doctor believed him to be sane, yet still kept him in the asylum. The patient's physical weakness, and inability to work, were the deciding factors in his continued residency in the institution. The comment that Hugh's detention was an act of kindness

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[21] Bartlett, *The Poor Law of Lunacy*, pp. 25-6.
[22] This further undermines the teleological account of the emergence of the 'voluntary' patient in work such as Jones, *Asylums and After*, pp. 135-40.
[23] J. Wilkie Burman, 'On the Separate Care and Special Medical Treatment of the Acute and Curable Cases in Asylums', *Journal of Mental Science*, 25(111) (1879), 315-25.
[24] *Report of the Metropolitan Commissioners in Lunacy* (London, 1844), pp. 92-3.
[25] LA, HRL/4/12/2/13, 26 Mar 1884-20 Dec 1886, p. 242.

reinforces the impression that he was being detained because he was at risk of economic deprivation, not because he was insane.[26]

Lancaster Asylum's Superintendents recognised that patients' poor standards of living post-discharge were often the cause of relapse. Superintendent David Cassidy wrote, 'Were there some blissful haven to which we could send all our discharged patients where there could be no struggle…and no drink, there would be few or no relapses.'[27] This suggests that Hugh's continued stay was not just an act of charity, but a mechanism of preventing relapse.[28] Such instances further suggest that although, technically, patients could not be admitted 'voluntarily' to Lancaster Asylum in this period, patients like Hugh were there on what, in practical terms, became an informal voluntary agreement between doctor and patient.[29] Hugh's case demonstrates that, often, patients recognised the benefits of asylum life. However, this did not necessarily mean that patients like Hugh were particularly happy during their stay in the asylum, or that they had some rose-tinted view of institutional life. In fact, on a previous occasion Hugh was said to have 'complained bitterly about his detention'.[30] Such sentiments echo King's findings in relation to pauper attitudes towards institutions in the early-nineteenth century, which held that it was 'better for a sick Man to be in the Poorhouse than a Hovel'.[31] Regardless of dissatisfaction with asylum life, for some it was still preferable to the alternative faced upon discharge.

Patients' family or home lives could also influence their preference to remain in the asylum. Exhaustion from looking after large families whilst living in poverty have been considered a significant factor in female admissions to nineteenth-century asylums.[32] Several women admitted to Lancaster appear to have struggled under the weight of such pressures. The case notes of Mary Ann L., a housewife admitted in 1885 with melancholia, describe her response to her admission: 'Says she was very unhappy at home and was glad to get back

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[26] Such notions of kindness may be usefully compared with Helen Rogers' discussion of kindness as a significant philanthropic motive in Helen Rogers, 'Kindness and Reciprocity: Liberated Prisoners and Christian Charity in Early Nineteenth-Century England', *Journal of Social History*, 47(3) (2014), 721-45.
[27] LA, QAM/5/37, *Reports* (1888), p. 20.
[28] Smith, *'Cure, Comfort and Safe Custody'*, pp. 106-7.
[29] This parallels the formal voluntary status of patients in private asylums, cf. Chaney, '"No Sane Person"', 37-53.
[30] LA, HRL/4/12/2/13, 26 Mar 1884-20 Dec 1886, p. 242.
[31] King, *Sickness, Medical Welfare and the English Poor*, pp. 260-1.
[32] Marland, *Dangerous Motherhood*, pp. 142-3.

here. Could not sleep or rest at home. Looked haggard and ill at first but is now better and more contented looking'.[33] Elizabeth C. was readmitted to Lancaster Asylum in 1876 and her case notes remarked that she, 'Appeared to appreciate the security offered her by the Asylum'.[34] Elizabeth was offered the opportunity to go home on a trial basis in 1880, however, she refused, due to her own anxieties about this proposal. The prospect of returning home was particularly distressing for Elizabeth, perhaps because she attributed her mental distress to the significant amount of time she had spent at home, with only her two children for company.[35]

For female patients in particular, the asylum could provide a refuge from the pressures of domestic life. By affirming her incapacity, asylum admission validated Elizabeth's inability to fulfil her roles as wife and mother, absolving her from responsibility for her failings to live up to feminine ideals. Indeed, Morantz-Sanchez notes that medical corroboration of women's inability to fulfil their duties as wives and mothers could be a source of comfort when they did not live up to the ideals of Victorian womanhood.[36] Feminist histories of the asylum have tended to understand these institutions as vestiges of social control, which enforced conformity to gender norms by pathologizing deviation from Victorian femininity.[37] This is arguably not the full picture. Elizabeth's case highlights the asylum and asylum doctors as potential allies, not only in providing a refuge for women who succumbed to the pressures of motherhood, but also in exonerating them from blame when they could not be the ideal wife and mother that Victorian society expected them to be.

Although admitting patients on a 'voluntary basis' did not become possible in the county asylum system until 1930, informal channels allowed asylum doctors to exercise some discretion. Although there was no legal category of 'voluntary' patient in the county asylum system, in practice there were patients who were in Lancaster Asylum voluntarily. Concerns about poverty, employment, reintegration and the relative comfortability of asylum life were all very real factors in patients' decisions to remain in, or to enter, Lancaster Asylum.

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[33] LA, HRL/4/12/3/11, 25 Sept 1883-27 Jun 1885, p. 274.
[34] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 105.
[35] The various pressures of maternal duties and their relationship to the onset of mental disorder have been explored in Hilary Marland, 'Disappointment and Desolation: Women, Doctors and Interpretations of Puerperal Insanity in the Nineteenth Century', *History of Psychiatry*, 14(3) (2003), 303-20.
[36] Morantz-Sanchez, 'Negotiating Power', pp. 298-9
[37] Showalter, *The Female Malady*.

Furthermore, these issues were recognized by doctors who allowed vulnerable patients to remain in the institution, even when there was no longer any medical evidence that they were insane. This highlights the significance of the asylum, not just as a place of medical treatment, but as a refuge from poverty, domestic stresses, and unemployment.

6.3 Choosing Between Institutions

The asylum was part of a landscape of nineteenth and twentieth-century institutions.[38] Throughout this period there were several institutions to which individuals with mental disorders could be admitted.[39] Insane paupers were treated on wards in workhouse infirmaries, which were a significant location for the treatment of chronic, long-term cases, despite the objections of nineteenth-century asylum doctors.[40] The insane could also be found amongst the population of prisons, either having been imprisoned whilst already suffering from mental disorder, or succumbing to mental distress during their incarceration.[41] Movement between these institutions was common, and even movement between different county asylums was not unusual.[42] It has been demonstrated that the insane poor could manipulate this 'mixed economy of care'.[43] Indeed, many individuals 'feigned' insanity or exaggerated their distress to gain access to the asylum, suggesting that they preferred the asylum to the workhouse or prison. Many patients who sought admission to the asylum did so, not simply because they believed life in the asylum to be more comfortable, but also because they believed that specialist treatment was necessary to cure mental disease. The language used by inmates to gain access to the asylum therefore explicitly endorsed the authority and expertise of asylum doctors in the treatment of insanity.

Faced with a choice between the workhouse and the asylum, many patients preferred the latter. This is perhaps unsurprising given the relative comfort asylum life offered, or at

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[38] Leonard Smith, 'The County Asylum in the "Mixed Economy of Care"', in Melling and Forsythe (eds.), *Insanity, Institutions and Society,* pp. 23-47.
[39] The home also remained a significant locus of care, Suzuki, *Madness at Home.*
[40] Leonard Smith, '"A Sad Spectacle of Hopeless Mental Degradation": The Management of the Insane in West Midlands Workhouses, 1815-60', in Jonathan Reinarz and Leonard Schwarz (eds.), *Medicine and the Workhouse* (Rochester NY, 2013), pp. 103-20.
[41] Cox and Marland, '"He Must Die or Go Mad in This Place"', 78-109.
[42] Bartlett, *The Poor Law of Lunacy,* pp. 1-9.
[43] Bartlett, *The Poor Law of Lunacy,* pp. 135-6; Cox and Marland, '"He Must Die or Go Mad in This Place"', pp. 99-101.

least its favourable image in the public imagination.[44] Workhouses were designed to deter the 'undeserving' poor, whereas asylums were designed to be comfortable, to mimic the family home and offer the patient a safe-haven from the outside world.[45] Although in reality the workhouse was not always less comfortable than the asylum, the 'competing mythologies' of the two institutions shaped individuals' preferences.[46] Such preferences reinforced the sentiments of professional asylum doctors, who sought to validate the asylum as the most appropriate venue for the treatment of acute insanity.[47] It is unsurprising then that patient preferences for the asylum could be accommodated by asylum doctors, affording patients a significant degree of agency in this respect. Furthermore, by recording these preferences in casebooks, to which the Lunacy Commissioners would be privy, asylum doctors provided further evidence for the necessity of their expert custody over the insane.[48]

The case notes of Susannah T. demonstrate the strength of some patients' preferences for the asylum over the workhouse: 'The Guardians wished to remove her to the workhouse on two occasions and tried to remove her with [force] but she resisted and struggled so much that the officers did not like to carry her off by force'.[49] Susannah had been in Lancaster Asylum for 22 years when she was discharged to the workhouse; her resistance to leaving the institution may have been shaped as much by attachment to the asylum as by reluctance to enter the workhouse. Another patient commented on the comparative suitability of the Asylum for her treatment compared to the workhouse. Bridget C.'s case notes state: 'Regrets very much being detained so long in workhouse and not sent here sooner'.[50] Bridget's statement acknowledged the necessity of specialist treatment of insanity early in the appearance of mental disorder. This was a constant bone of contention for doctors in Lancaster Asylum, who, while accepting that workhouse infirmaries could be suitable for chronic cases, frequently complained that local Guardians kept the acutely insane in

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[44] Bartlett, *The Poor Law of Lunacy,* pp. 135-6.
[45] Walton 'The Treatment of Pauper Lunatics in Victorian England', p. 167.
[46] Peter Bartlett, 'The Asylum, the Workhouse, and the Voice of the Insane Poor in 19th-Century England', *International Journal of Law and Psychiatry,* 21(4) (1998), p. 429.
[47] Scull, *The Most Solitary of Afflictions,* pp. 136-8.
[48] In their 1844 report, the Metropolitan Commissioners in Lunacy stressed the impropriety of treating the insane in workhouses, Smith, '"A Sad Spectacle"', p. 108.
[49] LA, HRL/4/12/3/4, 31 Dec 1869-3 May 1872, p. 67.
[50] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 226.

workhouse wards too long, sending them to the asylum only when their disease had progressed so far as to prevent their cure.[51]

In other cases, however, the methods employed by patients to secure their admission to an asylum could challenge the expertise of doctors. Asylum doctors' claims to specialist knowledge about insanity could be undermined by their inability to detect 'fake' cases.[52] Elizabeth S. had been in the workhouse for several months prior to her admission; her case notes state that Elizabeth 'wanted to come here and said she would do something to make them bring her'.[53] Whether or not Elizabeth understood the legal process of certification is not apparent from her case notes. However, what is clear is that she understood the necessity of appearing insane if she was to be removed to the asylum. To effect that removal, she threatened to 'do something' to demonstrate her mental instability. This threat, with its implication of self-injury, harm to others or even suicide, appears to have brought about her transfer. Elizabeth's knowledge of the system of Poor Law institutions, and of the criteria to be admitted to an asylum rather than a workhouse, enabled her to gain access to Lancaster Asylum. [54] She may well have been suffering from mental distress and seeking to make that distress more apparent in order to receive treatment. Equally, she may have been seeking to enter an institution which she perceived as more comfortable than the workhouse. Regardless of her motive, her threat forced the hands of the Guardians because it made her appear as a 'dangerous lunatic' – a prerequisite for an individual to be moved from a workhouse to an asylum.[55] Elizabeth's case illustrates that debates over the 'proper' institution for the custody of the insane did not just take place between Poor Law Guardians, magistrates, and asylum doctors as current scholarship suggests,[56] but that the insane themselves participated in these discussions.

Similar challenges to institutional expertise came from patients who sought to be admitted from prisons. Jane B. was admitted to Lancaster Asylum from prison in 1890 and was believed to be faking her mental symptoms. Her case notes record that Jane said, '…she would prefer 6 months here to 1 in prison' and conclude that she 'Evidently made it her

[51] LA, QAM/5/2, *Reports* (1853), p. 10.
[52] Cf. Cox and Marland, '"He Must Go Mad or Die in This Place"', pp. 99-100.
[53] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 131.
[54] Cf. Green, 'Pauper Protest', pp. 151-4.
[55] Smith, '"A Sad Spectacle"', p. 106.
[56] Smith, '"A Sad Spectacle"', pp. 106-9.

intention to be sent here. Shows no evidence of insanity'.[57] Despite this statement in Jane's casebook made on 21 August 1890, she was not discharged until 7 October and when she was discharged she was described as 'recovered', suggesting that her doctor continued to treat her as insane despite having stated previously that she showed no evidence of mental disturbance.[58] Although failure to detect cases of feigned insanity threated to undermine asylum doctors' claims to be able to diagnose and treat mental disease, cases such as Jane's suggest that the greater threat to professional credibility came from failure to safeguard the insane. As such, even when doubts as to the veracity of some patients' conditions were raised, doctors preferred to err on the side of caution.[59] The tendency of asylum doctors to be cautious in this respect meant that patients who were able to secure their transfer from prison to the asylum stood a good chance of being allowed to remain.

Despite affording individuals a significant degree of control over their placement within the institutional landscape, patient preferences for Lancaster Asylum could also be manipulated as a tool for patient management. Bertha S. was admitted with 'imbecility' in 1900, having spent time in Winwick Asylum previously. Her case notes record her fear of being sent back to Winwick Asylum: 'Lives at present in dread of being sent to Winwick- the possibility keeps her quiet'.[60] Bertha's preference was used by doctors to incentivise her to be well-behaved and this was apparently a successful tactic. This might be considered as an extension of the use of the ward system in moral treatment as part of the system of 'carrot and stick' incentives to induce patients to conform to institutional behavioural standards.[61] Rather than being threatened with removal to a 'worse' ward, Bertha was threatened with removal to a 'worse' asylum, and this threat was used to 'keep her quiet', in other words to manage her successfully. In this case, Bertha's preference for Lancaster Asylum – rather than affording her control over her position within the nineteenth-century institutional landscape – was used by the asylum to extend their authority over her.

Patient preferences for Lancaster Asylum over the workhouse, the prison, or indeed any other asylum in the area, were based on their familiarity with the wider institutional

[57] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 164.
[58] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 164.
[59] York, 'Suicide, Lunacy and the Asylum', pp. 138-9.
[60] LA, HRL/4/12/3/25, 9 Jan 1900-8 Mar 1901, p. 145.
[61] Digby, *Madness, Morality and Medicine,* pp. 81-3.

landscape.[62] Through their knowledge of these systems, some patients were able to manipulate them and negotiate their place within them. For some, admission to Lancaster Asylum was the most desirable option available. This choice was motivated by a variety of factors which often mirrored the medical rationale for asylum treatment – that specialist institutions were necessary to treat insanity.[63] Patient preferences for the asylum over other institutions mirrored the beliefs held by doctors that the asylum was the only appropriate institution for the treatment of insanity.[64] By seeking to be admitted to the institution, patients intentionally or unintentionally, provided support to the agenda of asylum professionals in promoting the asylum as the proper location for the insane.[65]

6.4 Patient Engagement with the Medical Model of Insanity

Patients were admitted to Lancaster Asylum suffering from physical and mental distress, and for some, this suffering stimulated their engagement with the institution. Such individuals believed that the asylum and its doctors could assist in the alleviation of their symptoms. Indeed, it should not be surprising that patients subscribed to medical models of insanity. Olive Anderson has shown in relation to coroner's inquests into suicides that lay understandings of insanity were very close to those of the medical profession, particularly amongst the lower social classes.[66] Many widely-available publications discussed causes, symptoms and cures for insanity. Buchan's *Domestic Medicine* (1784)[67] and *Haydn's Dictionary of Popular Medicine and Hygiene* (1874)[68] included discussions of insanity, not to mention numerous Victorian medical encyclopaedias which discussed the subject.[69] Newspaper articles also contributed to lay awareness of medical theories of insanity. For example, articles published during the wave of 'wrongful confinement' scandals in the mid-

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[62] Cf. Mandler, 'Introduction', in Mandler (ed.), *The Uses of Charity*, pp. 12-23; Hitchcock, *Down and Out*, pp. 125-49.
[63] This corroborated the arguments of asylum doctors in relation to the necessity of their profession, Scull, *Museums of Madness*, pp. 214-5.
[64] LA, QAM/5/29, *Reports* (1880), pp. 16-17.
[65] Such unintended consequences of patient agency demonstrate the importance of the soft understanding of intentionality and agency, Comaroff and Comaroff, *Ethnography and the Historical Imagination*, p. 36
[66] Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford, 1987), pp. 224-32.
[67] William Buchan, *Domestic Medicine* (London, 1784).
[68] Edwin Lankester (ed.), *Haydn's Dictionary of Popular Medicine and Hygiene* (London, 1874).
[69] Beier, *For Their Own Good*, p. 71.

nineteenth century contained testimonies from prominent alienists discussing causes and evidence of mental disturbance.[70] By the period in which this study begins, laymen and women would have had access to a large corpus of scientific and medical knowledge. Steven King notes that even in the late-eighteenth and early-nineteenth century, the sick poor had access to medical language from advertisements, novels, poetry, medical texts, consultations with doctors and more.[71] Medical language and ideas were prolific in popular culture.

There is much to suggest that patients in Lancaster Asylum were aware of such discussions.[72] Local newspapers carried articles discussing Lancaster Asylum, and the forms of treatment offered therein.[73] Lucinda Beier's study of working-class health and medicine in Lancashire suggest that mental illness was an exception to the rule of the home-treatment of the sick, with one interviewee discussed by Beier remembering that her grandmother would take people who were 'out of their minds' to Lancaster Asylum.[74] This suggests that working-class understandings of insanity acknowledged the necessity of specialist, institutional treatment. That some patients agreed that they were insane and believed that asylum treatment would cure them can be understood in the light of this overlap between lay and professional understandings of mental disorder.[75] The case notes of William B., admitted in 1885 with melancholia, illustrate the active role taken by patients in seeking asylum treatment:

> Came here of his own accord as his 'Brain wanted a complete rest'. Has read of suicide and was afraid that he might someday attempt to take his life. Has had desire to do so and was able to resist the inclination but feels that his power of self control is getting weaker.[76]

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[70] Joshua J. Schwieso, '"Religious Fanaticism" and Wrongful Confinement in Victorian England: The Affair of Louisa Nottidge', *Social History of Medicine*, 9(2) (1996), 159-74.
[71] King, *Sickness, Medical Welfare and the English Poor*, p. 74.
[72] Indeed, Lancashire has been highlighted as an area in which there was a strong culture of working-class science, Anne Secord, 'Science in the Pub: Artisan Botanists in Early Nineteenth-Century Lancashire, *History of Science*, 32(3) (1994), 269-315.
[73] Claire Delingny, '"The Borderlands of Insanity": Insanity and Poverty in the Lancaster, Prestwich and Rainhill Lunatic Asylums, 1845-1914', Unpublished PhD Thesis Abstract (Université Sorbonne, Paris, 2009), Personal Correspondence.
[74] Beier, *For Their Own Good*, pp. 60-1.
[75] Cf. Rosenberg, 'The Therapeutic Revolution', pp. 3-26.
[76] LA, HRL/4/12/2/13, 26 Mar 1884-20 Dec 1886, p. 168.

This extract from William's case notes uses the language of voluntarism, again reflecting the fact that many patients perceived themselves as submitting to treatment voluntarily.[77] William's statement also reflects the influence that contemporary medical literature could have on patients' perceptions of illness and on their evaluation of the necessity of institutional treatment. Clearly patients' own concern over their mental state could prompt them to seek out asylum treatment.

The beliefs of patients as to the benefits of medical intervention are further reflected in the efforts that some made to comply with medical advice and treatment regimens. Several patients asked to be given shower baths, a therapy that occupied an uneasy grey area between treatment and physical punishment.[78] This treatment has been considered controversial by historians and by contemporary medical practitioners, yet evidence from casebooks suggests that shower baths were requested by patients themselves. Hannah M., for instance, was given shower baths, but only 'at her own request'.[79] William I. also requested shower baths, 'declaring they do him good.'[80] Patient requests for such treatments may be likened to preferences in working-class health culture for 'working medicines' – medicines that did not necessarily cure, but had an expected and observable physical effect.[81] Efforts to engage with medical treatments suggest that, for some patients, medical intervention offered alleviation of symptoms that they identified themselves as problematic.

Patients' engagement with treatment related to the intersection of patients' understandings of the nature of insanity and medical models of mental disorder. Their engagement with the asylum was motivated by a positive attitude towards the treatment provided therein. Such attitudes towards asylum treatment resonate with King's discussion of pauper engagement with workhouse medicine in the early decades of the nineteenth century. King suggests that some paupers willingly entered the workhouse in times of sickness to obtain medical assistance.[82] Such engagements acknowledged medical expertise, enhancing the authority of the asylum.[83] At the same time, by engaging with asylum treatment, patients

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[77] Chaney, '"No Sane Person"', p. 41.
[78] Shower baths delivered water through a nozzle that sprayed water over the patient, which produced a greater physical shock because the water did not remain in constant contact with the patient's body, De Young *Encyclopaedia of Asylum Therapeutics,* p. 184.
[79] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 226.
[80] LA, HRL/4/12/2/13, 26 Mar 1884-20 Dec 1886, p. 280.
[81] Beier, *For Their Own Good,* p. 64-5.
[82] King, *Sickness, Medical Welfare and the English Poor,* p. 261.
[83] Morantz-Sanchez, 'Negotiating Power', p. 301.

were able to exercise influence over it.[84] This highlights the relationship between agency and authority in the asylum, and the symbiotic reproduction of patient and medical power. Patients' acknowledgement of medical authority and their subscription to medical models of insanity afforded them the capacity to choose their treatments and direct them in ways that they believed beneficial. In this way, asylum authority and patient agency were mutually reinforcing.

6.5 Accessing Physiological Treatments in the Asylum

Whether or not patients agreed with their designation as insane, or consented to their confinement, many took advantage of the availability of health care in Lancaster Asylum. Even those who complained about their detention sought out treatment for headaches, constipation and injuries.[85] This reinforced the medical authority of doctors over patients, albeit over their bodies rather than their minds.[86] Given the time many patients spent in Lancaster, and the large patient population, contracting an illness during confinement was common, and when they were afflicted with these complaints patients sought out medical assistance. Many patients suffered injuries during their detention, often associated with incidents of violence, falls, or complications arising from conditions such as epilepsy and general paralysis of the insane.[87] Distinction between body and mind was not a sharply drawn line in asylum medicine. [88] Not only were somatic theories of the aetiology of insanity prevalent, but good physical health was believed to promote mental health.[89] The treatment of physical illnesses was thus an important component of asylum treatment, and patient engagement with it necessarily acknowledged medical expertise.

Many patients complained about headaches and constipation during medical interviews rather than discussing their mental conditions. Complaints about bowel health were particularly common, reflecting perhaps the concern with 'inner hygiene' that was so common amongst the English public throughout this period[90] and was especially prominent in

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[84] Chaney, '"No Sane Person"', p. 49.
[85] Wallis, *Investigating the Body,* p. 14.
[86] Morantz-Sanchez, 'Negotiating Power', p. 301.
[87] Wallis, *Investigating the Body,* p. 39.
[88] L. S. Jacyna, 'Somatic Theories of Mind and the Interests of Medicine in Britain, 1850-1879', *Medical History,* 26(3) (1982), 233-58.
[89] Digby, *Madness, Morality and Medicine,* p. 131.
[90] Whorton, *Inner Hygiene.*

working-class health culture.[91] Coalescence of medical and lay opinion explains the willingness of asylum doctors to accommodate patient requests for laxatives. If patients wished to receive assistance for such complaints, however, they had to engage with medical authority by describing their symptoms and asking for relief. Given that such matters were not immediately apparent without physical examination, doctors relied on patients' self-reporting.[92] Reliance on patients to seek out medical attention in Lancaster Asylum continued despite improvements in diagnostic technologies and the physical examination in the nineteenth century.[93] This was due, at least in part, to the volume of patients in Lancaster Asylum – conducting daily physical examinations was simply not feasible. To receive medical help with 'invisible' illnesses, patients had to procure it.[94] As such, the argument that the 'sick man' had disappeared from the medical encounter by the nineteenth century does not apply in the context of the asylum where doctors continued to rely on patients' self-reporting.[95] Although patients were able to procure the interventions they desired, in doing so they affirmed the authority of asylum doctors. Although these interactions were not focused on their mental disorders, patients' complaints about bowel health tacitly recognized the medical authority of asylum doctors and appealed to their expertise to relieve physical discomfort.

In some cases where patients sought out medical treatments for physical illness, this could be part of a complex strategy of negotiating the asylum. Several patients who engaged with medical treatments still resisted other elements of institutional life.[96] Yet their decisions to seek treatment for physical disease entailed a significant acknowledgement of medical authority. For example, Eliza B. was frequently violent to other patients during her stay in Lancaster Asylum, and she also complained about her treatment by staff. Her case notes record that she shouted her complaints from the windows, 'in order that these messages may be telegraphed to her relations', and that she was 'saucy and abusive to officers'.[97] Yet, despite her resistance to detention, when Eliza had 'dyspepsia' (indigestion), she sought out treatment. Similarly, after a confrontation with another patient, she informed the doctor that

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[91] Beier, *For Their Own Good,* p. 64
[92] For a discussion of the importance of patients' constructions of their symptoms see Kleinman, *The Illness Narratives*.
[93] Porter, 'The Rise of Physical Examination', pp. 179-97.
[94] Wallis, *Investigating the Body,* p. 14.
[95] Jewson, 'The Disappearance of the Sick Man', 225-44.
[96] MacLeod, 'Hegemonic Relations', p. 534.
[97] LA, HRL/4/12/3/2, 2 April 1865-2 July 1867, p. 72.

she had pain in her shoulder.[98] When Eliza required treatment for physical ailments, she was apparently willing to acknowledge medical expertise. Such selective engagement can be explained as part of a strategy of maximizing benefits that could be derived from the institution. Upon admission, Eliza's occupation was given as 'hawker', suggesting that she was from the lower echelons of the working classes. As such, the availability of free health care in the asylum may have been useful to her.[99] While, of course, charity hospitals, self-dosing or mutual aid funds were options for some members of the poorer classes, Eliza was married and had some income from employment, potentially denying her access to such support.[100] Moreover, as has been demonstrated in relation to other Northern English Counties, following the advent of the New Poor Law, the quality of medical services available to the poor through parish provision were reduced.[101] Indeed, paupers in Lancashire appear to have had less interaction with doctors than their counterparts in other English counties.[102] Although alternative, self-help remedies were often the recourse of the poor in this period, the availability of free, orthodox medical treatments in institutions was something that paupers could take advantage of once admitted. Consequently, Eliza's willingness to seek help with physical illnesses may be perceived as strategic, a way of deriving some benefit from the institution. Nevertheless, her approach to medical expertise in Lancaster Asylum sanctioned doctors' authority and reinforced medical control over her body.

Patients who sought out medical expertise in relation to the treatment of physical complaints frequently rejected the expertise of asylum doctors in relation to their mental health. These strategies, which involved resisting some aspects of the asylum whilst engaging with others, reveal the complex nature of patient agency.[103] This partial, somewhat conditional, acceptance of medical authority reflected some of the concerns that nineteenth-century asylum doctors had about their own relationship to the wider medical profession.[104]

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[98] LA, HRL/4/12/3/2, 2 April 1865-2 July 1867, p. 72.
[99] Beier, *For Their Own Good,* p. 26.
[100] Keir Waddington, 'Unsuitable Cases: The Debate over Outpatient Admissions, the Medical Profession and late-Victorian London Hospitals', *Medical History,* 42(1) (1998), 26-46.
[101] Hilary Marland, *Medicine and Society in Wakefield and Huddersfield, 1780-1870* (New York, 1987).
[102] Steven King, 'Regional Patterns in the Experiences and Treatment of the Sick Poor, 1800-40: Rights, Obligations and Duties in the Rhetoric of Paupers', *Family & Community History,* 10(1) (2007), p. 75.
[103] MacLeod, 'Hegemonic Relations', p. 534.
[104] Scull, MacKenzie and Hervey, *Masters of Bedlam,* pp. 268-74.

This irony appears to have been lost on asylum doctors, who did not delineate between the treatment of mental and physical symptoms, the two being inextricably linked in medical aetiologies of insanity. As such, patients' engagement with physical treatments appeared as a validation of the authority of asylum doctors, unintentionally assuring asylum professionals of the efficacy of their interventions through patients' own demands for them.

6.6 Patient Gratitude

Patient engagement with the asylum is particularly apparent in their expressions of gratitude to staff and praise for institutional life. Such sentiments further underline that life in the asylum offered some patients a refuge from mental distress and the hardships of their lives outside the asylum. That life in Lancaster Asylum was desirable, comfortable and perhaps even enjoyable is reflected in statements made by patients and recorded in their casebooks. Given that such statements praised the institution, we may be assured that asylum doctors took care to record them. Such statements were not, however, used in publicity materials, like annual reports, as we might expect. [105] That they were recorded in casebooks suggests that patient praise and gratitude were important to the self-image of doctors in Lancaster Asylum during a period when therapeutic optimism declined year upon year.[106]

The gratitude of asylum patients has been explored by Leonard Smith in relation to patients in Gloucester Asylum. Several patients and their relatives kept in touch with the Superintendent after discharge to express gratitude for the role of the institution in their recovery.[107] Inmate gratitude has also been explored in relation to prisons, particularly the use of positive testimony of reformed prisoners in chaplains' memoirs and treatises. Such testimony was used to vindicate Christian reforming efforts. Helen Rogers has shown, however, that inmates' expressions of thanks were not merely evidence of 'brain-washing' but expressed sincere gratitude for the perceived kindnesses they had received from prison visitors.[108] John Welshman has also highlighted positive experiences of residential institutions in his study of Brentwood, a centre to rehabilitate mothers of so-called 'problem families'. Despite its apparently punitive nature, Welshman's analysis of letters written by

[105] Cf. Andrews, 'Case Notes, Case Histories', p. 273.
[106] Scull, *The Most Solitary of Afflictions,* p. 272; Melling and Forsythe, *The Politics of Madness*, pp. 46-7.
[107] Smith, '"Your Very Thankful Inmate"', pp. 237-52.
[108] Rogers, 'Kindness and Reciprocity', p. 723.

mothers following their stay demonstrate that many women did not experience their time in Brentwood as unpleasant.[109]

Expressions of gratitude could, of course, be understood as the result of patients' being over-awed by their middle-class doctors.[110] However, I suggest that the ways in which patients not only verbally expressed, but performed their gratitude, challenges this image. Sentiments of gratitude are evident in the casebooks of several patients. The case notes of Hannah H. suggest that doctors perceived her to be, 'very thankful for what is done for her'.[111] The asylum's annual reports do not contain transcriptions of such testimonies, which is surprising given the function of such reports in promoting the asylum positively.[112] The recording of patients' gratitude, therefore, must have been for the benefit of those who had direct access to the casebooks – the Commissioners in Lunacy and the asylum doctors. Of course, such sentiments would have been important for portraying the institution well during the annual inspections of the Commissioners. However, it is doubtful whether during their two-day inspections that the Commissioners read every case in detail.[113] The people most likely to read such comments were the Medical Officers themselves, and the Superintendent. As such we might see the care taken to record such positive evaluations as self-congratulatory, highlighting the role of patient engagement in promoting Lancaster Asylum doctors' own confidence in their capacity to treat the insane.[114]

The case notes of several patients contain similar references to statements made in praise of the asylum. John Augustus B. told doctors that he felt more secure in the asylum than he had prior to his admission: 'When outside felt very unsafe but now that he has arrived here has a feeling of security'.[115] The case notes of Joseph H. use quotation marks to directly transcribe his remarkably positive evaluation of life in the asylum: '"I don't know where I am but it is Heavenly rest!'.[116] For some individuals, the efforts of asylum staff, architects and

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[109] John Welshman, 'Recuperation, Rehabilitation and the Residential Option: The Brentwood Centre for Mothers and Children', *Twentieth Century British History,* 19(4) (2008), 502-29.
[110] Cf. Ursula Henriques, 'The Rise and Decline of the Separate System of Prison Discipline', *Past and Present,* 54(1) (1972), 61-93.
[111] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 201.
[112] Andrews, 'Case Notes, Case Histories', p. 273.
[113] LA, QAM 5/1-37, *Reports* (1852-88).
[114] Morantz-Sanchez, 'Negotiating Power', p. 301.
[115] LA, HRL/4/12/2/24, 25 Feb 1904-15 Feb 1905, p. 237.
[116] LA, HRL/4/12/2/25, 17 Feb 1905-21 Dec 1905, p. 221.

decorators produced an environment which genuinely provided them with a sanctuary from the outside world, a place in which they felt comfortable and wanted to remain. For others, the asylum became more than a secure haven or a comfortable place of rest: it became a home. Jane F., a patient admitted to Lancaster Asylum with chronic mania, told her doctors, 'this is her home and she has no home outside'.[117] As well as demonstrating a preference for the comforts and security offered by the asylum, patients' reluctance to leave could well be understood as a sign of what, in the twentieth century, would become known as institutionalization.

Some patients sought to show their gratitude through their actions, rather than verbally thanking doctors, by seeking to make contributions to the institution. This was seen as a way of repaying doctors for treatment and for their stay in the asylum. Pauper patients' places in the institution were paid for by their Poor Law Union, and as such they themselves did not pay for their maintenance.[118] For some patients, undertaking work allowed them to feel they were contributing to the economy of the asylum and thereby providing services in exchange for the room, food and medical care that they received. The case notes of Joseph W. record that his ill health prevented him from working, but that he very much wanted to be useful, describing him as 'anxious to render assistance'.[119] Joseph's desire to work is framed in terms of his being keen to contribute to the institution – to render assistance – rather than simply wanting to take up employment for his own sake, either to occupy his time or to benefit his mental condition. His request to work was phrased to indicate his concern that his ill-health prevented him from doing enough to contribute to the asylum, and so when his health was good, he demonstrated himself to be very concerned – 'anxious' – to make himself useful. Joseph's anxiety to contribute to the asylum suggests that he saw employment as a way to repay the treatment or lodging he received.

It has been suggested elsewhere that such language from poor recipients of aid from their social 'betters' was contrived to tell their benefactors what they wanted to hear.[120] However, as we saw in the previous chapter, when patients attempted to tell doctors what they wanted to hear, their language drew on the rhetoric of moral treatment to discuss

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[117] LA, HRL/4/12/3/25, 9 Jan 1900-8 Mar 1901, p. 114.
[118] Bartlett, *The Poor Law of Lunacy,* p. 41.
[119] LA, HRL/4/12/1/10, 9 Apr 1839-24 Jul 1840, p. 167.
[120] Gareth Stedman Jones, *Outcast London: A Study in the Relationship between Classes in Victorian Society* (Oxford, 1971), pp. 241-61.

work.[121] Work could, of course, have allowed patients to retain their sense of self and pride, which for working-class patients was closely tied to their ability to earn a wage. [122] However, this does not seem to adequately describe the *anxiety* of patients to 'render assistance'.[123] Repaying the asylum by working also enabled patients to even out the imbalance created by the 'gifting' of room, board, and medical care to them.[124] Given that the receipt of asylum treatment was not a 'gift' in the traditional sense, I suggest that efforts to even out any imbalances were not necessarily attempts to evade control, but to express genuine gratitude.[125]

6.7 Upholding the Rules of the Asylum

Regulation of patient behaviour in the asylum relied on effective observation of patients by staff members, which in Foucauldian accounts is explained with reference to the concept of the Panopticon.[126] However, there was a considerable gap between the ideal of ever-present surveillance and the everyday reality in Lancaster Asylum.[127] Observation was not always possible, and gaps in surveillance could lead to rule-breaking and accidents. However, these gaps in surveillance could be compensated for by patients themselves. Some patients reported the misbehaviour of others, intervened in incidents that staff could not get to quickly enough, or gave testimony in support of attendants who were accused of mistreatment. Such patients not only engaged with the asylum regime but constituted an integral element of Lancaster Asylum's institutional hierarchy.

Patients who assisted staff in maintaining the order of the institution derived status or power from this role.[128] One such patient, Joseph R., was admitted in 1890 as an 'imbecile' and he remained in the asylum until his death over twenty years later. Whilst in the asylum,

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[121] See Chapters Four and Five, pp. 84-8, 118-21.
[122] Rose, *Limited Livelihoods*, p. 176.
[123] LA, HRL/4/12/1/10, 9 Apr 1839-24 Jul 1840, p. 167.
[124] Marcel Maus, *The Gift: Forms and Functions of Exchange in Archaic Societies* (trans.), Ian Cunnison (London, 1954), p. 15.
[125] This approach to kindness is informed by Linda A. Pollock, 'The Practice of Kindness in Early Modern Elite Society', *Past and Present,* 211 (2011), 121-58.
[126] Foucault, *Discipline and Punish.*
[127] Gaps in surveillance are discussed more thoroughly in Chapter Seven, pp. 192-8.
[128] This analysis draws on models of heterarchy discussed in, Bakhtin, *The Dialogic Imagination*; Wolf, 'Distinguished Lecture: Facing Power', 586-96; Moore, *A Passion for Difference*; Spencer-Wood, 'Gendering Power'.

Joseph acted as messenger between staff in different areas of the institution, a service acknowledged to be genuinely useful to the running of the institution. Being trusted with these responsibilities gave Joseph a sense of pride, his case notes stated: 'contented and happy he performs a number of useful jobs about the asylum- sustained in his travels by an exalted sense of his own importance'.[129] Joseph's sense of 'self-importance' was connected to his position in the asylum as a 'trusted patient'. His pride in his contribution to the asylum is highlighted in how he decorated his uniform, 'he 'bedeck[ed] himself with medals', perhaps self-awarded trophies for his role in the institution.[130] Joseph's position not only afforded him personal pride, but also offered him greater privileges within the institution, most obviously his greater freedom of movement. Being able to move between wards would inevitably have given Joseph greater knowledge of the institution as a whole; carrying messages between staff would have entailed a greater familiarity with attendants and doctors than other patients possessed.[131]

The benefits that patients such as Joseph could derive from working actively to support staff in the running of the institution could clearly provide motivation for engaging with the asylum in this way.[132] We might then interpret Joseph's behaviour as a coping mechanism – a way of working the system.[133] However, this does not adequately explain Joseph's inclination to act as a messenger between staff. Instead, Joseph's pride in his role in the asylum should be understood in relation to the relative status he possessed within the institution compared to the outside world.[134] As an adult diagnosed with 'imbecility', Joseph would have been reliant on familial support to live in mainstream society.[135] In the asylum, by contrast, Joseph was not reliant on his relatives, but was able to undertake a role which afforded him genuine status in the asylum community.

The duties performed by patients in supporting nurses and attendants in Lancaster Asylum were integral to the maintenance of institutional authority. As patient numbers

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[129] LA, HRL/4/12/2/16, 25 Jul 1888-31 Mar 1891, p. 225.
[130] LA, HRL/4/12/2/16, 25 Jul 1888-31 Mar 1891, p. 225.
[131] Cf. Goffman, *Asylums*, pp. 256-8.
[132] Cf. Suderland, *Inside Concentration Camps*, pp. 192-205.
[133] See Chapter Four, pp. 109-11, 118-21.
[134] David Wright, '"Childlike in his Innocence": Lay Attitudes to "Idiots" and "Imbeciles" in Victorian England', in Anne Digby and David Wright (eds.), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London, 1996), pp. 118-33.
[135] Bartlett and Wright, *Outside the Walls of the Asylum*, pp. 9-10

increased, and Lancaster Asylum faced periodic recruitment problems, the ability of staff to keep patients under constant observation was eroded.[136] This issue was compounded by the physical expansion of the asylum, which created more spaces that also needed to be kept under observation.[137] The inability of asylum staff to effectively observe patients created opportunities for patients to misbehave and patients could be a significant resource in covering such gaps by monitoring their fellow asylum residents. Patients took on such responsibilities at their own initiative, and that the institution was grateful for the functions that these patients fulfilled is evident in casebooks. Reporting others for rule-breaking explicitly promoted asylum authority through providing additional surveillance. It also implicitly supported asylum authority by demonstrating patients' voluntary support of the institution. Walter Benjamin M.'s case notes describe his perceived utility in reporting the misdeeds of his fellow patients: 'Is fairly useful in X now- does a few errands and will spontaneously run to tell a nurse if any patient is doing wrong'.[138] Walter's case notes emphasize the spontaneity of his behaviour, stressing that this role was undertaken at his own initiative rather than as a work assignment set by the asylum. Such cases allowed the asylum to highlight the degree of voluntary cooperation in which several patients engaged, creating a positive image of the asylum and highlighting the progress made by some patients under its treatment.[139]

Not all patients who reported rule-breaking deliberately aligned themselves with the asylum authorities. Several individuals reported rule-breaking only when they were concerned about fellow patients. Much of this type of reporting appears to have been motivated by personal relationships between patients. Often, concern for the safety of another individual caused patients to let staff know about a particular incident or event. For example, Elizabeth H.'s case notes record an occasion on which a fellow patient reported her to nurses for taking an over-dose of 'Benzine [sic.]'.[140] Had the other patient not brought the overdose to the attention of staff, it appears that they would not have been able to intervene. Regardless of the motivations of Elizabeth's friend in informing staff of her overdose, the fact that

[136] Walton, 'Pauper Lunatics in Victorian England', pp. 190-1.
[137] See, Chapter Seven, pp. 157-63.
[138] LA, HRL/4/12/2/24, 17 Feb 1905-21 Dec 1905, p. 215.
[139] Morantz-Sanchez, 'Negotiating Power', p. 301.
[140] LA, HRL/4/12/3/12, 15 May 1889-15 Aug 1891, p. 169.

asylum staff were able to intervene to prevent a successful suicide prevented a potentially damaging blow to the institution's public image.[141]

On several occasions, patients intervened to help staff members who found themselves in precarious situations when other attendants were not in the vicinity. When John Henry W. leapt out of bed and attacked an attendant in a rather ill-conceived escape attempt another patient came to the aid of the attendant, 'Mr. Gerard [B.] (patient) helped to control him' until it was possible to move John Henry to a more secure area of the asylum.[142] Gerard's intervention prevented the attack on the attendant from continuing, and also enabled the attendant to prevent the patient from escaping. Gerard's behaviour appears to have, at the very least, been motivated by seeing that the attendant needed help. It is perhaps a stretch to suggest, based solely on casebook evidence, that there was some friendship or at least good-feeling between Gerard and the besieged attendant. However, there was at the very least a degree of empathy for a person in need of assistance.

Patients also assisted staff by giving testimonies in cases where accusations had been made about attendants' conduct. As we saw in Chapter Four, patients had several avenues of complaint available if they felt they had been mistreated by a member of staff, all of which usually resulted in a thorough investigation of the patient's accusations.[143] In order to decide whether a patient's complaint was valid, these investigations relied on witness testimony to determine whether an attendant had acted in a justifiable manner. While the testimony of other attendants was clearly preferred by asylum doctors, when this was not available patient witnesses were sought. An example of this can be seen in the case notes of Thomas S., who accused Attendant Mullane of assault. The veracity of this complaint was investigated, and patients who witnessed the events were integral to clearing Attendant Mullane's name: 'other patients who were present and capable of expressing an opinion say the accusation was false'.[144] These eye-witnesses supported the attendant's case, demonstrating that friendships and loyalties in the asylum did not necessarily operate along a simplistic staff/patient binary. By supporting Attendant Mullane's account of the incident, patients in Lancaster Asylum acted, intentionally or unintentionally, to support institutional authority in the face of the challenge made to it by Thomas S.

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[141] York, 'Suicide, Lunacy and the Asylum', p. 114.
[142] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23605.
[143] Chapter Four, pp. 74-82.
[144] LA, HRL/4/12/2/12, 14 Jun 1893-22 Nov 1895, p. 284.

Patients' decisions to intervene to support staff, rather than taking the side of their fellow patients, reflects the importance of patient engagement with the asylum as a form of individual agency. These acts were not undertaken in a deliberate effort to ensure the stability of institutional authority, but rather were the product of the micro-relationships between individual patients and individual members of staff. In incidents where patients saw members of staff at risk of being injured, assaulted, dismissed, or even subject to legal proceedings, they acted to support the individual identified as being wronged. Such decisions were not made based on the macro-relationship of staff/patient, but on a personal, individual level of Gerard B. and his attendant, or on the relationship between Attendant Mullane and the patients whose witness testimony supported his account. The good-feeling between staff and patients, in some cases, resulted in patients seeking to promote their authority. This can be seen in an incident involving a group of private patients. In 1910 these patients joined forces to complain about the behaviour of one of their fellow residents towards staff members. The case notes of Michael E., the offending party, describe how his behaviour towards staff was reported by his fellow residents: 'caused much indignation amongst the other patients by his offensive remarks to the staff at the Villa. A. W [K.] (patient) reported his conduct to us and asked us to interfere'.[145] The Villa patients apparently organized themselves as a collective to make a formal complaint through a spokesperson to assist in the maintenance of respectful relationships between patients and staff in the institution.[146] Incidents such as these highlight how patients' endeavours to support staff were based on ideas of civility, fairness, proper conduct and personal good-feeling. Regardless of patient intentions, however, this form of engagement was integral to maintaining asylum authority in an institution where patients significantly outnumbered staff.

The role of patients in reporting the misbehaviour or misdeeds of others was essential to shoring up asylum surveillance. It is interesting to note that the incidents discussed above all occurred in the period 1890-1910, coinciding with a period of increased staffing pressure and increased patient numbers. During this time, staff were not managing to observe everything that went on in the institution, if indeed they ever were. They were evidently

[145] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, p. 283.
[146] The Villas were constructed in the early twentieth century for private patients in Lancaster Asylum. They were made up of wards housed in separate blocks from the main institutional buildings, situated in the surrounding grounds. These buildings provided greater comfort and privacy to fee-paying patients at Lancaster Asylum and they also served to separate them from the main pauper population, see Chapter 1, pp. 14-15.

missing events and activities that endangered patients or other members of staff, as well as significantly undermining institutional authority. Patients' efforts to uphold the authority of the institution cannot be attributed to any deliberate strategy of shoring up medical power, yet that is precisely what was accomplished. Without the interventions of patients, the jobs of nurses and attendants would have been impossible, and acts of resistance and subversion undoubtedly more widespread. Patient efforts to uphold institutional authority are significant as a means by which they exerted influence over their lives in the institution. However, they are even more significant in highlighting the importance of patient agency in the development of medical authority in the institution.

6.8 Conclusion

Patients who engaged with asylum life were by no means the 'docile bodies' envisaged by Foucauldian scholarship.[147] Patients who adopted strategies which engaged with parts of the institution were no less exercising agency than their counterparts who embarked upon escape attempts, worked the system, or complained about their detention. Yet, so often, patient engagement is overlooked, or equated with passivity. Incidents in which patients requested a painkiller, promised to do their best to follow a doctor's recommendations, or prevented a fellow patient from attacking a member of staff, might be used as evidence that such patients had been successfully subjected to the control and authority of the asylum. Yet, as I have shown in this chapter, such actions were not the result of acquiescence to institutional ideals, but often the consequence of a number of forces which had shaped patients' views of the asylum, insanity, nurses, attendants and doctors. Current tendencies in historical scholarship to disregard actions of engagement are the consequence of dominant conceptualizations of agency, agents and historical change in which actors are posited as rational, self-aware, and autonomous.[148] Is this what historians believe to be the criteria by which agentive capacity is measured? I suggest that it is not, and that it is merely a relic of models of historical change which, as we saw in Chapter Two, are 'essentialist, masculinist, and Eurocentric'.[149] I have suggested in this chapter that asylum patients themselves, through their engagement with the institution, played an important role in the development of the asylum and medical authority.

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[147] Foucault, *Discipline and Punish.*
[148] Maynes, 'Age as a Category of Historical Analysis', pp. 114-24.
[149] Conlin Casella, *The Archaeology of Institutional Confinement*, p. 72.

This suggests that in cleaving to models of agency which ignore engagement, historians fail to understand an important way in which historical change is affected from below.

Active engagement was a significant form of patient agency, not only in relation to how it affected patients' lives in the asylum, but also in relation to the impact that patient engagement had on the development of Lancaster Asylum, and the treatment of insanity therein. Patients' decisions to engage with the asylum should be understood in the same way as resistance to it. Protest and engagement were likewise motivated by understandings that patients had of their condition, of medicine, and of what was in their best interest; understandings that were often structured by wider social and cultural milieus in which patients existed prior to institutionalisation. Those who resisted confinement frequently did not accept that they were unwell, and when they did agree that they were insane, they did not agree with the terms of their treatment in the asylum. Individuals who engaged with treatment accepted their position in the asylum because they agreed with asylum professionals that their best interests were promoted by treatment in the asylum. In cases where patients engaged with asylum treatment due to their subscriptions to medical models of insanity, they affirmed the professional expertise of asylum doctors in Lancaster Asylum. However, as we have seen, patients did not engage with the asylum solely due to their beliefs in the ability of doctors to cure insanity; many patients sought out the asylum for other reasons including personal hardship, consideration of the broader institutional landscape, or even to access physiological medicine. Such practices influenced how doctors at Lancaster Asylum understood the function of their institution and saw them allow patients to stay beyond their recuperation from mental disease because of their economic circumstances, continued physical illness, or even their emotional reaction to the prospect of discharge. In this way, patients' engagement with the institution fundamentally shaped the asylum.

Within the institution itself, patient expressions of gratitude and their support of the institutional regime further influenced institutional practices, supporting professional self-confidence amongst doctors and attendants. This bolstering of professional self-confidence was both ideological and practical. It was ideological in the sense that expressions and displays of gratitude attributed patients' cure or positive experiences of asylum life to the efforts of asylum staff. However, it was also practical in the sense that patients' self-appointed roles in assisting nurses and attendants in their management of the asylum population enabled them to run their wards more effectively, better observe patient behaviour, and defend themselves from false-accusations of mistreatment. I have suggested

that because of the effects that patients' engagements had upon institutional structures, these actions were vastly different from passivity. Indeed, the behaviours discussed throughout this chapter highlight the agentive capacity of patients within the institution. By examining the various ways in which patients engaged with Lancaster Asylum, I have demonstrated the importance of considering how patient behaviour shaped institutional structures. In addition to historical changes wrought in the treatment of insanity by the psychiatric profession, lay reformers, relatives of the insane, and local and national government, this chapter has demonstrated that the insane themselves played a significant part in shaping the institutions in which they were confined. Moreover, I have argued that patient engagement was as significant as patient resistance in its impact on these institutions. This highlights the importance of developing an understanding of agency that moves beyond its equation with resistance. By examining the effects of patient engagement on institutional structures in Lancaster Asylum, it becomes clear that a more nuanced understanding of agency as a spectrum of action which runs from the most determined resistance to the most active participation, can enhance our understanding of historical change.

7. Asylum Architecture and Patient Agency

7.1 Introduction

The significance of the built world of the asylum reflected widely-held Victorian beliefs in environmental determinism: the idea that one's surroundings could influence one's behaviour.[1] This faith in the reforming powers of buildings was amplified in the asylum, where space was organised to permit the classification of patients, to facilitate treatment without restraint, to ensure that suicidal or dangerous patients could be appropriately observed, and to facilitate the employment and leisure activities central to moral treatment. Journal articles, lectures and books were published by asylum professionals throughout the period suggesting the most effective designs to facilitate these aims.[2]

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[1] Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis, MN, 2007), pp. 8-9; Heather Tomlinson, 'Design and Reform: The "Separate System" in the nineteenth-century English Prison', in Anthony D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 1984), pp. 51-6; Felix Driver, *Power and Pauperism: The Workhouse System, 1834-1884* (Cambridge, 1993); Norman Johnston, *Forms of Constraint: A History of Prison Architecture* (Chicago IL, 2000).

[2] W. A. F. Browne, *What Asylums Were, Are and Ought to Be* (Edinburgh, 1837); Maximilian Jacobi, *On the Construction and Management of Hospitals for the Insane* (London, 1841); Connolly, *The Construction and Government of Lunatic Asylums;* W. H. O. Sankey, 'Do the Public Asylums of England, as presently constructed, afford the greatest facilities for the care and treatment of the Insane?', *The Asylum Journal of Mental Science,* 2(18) (1856), 466-79; John T. Arlidge, 'On the Construction of Public Lunatic Asylums', *The Asylum Journal of Mental Science,* 4(24) (1858), 188-204*;* John T. Arlidge, *On the State of Lunacy and the Legal Provision for the Insane, with Observations on the Construction and Organisation of Asylums* (London, 1859); Anonymous, 'Description of a Proposed New Lunatic Asylum for 650 Patients on the Separate-Block System, for the County of Surrey', *Journal of Mental Science,* 7(40) (1862), 600-8; E. Toller, 'Suggestions for a Cottage Asylum (With Plans)', *Journal of Mental Science,* 10(51) (1864), 342-9; C. Lockhart Robertson, 'Pavilion Asylums. (With a Ground-plan)', *Journal of Mental Science,* 12(60) (1867), 467-75; T. S. Clouston, 'An Asylum, or Hospital-Home, for Two Hundred Patients: constructed on the principle of adaptation of various parts of the needs and mental states of inhabitants; with Plans, &c.', *Journal of Mental Science,* 25(111) (1879), 368-88; Richard Greene, 'A Public Asylum, Designed for 414 Beds, capable of Extension to 600', *Journal of Mental Science,* 26(114), 233-44; Henry Burdett, *Hospitals and Asylums of the World: Their Origin, History, Construction, Administration, Management, and Legislation* (London, 1895); George T. Hine, 'Asylums and Asylum Planning', *Journal of the Royal Institute of British Architects,* 9(8) (1901), 161-80.

Yet, the fact that the mechanisms of agency discussed in the previous chapters could occur, suggests that the built world of Lancaster Asylum did not always function as intended. That patients were able to engage in such behaviours suggests that they evaded the observation of nurses and attendants, gained access to wards and work spaces that they preferred, and attached their own meanings to institutional space. This challenges traditional Foucauldian accounts of the asylum, which framed these buildings as edifices of social control.[3] Although buildings were designed to keep patients under the watchful eyes of attendants and nurses, this was by no means the only function with which they were endowed. Moreover, such social-control analyses rest on an examination of asylum space from the perspective of medical men and architects, who described how 'ideal asylums' would function. They neglect to consider how institutional space was changed in practice, not only by asylum authorities, but also by patients.[4] By exploring the spatial contexts of patient agency, this chapter will suggest that Lancaster Asylum patients did not passively consume the spaces of their confinement, but actively created them.[5]

This approach is influenced by William Whyte's challenge to interpret buildings through a process of 'translation', rather than 'reading'. Whyte argues that buildings cannot be compared to texts, they do not contain inherent meanings that can simply be read. The meanings of buildings are created by architects, the opinion of contemporaries, the lived experiences of inhabitants; each group transposes new meanings on to it. The job of the person interpreting the building is to trace these layers of meaning and understand these transpositions.[6] In this chapter I will trace the layer of meaning imparted to the built world of Lancaster Asylum by patients. Whilst textual sources including casebooks, annual reports, building surveys and professional journals will remain important, the buildings of the asylum are also central. I will draw on plans, descriptions, and photographs to trace changes in the

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[3] David Garland, *Punishment and Welfare: A History of Penal Strategies* (Aldershot, 1985); Michael Katz, Michael Doucet and Mark Stern, *The Social Organisation of Early Industrial Capitalism* (Cambridge MA, 1982); Rothman, *The Discovery of the Asylum*; Scull, *Museums of Madness*.
[4] De Certeau, *The Practice of Everyday Life*, pp. 115-30.
[5] Paul L. Knox, 'The Social Production of the Built Environment: Architects, Architecture, and the Post-modern City', *Progress in Human Geography*, 11 (1987), 354-77; Henri Lefebvre, *The Production of Space* (trans.), David Nicholson-Smith (Oxford, 1991); Yi-Fu Tuan, *Space and Place: The Perspective of Experience*, (Minneapolis, MN, 1977).
[6] William Whyte, 'How Do Buildings Mean? Some Issues of Interpretation in the History of Architecture', *History and Theory*, 45(2) (2006), 153-77.

physical structures of Lancaster Asylum and examine how the built world affected patient agency, and how patient agency affected the built world.

7.2 Space in Lancaster Asylum

The development of the buildings of Lancaster Asylum demonstrate that although the built environment was a central part of the therapeutic regime of the institution, practical challenges in implementing 'ideal' plans for the asylum created deficiencies in institutional space. The importance of the built world to the therapeutic mission of Lancaster Asylum is affirmed by the undertaking of major building alterations to accommodate the new regimen of moral treatment adopted at Lancaster Asylum with the appointment of Samuel Gaskell in 1840.[7] In order to facilitate the treatment of patients without restraint, a system of classification was adopted to group patients with the same diagnoses together.[8] This was believed to make the management of patients easier for attendants and nurses, who were invested with greater responsibilities than they had been previously.[9] Straitjackets, manacles, and chains were replaced with the watchful 'vigilance' of asylum staff, which in turn was aided through buildings constructed to support patient observation.[10] The gallery, or ward, system facilitated classification, providing self-contained worlds wherein patients with similar diagnoses and at similar stages of recovery lived. Wards contained dayrooms, sleeping rooms, galleries, baths, water closets, lavatories, and separate dining and sleeping spaces for attendants. Patients rarely had to leave the ward. However, the variety of spaces contained therein were to provide an environment that was more domestic than institutional, allowing for variation in patients' daily routines. Patients were promoted or demoted to better or worse wards in accordance with their behaviour. Patients literally progressed towards a cure, moving through asylum space in a highly ritualized manner.[11]

The layout of asylum spaces adopted in the 1840s and 50s contained many different rooms in one ward, a high proportion of single rooms, and small dormitories. This

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[7] Cf. Susan Piddock, *A Space of Their Own: The Archaeology of Nineteenth-Century Lunatic Asylums in Britain, South Australia and Tasmania* (New York, 2007), pp. 40-3.
[8] Scull, MacKenzie and Hervey, *Masters of Bedlam*, p. 169.
[9] LA, QAM 5/38, *Report* (Lancaster, 1841), pp. 15-21.
[10] 'Vigilance', 'observation', and 'surveillance' were the terms used by Lancaster Asylums' successive Superintendents to describe the attendants' role in monitoring patients in the absence of restraint, e.g., LA, QAM 5/39, *Report* (1842), p. 11.
[11] Cf. De Cunzo, 'Reform, Respite, Ritual', 1-168.

arrangement meant that a high staff to patient ratio was necessary for adequate supervision – attendants had to go from room to room within their ward to check on patients who were dispersed throughout the diverse spaces. As the patient population increased from the 1870s, this created significant challenges.[12] The pressure of patient numbers on the wards in Lancaster Asylum was commented on by the Commissioners in Lunacy during their annual visits. In 1872 the Commissioners observed that three male wards had a particularly low staff to patient ratio; Ward Four, Three and Eleven each had one attendant in charge of 20, 36 and 34 patients respectively.[13] The increase of patient numbers made effective observation of patients impossible by the number of attendants then employed by the asylum. By 1877, the Commissioners suggested that alterations or additions to the asylum's wards were urgently needed: 'The necessity for some early decision on this subject is shown by the fact that in the present year two men, who were epileptics, were suffocated during the night, no attendant being present.'[14]

To cope with the increasing numbers of patients, Lancaster Asylum added an additional building called the Annexe in 1883.[15] This building was specifically designed to house chronic, long-term patients.[16] The Annexe was a double pavilion, consisting of a long corridor punctuated by the central administration block and clock tower.[17] Either side of the central block, wards were placed perpendicular to the corridor, with large dormitories on one side and large day rooms on the other, and patients' time was mainly divided between these two spaces (Fig. 4). Patients left the building for employment, and for recreational activities such as playing cricket, taking exercise, attending a concert or ball in the recreation hall, or going to a Church service.[18] This arrangement was influenced by the Scottish 'open door' system, in which patients were encouraged to take exercise and work outside their wards to provide variety in their daily routines.[19] Within the wards however, patients' movement was

[12] Digby, 'The changing profile of a nineteenth-century asylum', 739-48.
[13] LA, QAM 5/21, *Reports* (1872), p. 13.
[14] LA, QAM 5/26, *Reports* (1877), p. 10.
[15] LA, HRL/1/1/1, 'Management Committee Signed Minutes, 1882-1889', p. 96.
[16] LA, CC/HBR/14, *Reports* (1904), p. 180.
[17] *Lancaster Gazette*, 23 December 1882.
[18] Dolly Mackinnon notes the importance of recreational activities in regimes of moral management, see Dolly Mackinnon, 'Divine Service, Music, Sport, and Recreation as Medicinal in Australian Asylums 1860s–1945', *Health and History*, 11(1) (2009), 128-48.
[19] LA, QAM/5/31, *Report*, 1882 pp. 20-1; 'Twenty-third Annual Report of the General Board of Commissioners in Lunacy for Scotland, for the year 1880', *Journal of Mental Science*, 27(120) (1882), 570-83.

limited, gathering them together in one space rather than allowing them to be dispersed throughout multiple rooms. This made supervision possible, even with a low staff to patient ratio, reflecting attempts to cope with ever-larger patient populations.

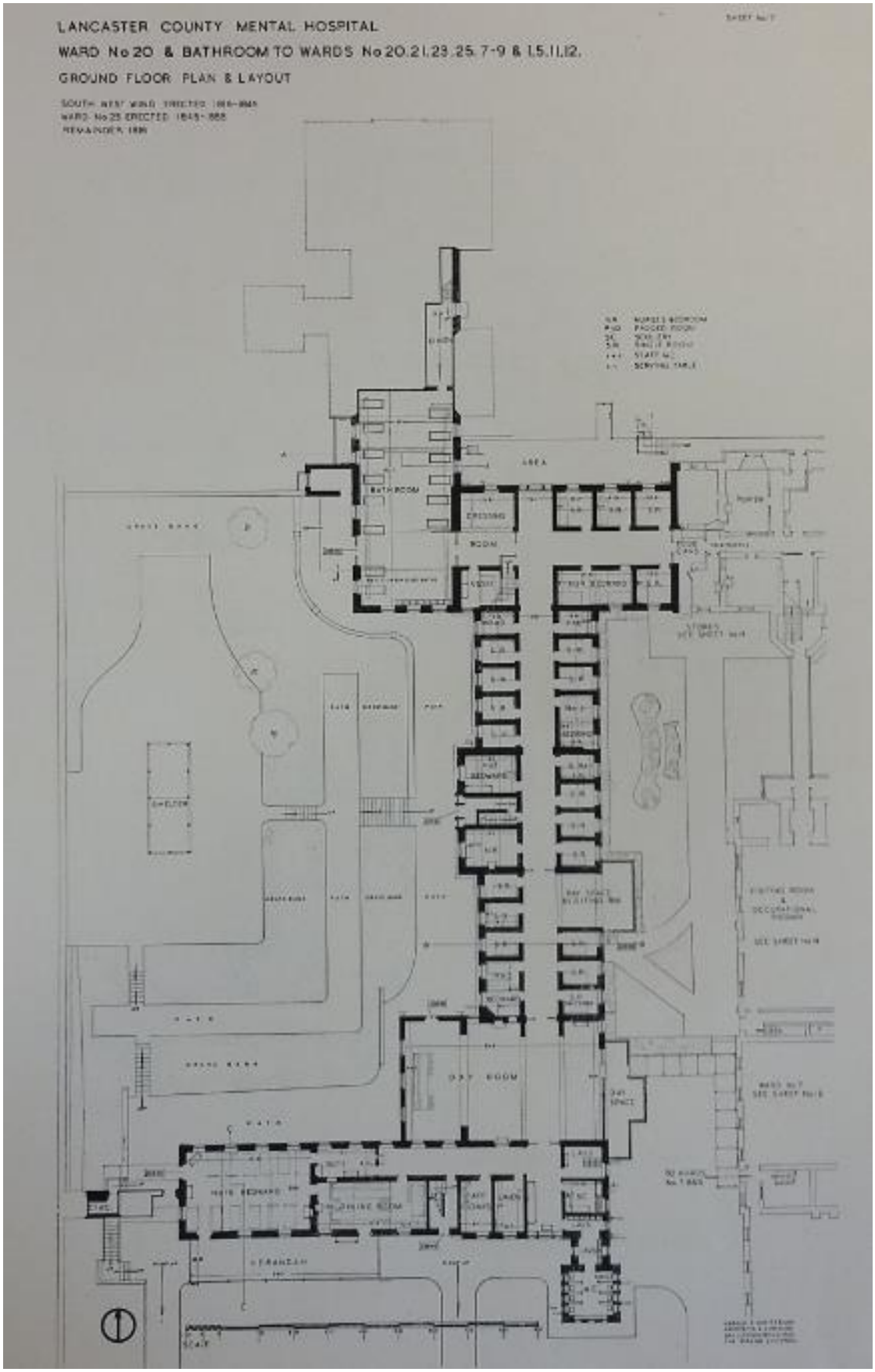

Figure 3. Ward 20 was designed to facilitate moral treatment (1816-55).

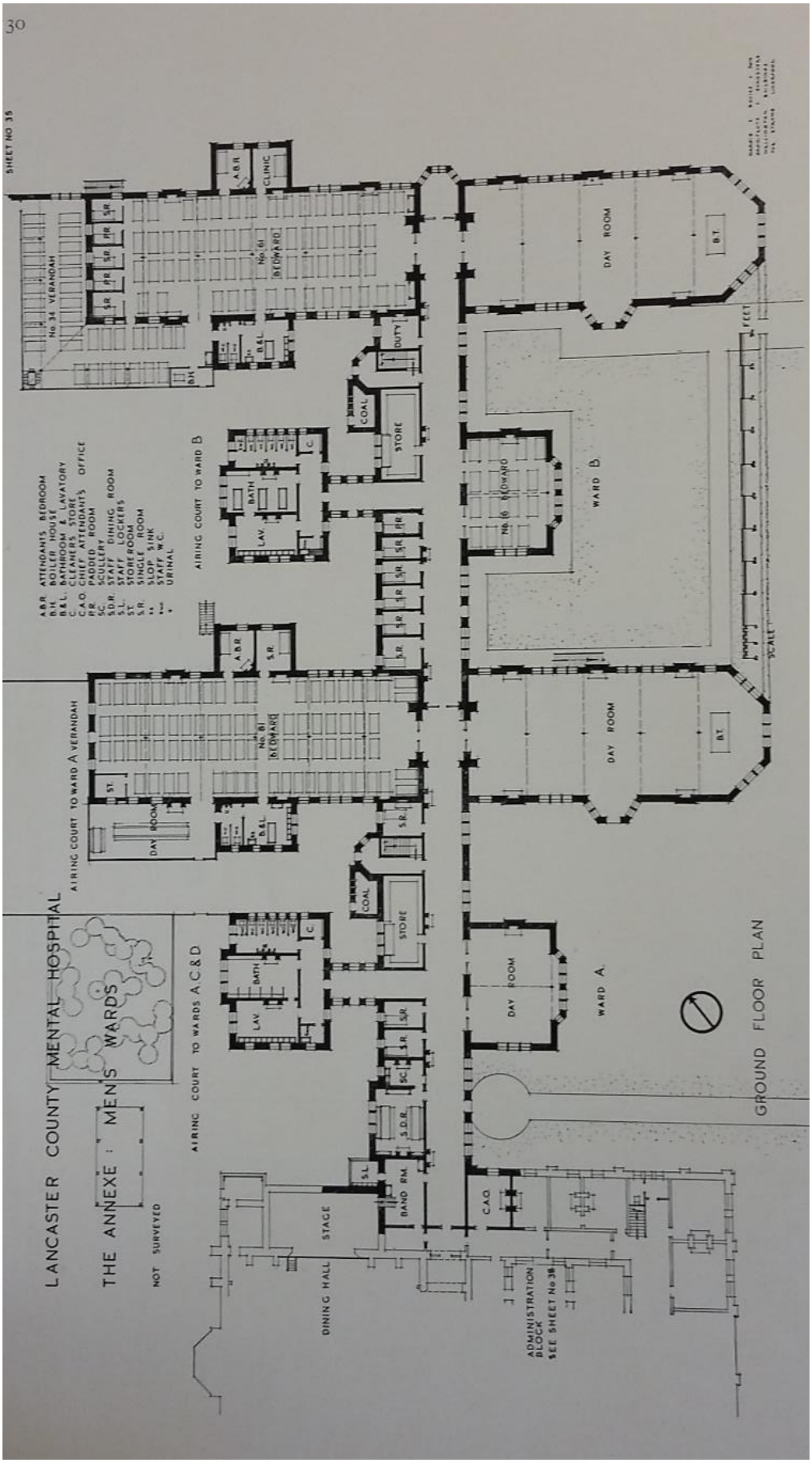

Figure 4. Male Wards A, C and D were designed to facilitate moral management (1883).

Despite the new Annexe, the earlier wards on the 'old side' of the institution remained overcrowded and difficult to control. During their 1883 inspection, the Lunacy Commissioners commented on the unsuitability of the older wards, which were used to accommodate the more 'turbulent patients'.[20] Efforts were made to 'open them up more … to facilitate supervision', however, the problem of overcrowding remained significant. Managing 'turbulent' patients became even more problematic by the 1890s, when demand for spaces for acute patients increased. This influx of 'noisy and troublesome cases' was attributed to 'the selecting of quiet, chronic cases periodically for removal for Workhouse treatment, and partly to the Unions sending mainly their worst cases when they could not find room for all'.[21] Moreover, the big, open rooms of the Annexe, which were designed for chronic patients, were unsuitable for acute, suicidal, violent, or epileptic patients, for whom more rigorous observation was considered necessary. These problems were addressed through modifications to asylum buildings and attempts to reorganise the spaces therein. Partitions were used to create smaller cubicles within the dormitories of the Annexe in lieu of single rooms. This solution, however, was 'merely palliative'.[22]

The solution to the deficiency of single rooms, was a U-turn in institutional approaches to classification. At the time the Annexe was constructed, excessive classification had been considered a barrier to gathering large groups of patients in one space, which had been considered the best solution to growing chronic populations.[23] However, as more acute and disruptive patients were admitted, Superintendent David Cassidy reconsidered this:

> Experience has led me gradually to a belief in the virtues of a stricter classification of cases than used to prevail, and I no longer allow recent cases to mix with epileptics and chronics, or epileptics with the general body of patients. So, also, I have come to think, the noisy and violent, the various classes of workers, the quiet and harmless, but useless, and those convalescent and approaching the period of their discharge, should all be separated out and treated differently.[24]

This revelation as to the benefits of a more rigorous system of classification came at an opportune time and was implemented by repurposing the Annexe. Instead of being used to

[20] LA, QAM/5/32, *Reports* (1883), p. 10.
[21] LA, CC/HBR/3, *Reports* (1893), p. 15.
[22] LA, CC/HBR/3, *Reports* (1893), p. 15.
[23] Robertson, 'Pavilion Asylums', 467-75.
[24] LA, CC/HBR/6, *Reports* (1896), p. 136.

house chronic cases, the Annexe was used to house male patients, who outnumbered females in Lancaster. [25] Within their respective sides of the institution, men and women were classified according to the type or severity of their mental disorder, marking a return to the system of classification favoured by Gaskell's generation of asylum managers.[26] In 1908, a detached unit was planned to treat male patients whose insanity was acute and who could not be managed in the wards of the Annexe.[27] However, after it was completed the 'closed house' was named 'The Retreat' and used as accommodation for private patients.[28] Alongside problems in staffing that plagued the entire institution, the older buildings were in constant need of repair and alterations 'to maintain [them] near the level of modern requirements'.[29] Despite being constructed to promote the observation of patients in an environment conducive to their cure, the built world of Lancaster Asylum continually presented challenges to effective medical observation. These deficiencies provided opportunities for patients, who could exploit the inadequacies of the built environment to exercise agency in the institution.

7.3 A Neglected Perspective: Patients' Use of Asylum Space

Social control-oriented studies of institutions paid little attention to their built environments. Following Foucault, many revisionist historians also treated institutional buildings as peripheral to their inquiries. When they were discussed at all, institutional spaces were framed as outcomes of disciplinary regimes, not as formative objects.[30] Susan Piddock suggests such tendencies resulted from revisionists' suspicions of the motives professed by lunacy reformers in their writings on asylum buildings.[31] Their scepticism of the testimony of social reformers led them to discount the emphasis contemporaries placed on the curative functions of asylum structures, and instead explained their significance largely in reference to their inadequacies and their panoptic functions.[32]

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[25] LA, CC/HBR/7, *Reports* (1897), pp. 8-9.
[26] Browne, *What Asylums Were, Are, and Ought to Be,* pp. 183-6; Jacobi, *On the Construction and Management of Hospitals for the Insane,* pp. 55-7.
[27] LA, CC/HBR/18, *Reports* (1908), p. 7.
[28] LA, CC/HBR/ 23, *Reports* (1913), p. 8.
[29] LA, CC/HBR/12, *Reports* (1902), p. 97.
[30] Scull, *Museums of Madness,* pp. 104-6.
[31] Piddock, *A Space of Their Own,* pp. 22-3.
[32] Scull, *Museums of Madness,* pp. 104-6.

This position was challenged by historical geographers and architectural historians, who highlighted the importance of buildings to various nineteenth-century projects of reform.[33] In this view, asylum buildings were re-positioned; they were not merely tools of the medical profession, facilitating the extension of the medical gaze over patients, but themselves created changes in the treatment of insanity.[34] By analysing the built environment itself rather than solely focussing on written sources, the role of architecture in shaping the treatment of insanity became apparent. As Barry Edginton explained, '"sane" sensations, ideas, and behaviours were encoded in a design that would transform its patients'.[35] The asylum itself had curative powers.[36] Institutional buildings were also shown to have shaped the development of approaches to treating insanity. Christine Stevenson highlighted that the centrality of domesticity in nineteenth-century moral treatment could be traced to the use of mad-doctors' homes as places of treatment in the eighteenth-century trade-in-lunacy.[37] While such studies added a great deal to our understanding of the importance of the built world to the treatment of insanity, they remained focused on the role intended for buildings by architects, neglecting how spaces were transformed by the activities of their inhabitants.[38]

Eleanor Conlin Casella has demonstrated that inmates of nineteenth-century female convict prisons in Tasmania resisted the controlling facets of the built world. When they were confined to solitary cells, female prisoners hoarded caches of 'currency' which enabled them to retain a connection to the outside world. Women further resisted spatial segregation by destroying their cells through arson.[39] In his study of Rhode Island State Prison, James Garman highlights the impact of the planned and unplanned actions of those confined therein on its buildings. Garman argues that: 'escapes, illicit meetings between prisoners of different sexes, the stashing of contraband beneath cell floors, and even the forbidden decoration of

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[33] Chris Philo, '"Enough to Drive One Mad": The Organization of Space in 19th-Century Lunatic Asylums', in J. Wolch and M. Deer (eds.), *The Power of Geography: How Territory Shapes Social Life* (London and New York, 1989), pp. 258-90; Thomas Markus, *Buildings and Power: Freedom and Control in the Origin of Modern Building Types* (London, 1993); Jeremy Taylor, *Hospital and Asylum Architecture in England 1840-1914: Building for Health Care* (London, 1991).
[34] Markus, *Buildings and Power* p. 130.
[35] Barry Edginton, 'The York Retreat', *Victorian Review*, 39(1) (2013), p. 9.
[36] Tony Bennett and Patrick Joyce (eds.), *Material Powers: Cultural Studies, History, and the Material Turn* (Abingdon and New York, 2010).
[37] Stevenson, *Medicine and Magnificence*, pp. 31-7.
[38] Whyte, 'How Do Buildings Mean?', 153-77.
[39] Eleanor Conlin Casella, 'To Watch or Restrain: Female Convict Prisons in 19th-Century Tasmania', *International Journal of Historical Archaeology*, 5(1) (2001), 45-72.

cell walls' all altered the meaning of prison space.[40] De Cunzo's study of Magdalen Asylums also demonstrates how inmates created new meanings for space. The spaces of these institutions were intended to impart feminine virtues to the 'fallen' women who entered therein. However, De Cunzo shows that the Magdalens did not think of themselves as fallen, and rather than internalizing the feminine values which the institution sought to impart to them through their ritualized progression through space, many women simply used the institution as a refuge from poverty.[41]

The use of buildings by patients (and by attendants and nurses) in Lancaster Asylum also altered the meanings of institutional space. Effective observation of patients relied on the diligence of nurses and attendants, and human error was not uncommon.[42] It is clear that Lancaster Asylum faced such issues given that 'tell-tale' clocks were introduced from the 1880s in order to 'test the wakefulness of the attendants' at night.[43] The efficacy of staff was also limited by the continued use of old buildings alongside newer additions, and the deficiencies of the early buildings created significant managerial challenges.[44] Under the pressure of patient numbers, the smaller rooms which had once promoted a home-like atmosphere became difficult to manage.[45] Staff mistakes, incompetence or complacency, alongside deficiencies in the built world, presented opportunities for patients to engage in activities which would otherwise have been prevented.

The built world of Lancaster Asylum, thus, did not function as its designers had envisaged and institutional space changed profoundly as a result of its use by successive generations of inhabitants. Henry Lefebvre summarizes the ways in which institutional buildings like Lancaster Asylum took on lives of their own: 'The social and political (state) forces which engendered' the space fought to retain control of it but ultimately failed to 'master it completely'.[46] In other words, the building took on a life of its own, ultimately evading the will of its creators. The inability of asylum authorities to ensure that the built

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[40] James C. Garman, *Detention Castles of Stone and Steel: Landscape, Labour and the Urban Penitentiary* (Knoxville TN, 2005), pp. 109-12.
[41] De Cunzo, 'Reform, Respite, Ritual', 1-168.
[42] Kai Sammet, 'Controlling space, transforming visibility: Psychiatrists, nursing staff, violence, and the case of haematoma auris in German psychiatry c.1830-1870', in Topp, Moran, and Andrews (eds.), *Madness, Architecture and the Built Environment,* pp. 287-304.
[43] LA, QAM 5/27, *Reports* (1878), p. 58.
[44] Sankey, 'Public Asylums of England', 466-79.
[45] LA, HRL/1/14/4, 'History, Description and Problems', p. 104.
[46] Lefebvre, *Production of Space*, p. 26.

world was organised to support the modes of treatment being administered in Lancaster Asylum, created opportunities for patients to colonise institutional space. In their uses and misuses of space, patients could thus create another layer of institutional geography.

7.4 Locating Patient Agency

Discussions of patients' ability to shape the spaces of mental health care have largely been confined to twentieth-century institutions, where interviews and observation facilitate understandings of patient-created institutional geographies. Hester Parr suggests that patients were not simply controlled by medical spaces but were 'creative actors ... capable of resistance, self- and collective-empowerment and determination in the diverse spacings of madness.'[47] Oral histories of mental health care highlight the significance of space in patients' experience of institutions. Kerry Davies analysed the relationship between patients and space in a twentieth-century in-patient facility. Davies' analysis reveals a geography of the institution which organised it into 'good' and 'bad' places depending on patients' spatial preferences.[48] Goffman's sociological approach in *Asylums* also highlights the importance of space to patients' experiences of the psychiatric hospital, and the significant role of patients in shaping the meanings of hospital space. Through his observations of patients, Goffman demonstrated how patients were able to appropriate hospital spaces to facilitate agency. Patients used 'free space' to engage in illicit activities, escape the surveillance of staff, and the chaos of ward-life.[49]

Less attention has been paid to a history of nineteenth-century asylum space from the perspective of patients, a neglect stemming from the dearth of sources available for this purpose. Looking at nineteenth-century American asylums, Carla Yanni has suggested that patients' memoirs and diaries could be used to investigate how asylum buildings were experienced by users.[50] However, such accounts are rare, and privilege the perspectives of literate, middle-class lunatics, which limits their utility for public institutions like Lancaster.

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[47] Hester Parr, *Mental Health and Social Space: Towards Inclusionary Geographies* (Oxford, 2008), p. 12.
[48] Kerry Davies, '"A small corner that's for myself." Space, place, and patients' experiences of mental health care, 1948-98', in Topp, Moran and Andrews (eds.), *Madness, Architecture and the Built Environment,* pp. 305-20.
[49] Goffman, *Asylums*, p. 205.
[50] Yanni, *The Architecture of Madness,* p. 14.

Letters written by patients to family and friends have been used by Jane Hamlett to explore patients' points of view on asylum interiors.[51] However, these letters discussed the furnishing of the establishment or requests for material goods as opposed to patients' uses of space. Additionally, for county asylums, including Lancaster, letters written by patients have a very low and sporadic survival rate, making them a rather unrepresentative source of information.[52]

Yet, if work on twentieth-century psychiatric spaces demonstrates the centrality of the built world to patients' experiences and their ability to exercise agency, are we to assume that the built environment only took on this role from the mid-twentieth? In previous chapters, we have discussed patient escapes, requests to be placed on certain wards, or to work in specific trades.[53] These mechanisms of agency had distinct spatial dimensions, suggesting that a relationship between asylum space and patient agency did exist. We have seen in previous chapters that an important method by which patients negotiated their confinement was to request access to particular spaces; wards, workspaces, dormitories etc.[54] The remainder of this chapter will analyse these spaces, to explore what made them attractive to patients using case notes, descriptions, plans and photographs.[55] Rather than attempting a broad survey of the whole asylum, we will concentrate on three main areas: work spaces, sleeping spaces, and 'free spaces'. The areas considered throughout this chapter highlight patients' ability to transform the meaning of asylum space, and to manipulate the structures of the institution to facilitate agentive behaviours.

7.5 Spaces of Work

The built environment of Lancaster Asylum provided dedicated spaces for patients to engage in productive employment. In an ideal asylum, patient labour was gendered.[56] Options for female patients were fairly limited; women were encouraged to do sewing and household

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[51] Hamlett, *At Home,* p. 15.
[52] Smith, "'Your Very Thankful Inmate"', p. 238.
[53] See, Chapters Four-Six, pp. 89-92, 110-12, 119-22.
[54] See Chapter Five, pp. 109-11, 118-21.
[55] Such an approach is advocated for in, Lu Ann De Cunzo 'On Reforming the "Fallen" and Beyond: Transforming Continuity at the Magdalen Society of Philadelphia, 1845-1916', *International Journal of Historical Archaeology,* 5(1) (2001), p. 23; Piddock, *A Space of Their Own,* pp. 14-5.
[56] Hide, *Gender and Class,* pp. 102-17.

cleaning jobs, which often occurred within day rooms on their wards and thus did not require purpose-built structures.[57] Other than cleaning and sewing, the main occupation available to women was laundry work, which took place in a purpose-built laundry block.[58] Male patients had a wider range of occupations, including working in the farms and gardens, or in one of the workshops, which provided space for occupations including carpentry, tailoring, joinery etc.[59]

Our discussion of patients' use of spaces of labour will concentrate on the laundry and the workshops. These spaces were most frequently mentioned in patients' requests for work and therefore provide useful spaces through which to explore patients' spatial preferences. Within the sample of casebooks used in this thesis, laundry work was requested on 24 occasions, including two requests from male patients.[60] In the context of the overall number of requests made for specific occupations, this is noteworthy constituting 12.2 per cent of the total number of occupational requests made by patients. It is even more significant in relation to female patients, making up 26.8 per cent of occupational requests made by women. Similarly, male patients' requests to be employed in workshops made up 7.7 percent of the total number of patients' occupational requests, and 13.2 per cent of male patients' occupational requests.

7.5.1 The Laundry

Requests to work in the laundry are remarkable considering the nature of laundry work.[61] Laundry work was utilised in both the asylum and the workhouse, despite employment in the latter being connected with punishment.[62] Magdalen laundries utilised this trade as a means of 'washing away the sin' of women who had 'fallen' or were at risk of 'falling'.[63] Not only

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[57] Susan Piddock, 'Convicts and the Free: Nineteenth-Century Lunatic Asylums in South Australia and Tasmania (1830-1883)', *Australian Historical Archaeology,* 19 (2001), 84-96.
[58] Davies and Davies, *Lancaster County Mental Hospital Survey* (1939), p. 118.
[59] Davies and Davies, *Lancaster County Mental Hospital*, p. 119.
[60] For discussion of the sample size see, Chapter Three, pp. 56-64.
[61] Simon Fowler, *Workhouse: The People, The Places, The Life Behind Doors* (Kew, 2007), p. 61.
[62] M. A. Crowther, *The Workhouse System 1834-1929: The History of an English Social Institution* (London, 1981), pp. 196-201.
[63] Barbara Littlewood, 'Prostitutes, Magdalenes and Wayward Girls: Dangerous Sexualities of Working-Class Women in Victorian Scotland', *Gender & History,* 3(2) (1991), 160-75; Joanne Monk, 'Cleansing Their Souls: Laundries in Institutions for Fallen Women', *Lilith,* 9

did laundry-work have punitive connotations, but it was also physically strenuous. Patricia Malcolmson has emphasized the physically demanding nature of this work. Laundry work entailed strenuous manual labour, and unpleasant working environments created by the chemicals and damp of the laundry room.[64]

Some patients explained the reasons for their preference when they requested laundry work, and doctors recorded them in their case notes. It is unclear how far we should accept at face value the rationales that patients offered to medical staff. Given that patients' requests had a far greater chance of success if they were framed in ways which appealed to medical ideas, were they just telling doctors what they wanted to hear to get what they wanted?[65] Bridget C., whose request for laundry work was discussed in Chapter Five, cited the 'active' nature' of laundry work when requesting to be employed in the laundry, explaining to doctors that it occupied her 'attention and thoughts'.[66] Indeed, employment in the asylum was an important coping mechanism for patients, allowing them to occupy their time, relieve the monotony of institutional life, and to retain a connection to their pre-institutional self.[67] Similarly, we have already seen in Chapter Six that lay and medical ideas about insanity and its treatment overlapped significantly, suggesting that taking statements such as Bridget's at face value may not be as problematic as it first appears.[68]

However, by supplementing such requests with analysis of plans of the laundry, descriptions about its spatial arrangements, and photographs, it becomes clear that the space of laundry-work could *also* make it an attractive environment for patients. Although patients may have agreed with doctors as to the benefits of active work and been keen to avoid the boredom of institutional life, these aims could have been met through other types of employment. I suggest that preferences for the laundry, specifically, were closely connected with the spatial arrangement of this activity. In Goffman's view, employment could provide access to 'free spaces' in the institution – areas in which patients could gain reprieve from

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(1996), 21-32; James M. Smith, *Ireland's Magdalen Laundries and the Nation's Architecture of Containment* (Notre Dame, IN, 2007); Clara Fischer, 'Gender, Nation, and the Politics of Shame: Magdalen Laundries and the Institutionalization of Feminine Transgression in Modern Ireland', *Signs*, 41(4) (2016), 821-43.

[64] Patricia Malcolmson, *English Laundresses: A Social History, 1850-1930* (Urbana IL, 1986).

[65] Cf. Stedman Jones, *Outcast London*, pp. 241-61.

[66] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 226.

[67] Hide, *Gender and Class*, p. 102.

[68] See Chapter Six, pp. 137-40.

observation and engage in prohibited activities.[69] Although the laundry was by no means a totally free space, it offered some of the benefits of such areas including less stringent observation, greater independence, opportunities for socialisation, and gave patients a means of distancing themselves from their institutional identities.

[69] Goffman, *Asylums*, pp. 189-97.

Figure 5. Lancaster Asylum Laundry, c. 1890s

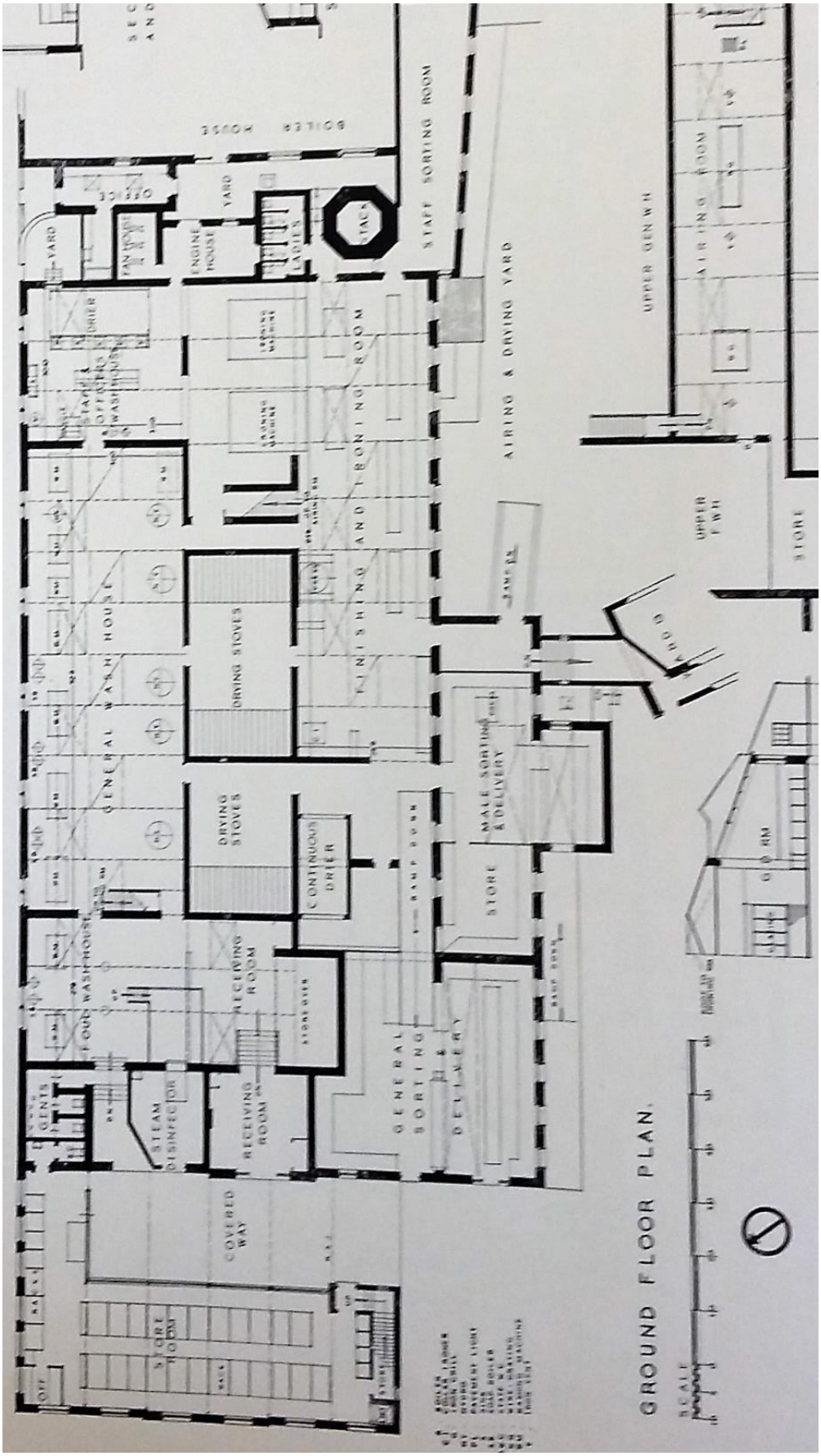

Figure 6. Lancaster Asylum Plan of Laundry, 1879

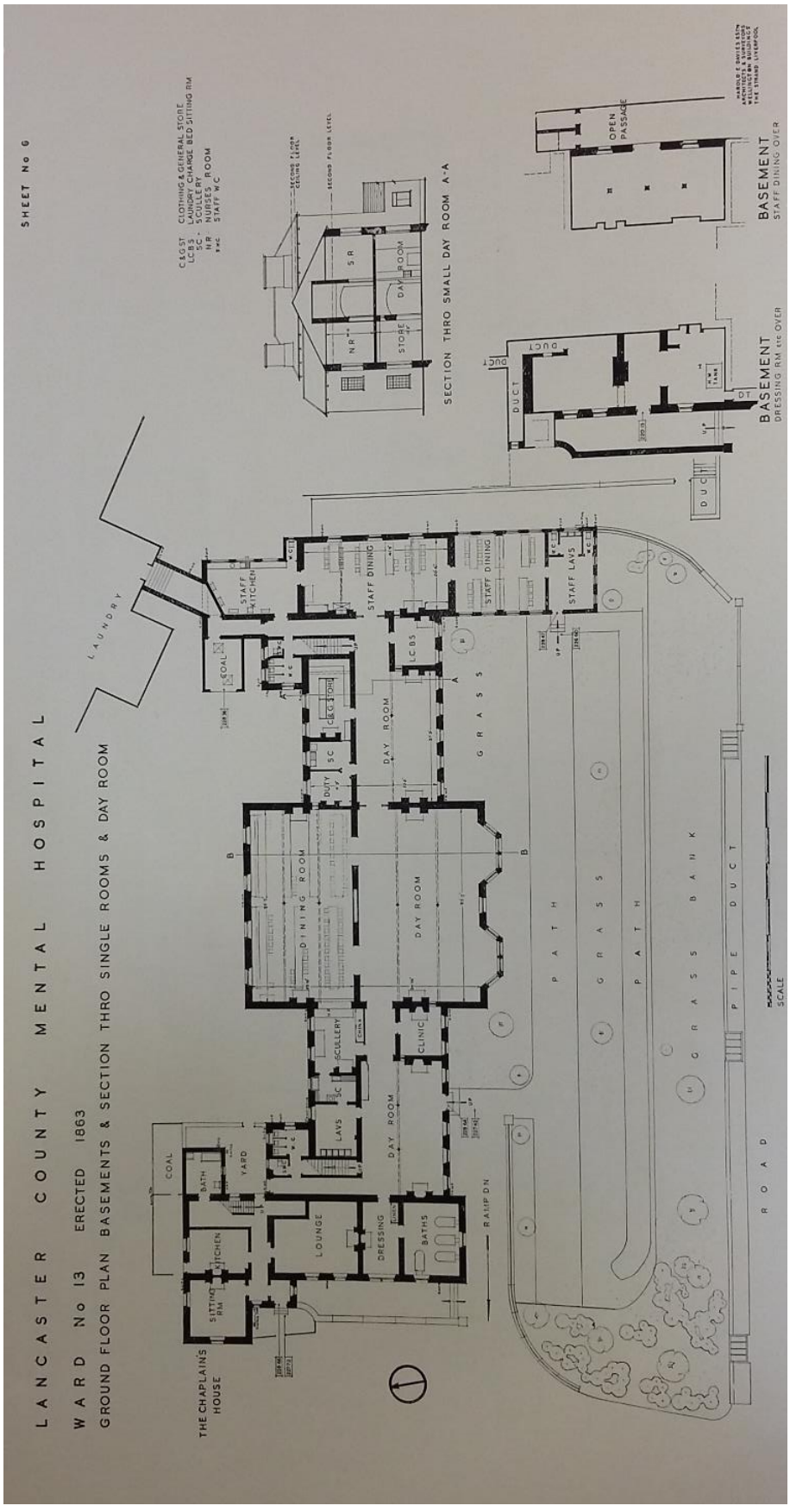

Figure 7. Lancaster Asylum Ward 13 Ground Floor Showing Access to Laundry.

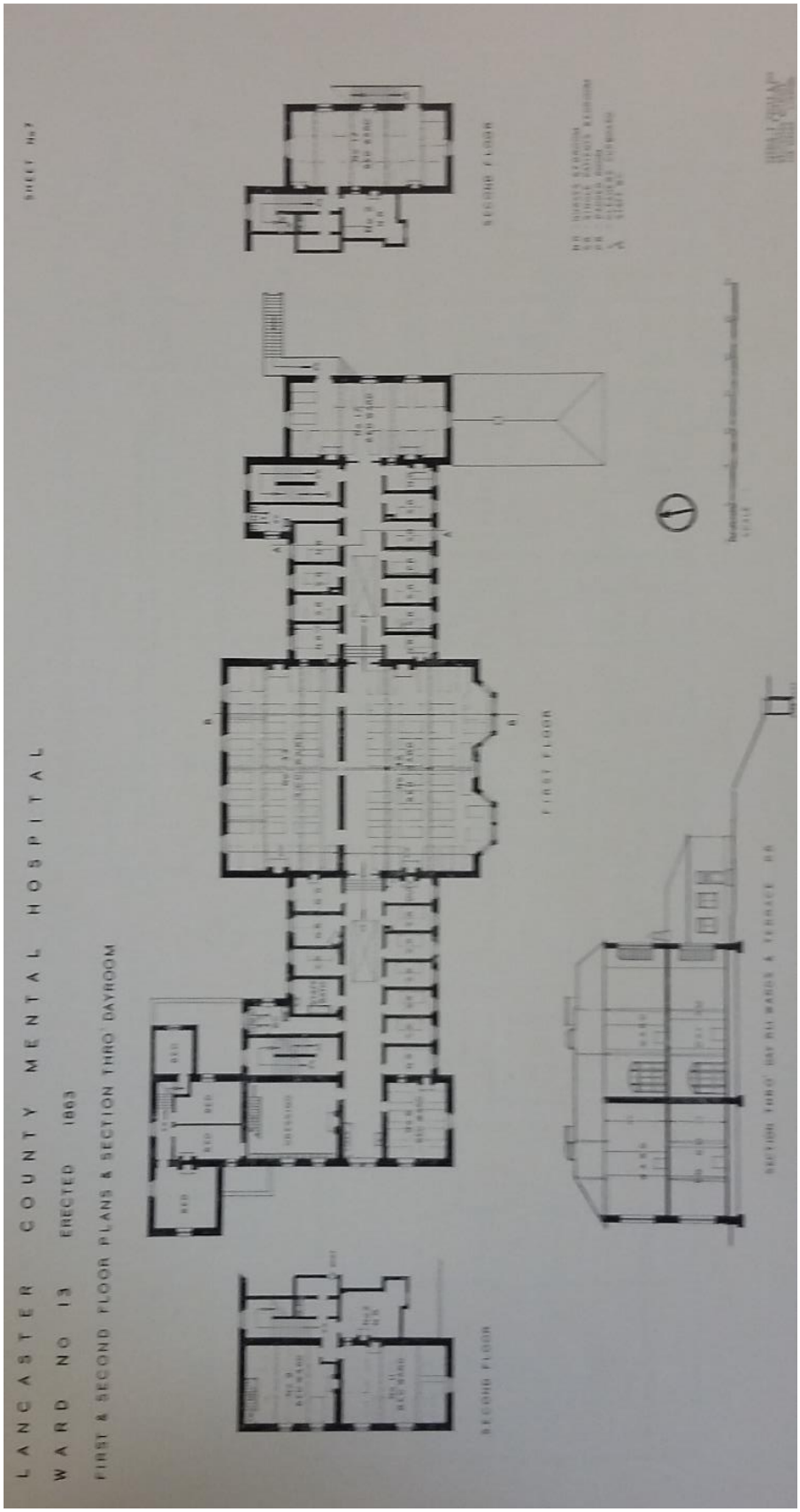

Figure 8. Lancaster Asylum Ward 13 First and Second Floor Housing Night Accommodation

The observation of patients was important throughout the institution, but took on an additional significance in the laundry due to the presence of hazardous tools and machinery.[70] Although patients employed in the laundry block were those who had made significant progress towards their recovery, incidents of self-injury or violence could (and did) occur.[71] Yet, despite this, the layout of the laundry presented challenges in ensuring that patients employed therein were observed by nurses. The above floor plan (Fig. 6) shows that the laundry included numerous, separate rooms. Women worked in different parts of the laundry depending on what tasks they were doing and as such were widely dispersed through the space. The use of small-capacity rooms was widely discouraged in writing on asylum construction for precisely this reason, with many writers in the 1860s advising the creation of large spaces in which large numbers of patients could be effectively monitored by small numbers of staff.[72] As such, the laundry provided a space relatively free from observation, especially when compared with other spaces of female employment.

Not only did the laundry itself contain opportunities for patients to elude observation, but the ward to which it was attached presented opportunities for privacy. Women who worked in the laundry were housed in Ward 13, a ward exclusively for working female patients. This arrangement was known as 'industrial classification', whereby patients were grouped together based on their ability to work, rather than their diagnosis or stage of recovery.[73] From Ward 13, access to the laundry was via a staircase leading directly from the ward (Fig. 7), meaning that patients rarely had to leave the building, reducing chances of escape or injury. This arrangement of living and working space was suggested by some commentators as a mechanism of creating small, self-contained communities which were easier to manage.[74] However, others criticized 'industrial classification' because it encouraged patients to feel that they were 'laundry maids' rather than 'patients' recovering in an asylum.[75] Although such an arrangement certainly controlled patients movement more stringently, this separation from the rest of the institution may have been welcomed by some.

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[70] LA, CC/HBR/9, *Reports* (1889), pp. 15-16.
[71] For example, James D. threw a pale of scalding water over one of the Laundry Maids in 1910, LA, HRL/4/12/2/27, 18 Aug 1909-18 Feb 1911, no. 23377.
[72] Sankey, 'Public Asylums of England', pp. 467-70.
[73] Piddock, *A Space of Their Own*, pp. 71-5.
[74] Toller, *Suggestions for a Cottage Asylum*, pp. 342-49.
[75] Arlidge, *On the State of Lunacy*, p. 143.

Feeling more like a laundry maid than a patient may have allowed some individuals a connection to their pre-institutional identities.[76]

Due to the connection between Ward 13 and the laundry, patient requests to be employed in laundry work must be considered in relation to the types of living spaces that were available on this ward. Night accommodation was made up of two mid-size dormitories and several single rooms. Large dormitories were considered, by the 1870s, to be optimal for observation. However, the positioning of two dormitories back-to-back caused problems for staff as it doubled the amount of space to be monitored at night time, when fewer staff were on duty.[77] The number of single rooms exacerbated this problem, creating even more spaces for night staff to check on. Although single rooms were preferred at the height of moral treatment due to the privacy they offered, by the 1870s, as moral management became the *modus operandi* of large county asylums like Lancaster, such arrangements became impractical if patients were to be kept under observation without restraint.[78] The proliferation of sleeping areas meant that there would have been periods during the night when rooms were not under observation – particularly single rooms. From patients' perspectives, the arrangement of space in Ward 13 offered greater privacy than the large, open dormitories of the Annexe.

The patients who sought employment in the laundry thus also gained access to living spaces where more privacy was available. Access to this level of privacy may well have contributed to patients' preferences for employment in the laundry. The way in which requests to work in the laundry were framed by some patients reflects that the associated ward allocation may have been a key factor motivating their preference. Mary P. who was re-admitted in 1890 with mania, 'Asked to go back to her old ward 13 and to the laundry'.[79] Although Mary's request was for a particular type of employment, her request prioritised her allocation to Ward 13. Although re-admitted patients may also have asked to return to old wards due to relationships with patients and staff who lived there, they would surely not request to live in areas that were undesirable, uncomfortable, or where they were unhappy.

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[76] In their study of twentieth-century long-stay residential institutions, Armstrong and Day observed that for women, doing laundry created a feeling of being at home, Pat Armstrong and Suzanna Day, *Wash, Wear and Care: Clothing and Laundry in Long-Term Residential Care* (Montreal, 2017), p. 19.
[77] Davies and Davies, *Lancaster County Mental Hospital*, pp. 117.
[78] Piddock, *A Space of Their Own*, pp. 40-3.
[79] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 100.

While multiple motivations undoubtedly shaped requests to live on Ward 13 the way in which space was arranged therein contributed to its desirability.[80] Based on a spatial analysis of this area of the institution it is clear that it offered a degree of privacy, and free-space that by the time of Mary's re-admission in 1890 would have been unattainable in the dormitory spaces of the Annexe.

7.5.2 Workshops

The absence – or at least the dilution – of observation may also explain why male patients requested to be employed in the workshops. Lancaster Asylum constructed workshops to cater for a variety of trades including tailors, joiners, bakers, plumbers, painters and blacksmiths.[81] As in the laundry, the workshops were made up of a number of different rooms that constituted self-contained spaces of work. Each trade was housed in a separate room within the workshop complex, leading to a multiplication of areas to be kept under observation.[82] The workshops were also attached to a ward for male working patients – Ward 27, which afforded the same opportunities as the laundry for allowing patients to identify as workers rather than as patients. This could be particularly significant for men who had followed a trade prior to admission, for whom employment in a workshop could provide an element of 'normality' which was reinforced by the separation of the workshop and its associated ward from the rest of the institution.[83]

The organisation of space in Ward 27 was even more conducive to patient privacy than the equivalent areas on the female industrial ward. The first floor had originally been designed as an attendants' block, but from the late-nineteenth century was used to house patients due to overcrowding.[84] Its original purpose as accommodation for attendants meant that single rooms were prolific, which presented challenges for keeping patients under observation. Indeed, asylum authorities noted that 'Since it was planned for attendants it is

[80] For discussion of other motivations driving patients requests for particular wards see Chapter Five, pp. 109-11.
[81] Davies and Davies, *Lancaster County Mental Hospital Survey*, p. 119.
[82] The fact that this arrangement was suboptimal in terms of observing inmates is evident in the open-plan workshops adopted in other carceral institutions. See Garman, *Detention Castles*, pp. 80-2.
[83] See Chapter Five, pp. 118-21.
[84] Davies and Davies, *Lancaster County Mental Hospital*, p. 121.

unsuitable for patients'.[85] For patients, such re-purposing of space allowed opportunities for agency, to engage in subversive behaviours, or simply to obtain a degree of privacy.

[85] Davies and Davies, *Lancaster County Mental Hospital,* p. 121.

Figure 9. Plan of Boiler House (1930), Workshops, and Ward 27 (1888).

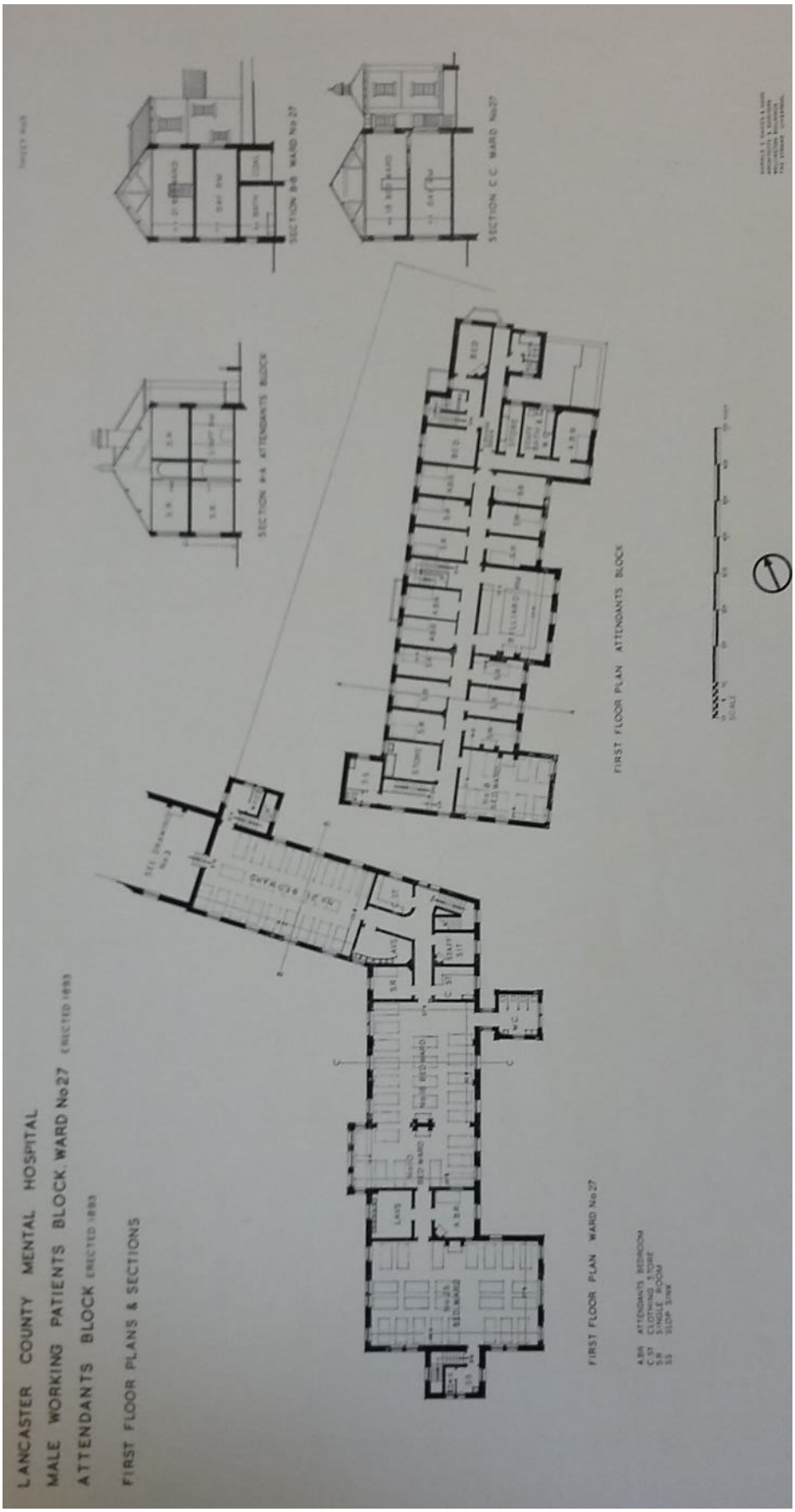

Figure 10. Male Working Patients Block. Ward 27 and Attendants Block (1893)

The male areas of the laundry were also classified as workshops, and they were situated in close proximity to the main workshop area. Although employment in Lancaster Asylum was strictly gendered, the laundry was arguably the exception to this rule. Even in the idealised image of the laundry photographed for publicity material (Fig. 5), a male employee is depicted working alongside female colleagues. Although the majority of patient-workers in the laundry were female, some male patients also occupied this space (Fig 6). Consequently, this space constituted one of the few areas in Lancaster Asylum in which the barrier between male and female patients became porous. Indeed, the Commissioners in Lunacy questioned this practice in Lancaster Asylum, noting that it was 'not without danger'.[86] This may explain the requests of male patients like James P. who asked to work in the laundry.[87] Requesting jobs that offered increased privacy, sociability, and interaction with the opposite sex offered opportunities for experienced patients to 'work the system'.[88] The spatial proximity of the workshops and the laundry building may in itself have influenced patients' choices to work in these areas. It should be noted, however, that in the sample of casebooks used in this study there is no mention of men and women having been caught in illicit interactions. Nevertheless, the possibility for engagements with the opposite sex may have been incentive enough to seek access to this area.

7.6 Sleeping Spaces

In addition to expressing preferences for work spaces, patients also made requests in relation to 'domestic' areas of the institution. Although there were a number of different domestic spaces in the institution, I will focus here on sleeping spaces, i.e. dormitories and single rooms, in order to explore the patient's role in shaping the meaning and functions of these areas of the institution.[89] During the nineteenth-century many different institutions, custodial and non-custodial, sought to harness the power of the domestic to reform, mould, or cure institutional populations.[90] As we have already discussed, the influence of domesticity was evident in the design of Lancaster Asylum from the 1840s onwards. Domestic rooms such as day-rooms, sleeping rooms, gallery spaces and dining halls were contained in each ward, and

[86] LA, CC/HBR/9, *Report* (1899), p. 88.
[87] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23546.
[88] Goffman, *Asylums*, pp. 197-201.
[89] For further discussion of domestic spaces in the asylum see, Hamlet, *At Home*, pp. 16-37.
[90] Hamlett, Hoskins and Preston (eds.), *Residential Institutions in Britain*.

depending on the 'class' of patient contained in each ward the decoration used to create a domestic environment was more or less comfortable.[91] Patients' progression through wards symbolized their journey to cure. As they moved to increasingly domestic wards, they also progressed closer to their discharge back to *actual* domestic space – their home. Domestic space in the institution was thus intended to facilitate patients' ritual movement from insanity to cure.[92] However, by making requests to move to areas of the institution which they preferred, patients undermined this 'ritual' movement, and forged their own paths through the institution. By examining patient requests to occupy single rooms or dormitories, competing geographies of institutional space will be highlighted, demonstrating the significance of patients' (mis)uses of space in shaping the institutional environment in Lancaster Asylum.

7.6.1 Single rooms

As demonstrated by Yanni and Davies, single rooms could hold multiple meanings for their occupants, ranging from punishment to luxury, and such divergent interpretations of these spaces affected how patients experienced them.[93] Indeed, single rooms were associated with solitary confinement and the separate system used in early-nineteenth century prisons to force criminals to reflect on their sins in the hopes that introspection would lead to reform.[94] Yet, in other contexts, single rooms had positive connotations, for example the association of solitude with religious enlightenment in monastic houses.[95] The competing meanings of single rooms are also evident in the writings of asylum doctors and designers on this topic. John Conolly argued that single rooms were preferable to dormitories because they offered patients quiet and solitude, whereas the noise and activities of patients could disturb sleep in dormitories.[96] Browne, by contrast, recommended dormitories where attendants could also sleep to watch over patients during the night, offering 'the pleasure of society and protection' during the night.[97] Indeed, the use of single-rooms in asylums became the topic of heated

[91] Edginton, 'Moral architecture', 91-9.
[92] Cf. De Cunzo, *Reform, Respite, and Ritual*, p. 46.
[93] Yanni, *The Architecture of Madness*, pp. 33, 47-8; Davies, '"A small corner that's for myself"'. pp. 310-11.
[94] Forsythe, 'Loneliness and Cellular Confinement', 759-70.
[95] Barbara Taylor, 'Separations of Soul: Solitude, Biography, and History', *American Historical Review*, 114(3) (2009), 640-51.
[96] Conolly, *The Construction and Government of Lunatic Asylums*, pp. 24-5.
[97] Browne, *What Asylums Were, Are, and Ought to be*, p. 186.

debate during the nineteenth-century. Proponents of non-restraint advocated their use, whilst asylum doctors who took a more ambivalent view of the non-restraint movement highlighted their lack of transparency, their liability to be abused and their parallels with solitary confinement in the prison system.[98] As well as provoking a variety of responses from the medical profession, the requests that some patients made for single rooms or dormitories suggest that there were a range of different interpretations of sleeping spaces amongst patients. I will suggest that this divergence reflects competing understandings of sociability, privacy, and the patient identity, and that such understandings were influenced as much by patients' experiences of domestic space outside the institution as by considerations of privacy within it.

In Lancaster Asylum, removal to a single room was used to punish violent or disruptive patients. This punished misbehaviour without the use of mechanical restraint: solitary confinement served in place of corporeal punishment.[99] Although it was framed as humane, the seclusion of patients in a single room had an unmistakeably punitive dimension.[100] Indeed, the use of solitary confinement as punishment paralleled developments in prison discipline in the same period.[101] That asylum authorities in Lancaster used single rooms for these purposes is evident in the language used to describe such measures in patients' casebooks. The case notes of John S. provide an example of this: 'During the last week has been quarrelsome and dissatisfied with his food, the temporary degradation of being obliged to sleep in a single room for one night has however rendered him tractable and quiet again.'[102]

However, some patients did not interpret solitary confinement as a punishment. Single rooms could also have connotations of privacy, quiet, and even luxury. Private asylums for the upper and middle-classes emphasized single rooms over dormitories in their design. Charlotte Mackenzie has suggested that such establishments were influenced by the development of hotels rather than hospitals, emphasizing the luxurious provisions for rich, fee-paying patients in Ticehurst Asylum.[103] The work of Jane Hamlett, Lesley Hoskins and

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[98] Leslie Topp, 'Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums, 1838-1844', *Social History of Medicine,* 31(4) (2018), 754-73.
[99] Tomlinson, 'Design and Reform', pp. 51-6.
[100] Hide, *Gender and Class,* pp. 134-5.
[101] Forsythe, 'Loneliness and Cellular Confinement', pp. 759-60.
[102] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 371.
[103] Mackenzie, *Psychiatry for the Rich,* p. 100.

Rebecca Preston discusses the opportunities for privacy provided by spaces of solitude such as private alcoves and single bedrooms in boarding schools and asylums.[104] Thomas Crook has also highlighted the role of solitary spaces in supporting privacy, providing space for deviance and for the expression of individuality.[105] For some patients, dormitory accommodation was considered inadequate because they expected to be able to sleep on their own. One patient, Ellen M., complained of dormitories on such grounds, including them in a list of complaints about material conditions in Lancaster Asylum: 'Is very dissatisfied with the food and complains of want of proper clothing and separate room etc.'[106]

Davies' study of twentieth-century psychiatric facilities suggests that some patients preferred single rooms because they offered them privacy, not from staff, but from other patients.[107] Single rooms allowed patients quiet from night-time disruptions, which were a common occurrence.[108] William A. was moved to a single room after being injured by another patient in his dormitory who had 'inflicted a scalp wound by striking him with his pot'.[109] William was not being punished – given that he was the victim of the attack rather than the perpetrator. Rather, his removal to a single room appears to have been undertaken because he was fearful of the dormitory after the incident. Single rooms offered an opportunity to escape other patients.[110] Some patients, like Ellen M., relished this solitude from the company of other patients. Her case notes remark that she preferred to be in a single room because, 'she cannot bear the presence of the other women'.[111] Regardless of whether they were motivated by fear, misanthropy, or a desire to distance themselves from patient-status a space intended for punishment became a refuge for some individuals.

The removal of patients to single rooms was also undertaken to facilitate tighter control of dangerous or difficult patients. This strategy further restricted patients' movement, removing them from contact with other patients and with objects and furnishings which could be dangerous. Particularly violent patients were moved to single rooms that contained

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[104] Hamlett, Hoskins and Preston, 'Introduction', in Hamlett, Hoskins and Preston (eds.), *Residential Institutions,* pp. 1-15.
[105] Thomas Crook, 'Power, Privacy and Pleasure: Liberalism and the Modern Cubicle', *Cultural Studies,* 21(4-5) (2007), 549-69.
[106] LA, HRL/4/12/1/16, 13 Jan 1849-4 Mar 1852, p. 309.
[107] Davies, '"A small corner that's for myself"', p. 311.
[108] Hamlett, *At Home,* p. 30.
[109] LA, HRL/4/12/2/2, 12 Apr 1865-2 Feb 1867, p. 34.
[110] Cf. Davies, '"A small corner that's for myself"', p. 311.
[111] LA, HRL/4/12/3/11, 25 Sept 1883-27 Jun 1885, p. 326.

furniture that was fixed in place, windows with shutters to protect the glass, or padded rooms.[112] Patients in padded rooms could be checked on regularly, and during staff absences were (theoretically) in spaces where they did not have access to objects that could be damaged or that could allow them to damage themselves.[113] The single room was, in this way, used in place of restraints in nineteenth-century asylums. Single rooms featured in the plans of 'ideal' asylums put forward by experts throughout the period; even those writers who generally favoured dormitories included single rooms for manic patients.[114] The importance of single rooms was keenly realised in Lancaster Asylum during the 1890s, when the adoption of large, open dormitories in the Annexe restricted the amount of space available to manage acute, suicidal, and violent patients.[115]

Despite the use of single rooms to manage particularly difficult patients, Lancaster Asylum's casebooks demonstrate that single rooms presented major problems for nurses and attendants. The limitations of single rooms for observing large numbers of patients were clearly recognized by asylum authorities, given that wards in the Annexe building (Fig. 12) featured significantly fewer single rooms than wards constructed in earlier periods (Fig. 11). Indeed, writers on asylum design from the 1860s onwards began to advocate the employment of large dormitory spaces to promote the easier observation of large numbers of patients by much smaller numbers of attendants.[116] The proliferation of single rooms that had been favoured during the era of moral treatment was impractical for the large patient populations of the late-nineteenth century. As Piddock points out, large dormitories prioritized the management of patients above their individual comfort.[117] This was the hallmark of moral management, and its influence can be seen on the increased emphasis placed on dormitories over single rooms in ward design at Lancaster Asylum over the period under study (Figs. 11 and 12). Although single rooms were considered more effective for managing acute or dangerous patients, they relied on a high staff to patient ratio, a ratio that was not achievable in Lancaster Asylum by the 1880s. If staff were not able to check on single rooms frequently, they could become particularly risky spaces for some patients.

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[112] E.g. LA, HRL/4/12/2/3, 21 Jul 1868-8 Dec 1870, p. 212; LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 171; LA, HRL/4/12/3/33, 21 Mar 1908-3 Sep 1909, p. 240.
[113] Topp, 'Single Rooms', p. 771-3.
[114] Piddock, *A Space of Their Own,* pp. 60-87.
[115] LA, CC/HBR/3, *Reports* (1893), p. 15.
[116] Sankey, 'Public Asylums of England', pp. 474-5.
[117] Piddock, *A Space of Their Own,* p. 66.

Several incidents occurred in single rooms which demonstrate that patients went for long periods of time in these areas without being checked on. Temporary absences of staff may have made these rooms particularly attractive to patients who wished to engage in subversive behaviours. Thomas C. W. managed to escape from his single room by forcing the lock on the door and got out of the asylum by climbing over the airing court wall.[118] Not only did staff absences provide opportunities for patient subversion, but the built environment of single rooms included features – such as ventilators – that facilitated subversive behaviour. Several patients managed to climb into the ventilators of their single rooms and crawling through them get out of the room and then the institution.[119] By using these features in ways that had not been foreseen by designers, patients were able to turn an inherently controlling element of asylum design to their advantage. For other patients the periodic absence of staff during the night could end in tragedy. Throughout the period, several epileptic and suicidal patients died in single rooms during periods of staff absence.[120] Although such rooms were utilised to control recalcitrant, violent or otherwise dangerous patients by placing them under stringent spatial control, their efficacy relied on them being diligently checked by staff.

7.6.2 Dormitories

The incidents that took place in single rooms indicate that the advice of writers on asylum design from the 1860s as to the efficacy of dormitories had some merit. However, dormitories presented their own challenges to staff, as well as opportunities for patients. Patients who preferred single rooms due to their dislike of the company of other patients were not mistaken in their impression of the dormitory as a social space.[121] For asylum authorities, the sociability of dormitories was considered useful: patients could watch over one another rather than requiring attendants to be present constantly.[122] Chris Philo has suggested that this feature of dormitory space was a text-book example of panopticism in practice.[123] However,

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[118] LA, HRL/4/12/2/2, 12 Apr 1865-2 Feb 1867, p. 61.
[119] LA, HRL/4/12/2/2, 12 Apr 1865-2 Feb 1867, p. 39.
[120] LA, QAM/5/23, *Reports* (1874), p. 18.
[121] The importance of dormitories to sociability can be seen in discussion of their incorporation into College residential halls, see, Carla Yanni, 'Housing Lunatics and Students: Nineteenth-Century Asylums and Dormitories', *Change Over Time,* 6(2) (2016), 154-72.
[122] Sankey, 'Public Asylums of England', 474-5.
[123] Philo, '"Enough to Drive One Mad"', pp. 258-90.

casebook evidence suggests that patient interaction in dormitories did not always take the forms desired by asylum authorities. In fact, for patients, the potential for sociability in dormitories shaped their preferences for this space because it presented opportunities for friendships and sexual relationships in the institution.

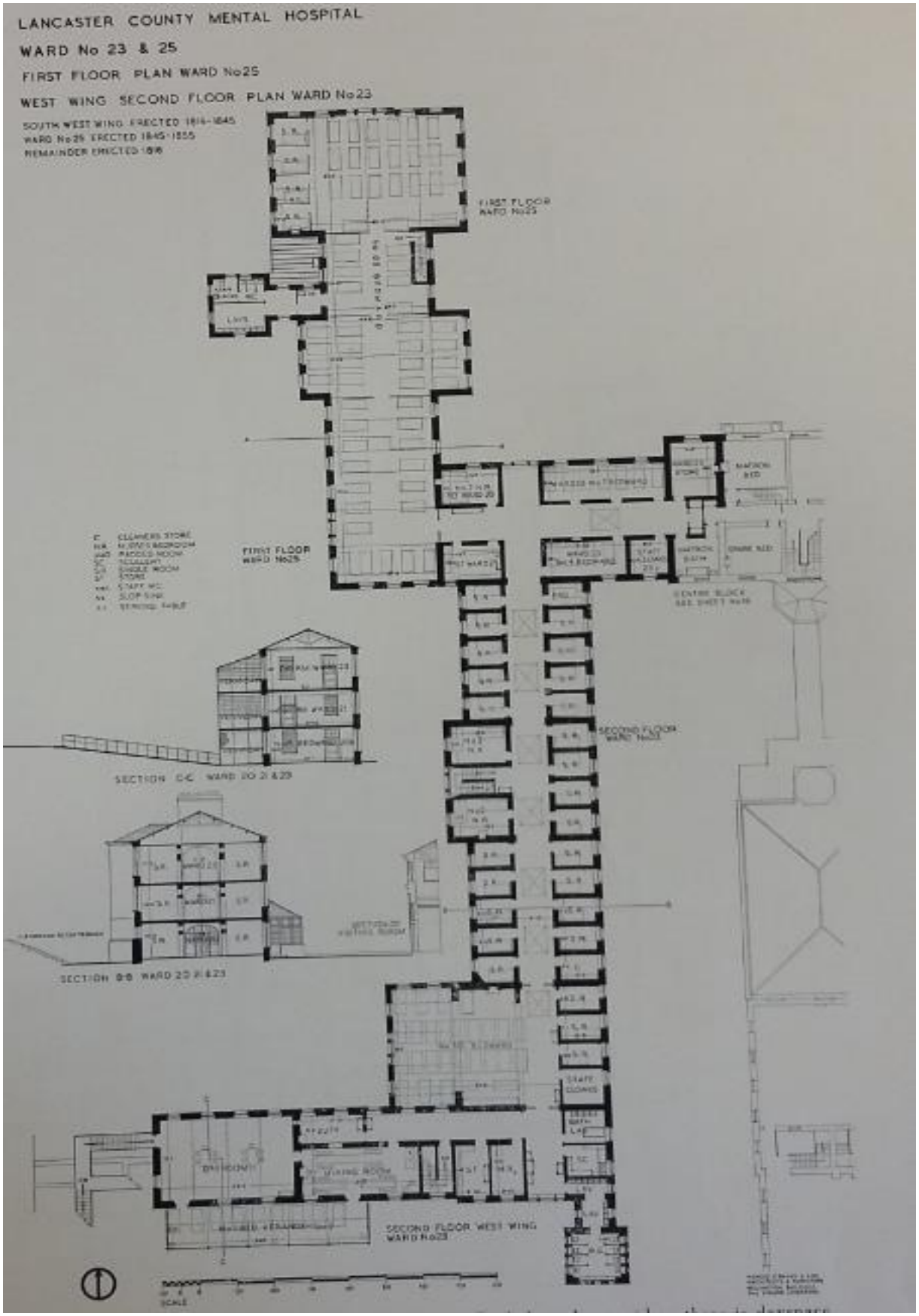

Figure 11. Ward 23 (1816-45) and Ward 25 (1845-55)

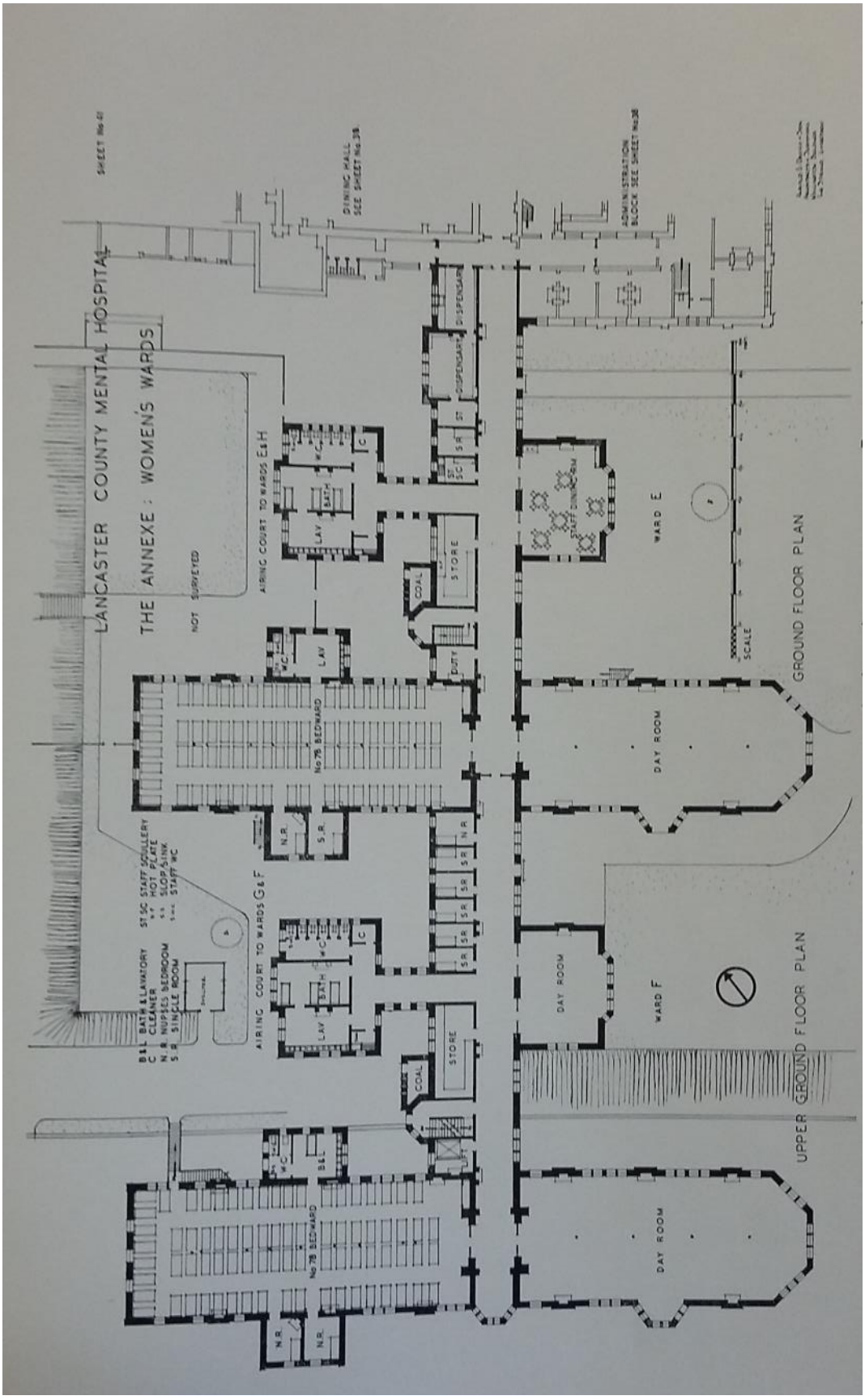

Figure 12. Female Wards in The Annexe (1883)

Dormitories provided opportunities for friendships, conversations, and even romantic relationships. Jane Hamlett notes that dormitories were preferred by some patients in pauper asylums for exactly this reason. According to Hamlett, John Weston, one of the few pauper patients who left a first-person account of his experiences of life in Bristol Asylum, preferred sleeping in a dormitory, finding sleeping in a single room frightening.[124] Some patients in Lancaster Asylum also preferred dormitories because of the associations of single rooms with punishment. Sarah B. slept in the observation dormitory because she was 'afraid of the padded room'.[125] For patients like Sarah, the meanings attributed to space by the asylum authorities were internalized, and the threat of removal to a single room functioned as intended by institutional authorities.

In addition to preferences for dormitories shaped by fear of solitary confinement, patients' preferences for communal sleeping spaces may well have been shaped by patients' social class. Working-class patients would have been used to sharing sleeping space in their homes, perhaps making single rooms feel more institutional than dormitory spaces.[126] The need for company can be identified in the ways in which some patients framed their requests to be moved to a dormitory. Elizabeth H. bargained with asylum staff to get out of her single room, promising to 'control her temper' if she was allowed to join the communal areas of her ward. Her request was granted during the day, however, she was still removed to a single room at night.[127] The comfort that the company of other patients could provide during the night can be seen in the case notes of Esther L. who went around her dormitory 'rubbing epileptics hands', a gesture which perhaps offered comfort to a group of patients for whom night time could be a particularly dangerous period due to the risk of suffocation during a seizure.[128]

Dormitories were employed by asylum authorities to regulate patient sexuality, ensuring men and women were separated at night.[129] However, for homosexual patients, the

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[124] Hamlett, *At Home,* pp. 34-5.
[125] LA, HRL/4/12/3/19, 23 Oct 1894-6 April 1896, p. 171.
[126] Michael Anderson, *Family Structure in Nineteenth Century Lancashire* (Cambridge, 1971), pp. 31-2; Joanna Bourke, *Working Class Cultures in Britain, 1890-1960: Gender, Class and Ethnicity* (London and New York, 1994), p. 27; Geoff Timmins, 'Housing Industrial Workers During the 19th Century: Back-to-Back Housing in Textile Lancashire', *Industrial Archaeology Review,* 35(2) (2013), 111-27.
[127] LA, HRL/4/12/3/19, 23 Oct 1894-6 April 1896, p. 229.
[128] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 35.
[129] Hamlett, *At Home,* p. 30.

dormitory could provide opportunities for sexual relationships in periods when staff were absent.[130] The problem of ensuring that dormitories were properly monitored at night was much discussed by asylum managers. On the recommendation of the Commissioners in Lunacy following their annual visit in 1876, tell-tale clocks were adopted at Lancaster Asylum to ensure that night attendants regularly visited the dormitories.[131] Even when these clocks were widely adopted in all the wards of Lancaster Asylum, their efficacy was often questioned by asylum managers.[132] As Hamlett notes, during the night, attendants could be absent for over an hour in some institutions due to the number of dormitories to patrol and the smaller number of staff on duty.[133] Consequently, in the absence of staff, patients were able to pursue relationships in these areas that transcended the bounds of 'healthy sociability', as discussed in relation to same-sex sexual relationships in the previous chapter.[134] However, the official medical record offers access only to the incidents of patient misbehaviour that were caught by the authorities. Although patients like Patrick O. were caught engaging in sexual relationships thus bringing them to our attention, it is likely that such cases represent a larger quantity of these illicit activities that went undetected, and thus unrecorded in casebooks.[135]

Asylum authorities believed dormitories were more effective than single rooms in ensuring that patients were monitored during the night, which was particularly important for epileptic patients and those who demonstrated suicidal impulses. Dormitories not only gathered patients together in one place but also allowed patients to keep watch over one another. Indeed, in some cases this practice became too common in Lancaster Asylum, and the Commissioners in Lunacy condemned the level of responsibility held by some patients for keeping an eye on others in dormitories.[136] Conversely, however, this association of patients in dormitories could also provide opportunities for social interaction and alleviate solitude. The social opportunities present in dormitories were identified by patients who preferred the company available therein to the solitude of single rooms. Patient sociability in these spaces could transgress the bounds deemed acceptable by asylum authorities. Indeed, that sexual relationships could be attempted in dormitories suggests that the periodic absence

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[130] Concerns about homosexuality and dormitories were also prominent in discussions of other residential institutions e.g. Yanni, 'Housing Lunatics and Students', p. 161.
[131] LA, QAM/5/25 *Reports* (1876), p. 15.
[132] LA, CC/HBR/1, *Reports* (1891), p. 10.
[133] Hamlett, *At Home,* p. 29.
[134] See, Chapter Five, pp. 113-19.
[135] Patrick O., LA, HRL/4/12/2/24, 17 Feb 1905-21 Dec 1905, p. 202.
[136] LA, CC/HBR/1, *Reports* (1891), p. 12.

of staff during the night created temporarily ‘free spaces’ which some patients took advantage of.

7.7 Free Space in Lancaster Asylum

The areas of Lancaster Asylum discussed so far were favoured by some patients because they presented obstacles to the medical gaze. Due to temporary absences of staff, at times these areas took on many of the characteristics that Goffman identified as having produced ‘free spaces’.[137] These areas, however, were only ‘free’ periodically. Patients had to take advantage of temporary absences of staff, which often resulted in any subversive acts being discovered when staff re-entered the space. However, there were some areas of the asylum in which the structure of the building itself created pockets of privacy within the institution. Patients appear to have deliberately selected such areas to engage in subversive activities. These areas constituted ‘free space’ in precisely the way in which Goffman used the term.

Free spaces in Lancaster Asylum were generally small, self-contained rooms which could only be occupied by one or two individuals at a time. The presence of so few people in these spaces meant that nurses and attendants periodically left them to check on the majority of patients in their charge. There are many examples of rooms that fitted this description in the asylum including areas such as the boot rooms, closets, lavatories and store rooms. These are mentioned in case books in relation to discussion of patient escapes, hiding from staff, and acts of self-injury, but only on a handful of occasions. This does not necessarily mean that these spaces are less significant but could merely affirm the lack of staff supervision of these areas. I believe that this handful of incidents represents the tip of the iceberg of a geography of free-space in Lancaster Asylum, a geography which was known to patients, and perhaps attendants, but by definition was hidden from institutional authorities.[138]

One such space was the potato vaults, where patients worked peeling vegetables (Figs. 13 and 14). Three patients escaped from this area, including one criminal lunatic.[139] A comment in a survey of the asylum buildings reinforced the impression that the room itself made supervision of patients working therein difficult: ‘The various stores departments are in

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[137] Goffman, *Asylums*, pp. 205-8
[138] Goffman, *Asylums*, p. 205.
[139] LA, HRL/4/12/1/10, 28 Jul 1840-25 May 1840, p. 211; LA, HRL/4/12/2/20, 27 Jun 1898-6 Jul 1902, p. 190.

the first place wrongly situated; they are scattered and difficult to control and supervise'.[140] The size of the room and the small proportion of patients engaged in this activity, meant that a staff member could not have been constantly present in that space.[141] The presence of few patients in a self-enclosed area was recognised as a potential safety problem, particularly in the context of the large institutional populations of the late-nineteenth century.[142]

[140] LA, HRL/1/14/4, History, Description and Problems', p. 46.
[141] The numbers of patients employed in different occupations are tabulated in the Asylum's Annual Reports: LA, QAM 5/38-45, *Annual Reports* (1841-47)*;* LA, QAM 5/1-37, *Reports of the County Lunatic Asylums* (1852-88); LA, CC/LAR/1-2, *Reports of the County Lunatic Asylums* (1891-2); LA, CC/HBR/2-25, *Reports of the County Lunatic Asylum* (1892-1915).
[142] Sankey, 'Public Asylums of England', 466-79.

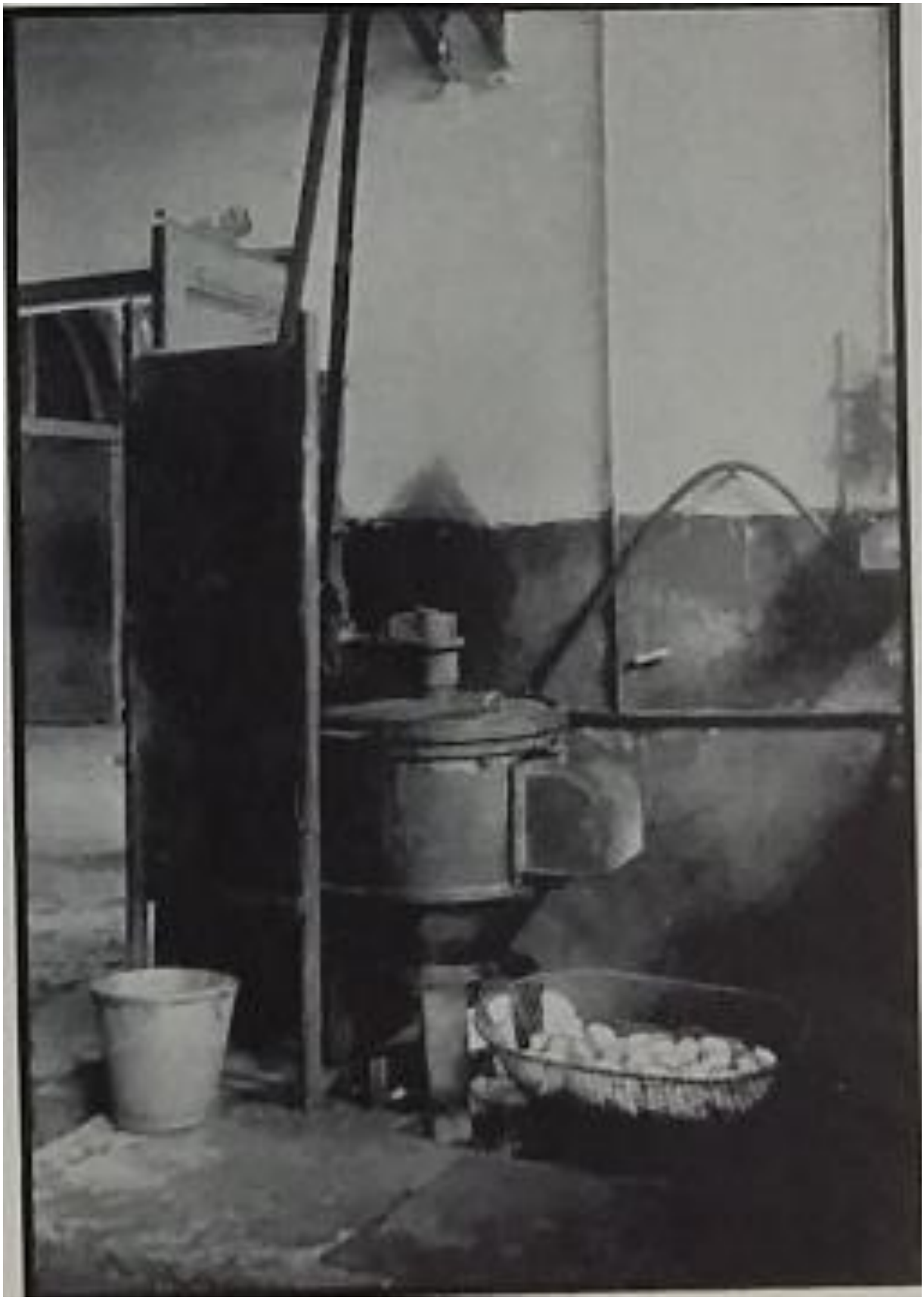

Figure 13. Potato Peeling Room

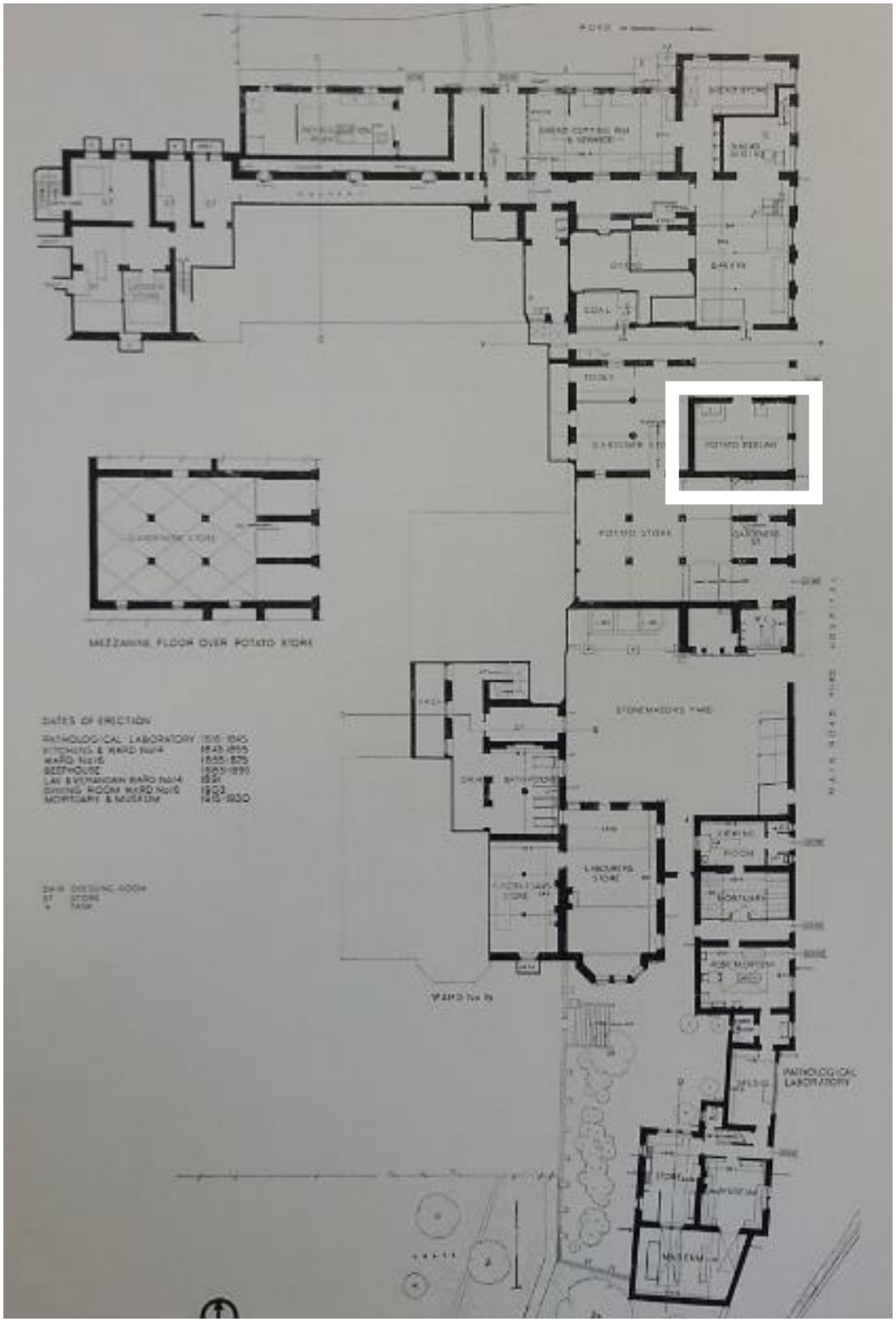

Figure 14. Plan Showing Potato Peeling Room

Self-enclosed spaces like cupboards, closets and lavatories were also used by patients to engage in subversive activities. The behaviours in which patients engaged in these spaces were those that relied on their not being caught, in particular, escapes and suicides were enacted in such areas. Frederick John C. attempted to escape from a closet in his ward, an area used to store clothing. His case notes comment on his discovery: 'Has been found trying to escape, by taking out the screws from the window casement in B Closet'.[143] Interestingly, Frederick's previous occupation was given as an Asylum Attendant, which suggests that he would have had a good knowledge of challenges facing attendants, explaining perhaps his selection of an area which was particularly hard to observe. As Goffman points out, patients' ability to use free space was predicated on their knowledge of these alternate geographies of institutional space.[144] The use of storage closets on wards to hide from asylum authorities is mentioned in a number of patients' case notes. John H. M. was moved to another ward as a consequence for misbehaving, however, after his removal he escaped from his new ward and hid himself in a clothes cupboard on his old ward.[145] In doing so, John resisted the attempts of the asylum authorities to control his movement – he moved himself back to the ward he preferred. John's case not only illustrates how patients could manipulate asylum space to facilitate acts of resistance, but also demonstrates the importance of asylum space to patient coping mechanisms – John made institutional life more comfortable for himself by securing his removal to a preferred ward.

The escape of Joseph B. is particularly interesting in affirming the existence of free space in Lancaster Asylum because institutional authorities could not find out how he had escaped. The description of Joseph's escape was recorded over several days as new information came to light. His escape took place on 6 May 1909: 'He was in ward at 1.30 pm to day when he was last seen; at 1.45 pm he was missed but could not be found; no one had let him out and there was no obvious means of escape'.[146] It was only when Joseph was returned to Lancaster Asylum two days later that he revealed his escape route: 'He has pressed spring of lock back with a piece of tin so enabling lock to be opened with a knife thus picking lock of an outer door of boot room'.[147] The boot room was clearly not readily monitored (cf. Fig. 15), given that Joseph was not only able to escape but was able to do so in

[143] LA, HRL/4/12/2/18, 14 June 1893-22 Nov 1895, p. 206.
[144] Goffman, *Asylums*, p. 191.
[145] LA, HRL/4/12/2/10, May 1880-30 Nov 1881, p. 135.
[146] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23334.
[147] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23334.

a manner that was totally unnoticed until he told staff how he had got out of the building. Indeed, had Joseph not been re-captured, this area would never have been mentioned in the asylum casebooks. Joseph's escape thus illustrates not only the existence of free spaces, but also the fact that the extent to which we can know of these spaces is necessarily limited by the sources available for this period. Again, the impression of seeing only the tip of the iceberg of Lancaster Asylum's free spaces is reinforced.

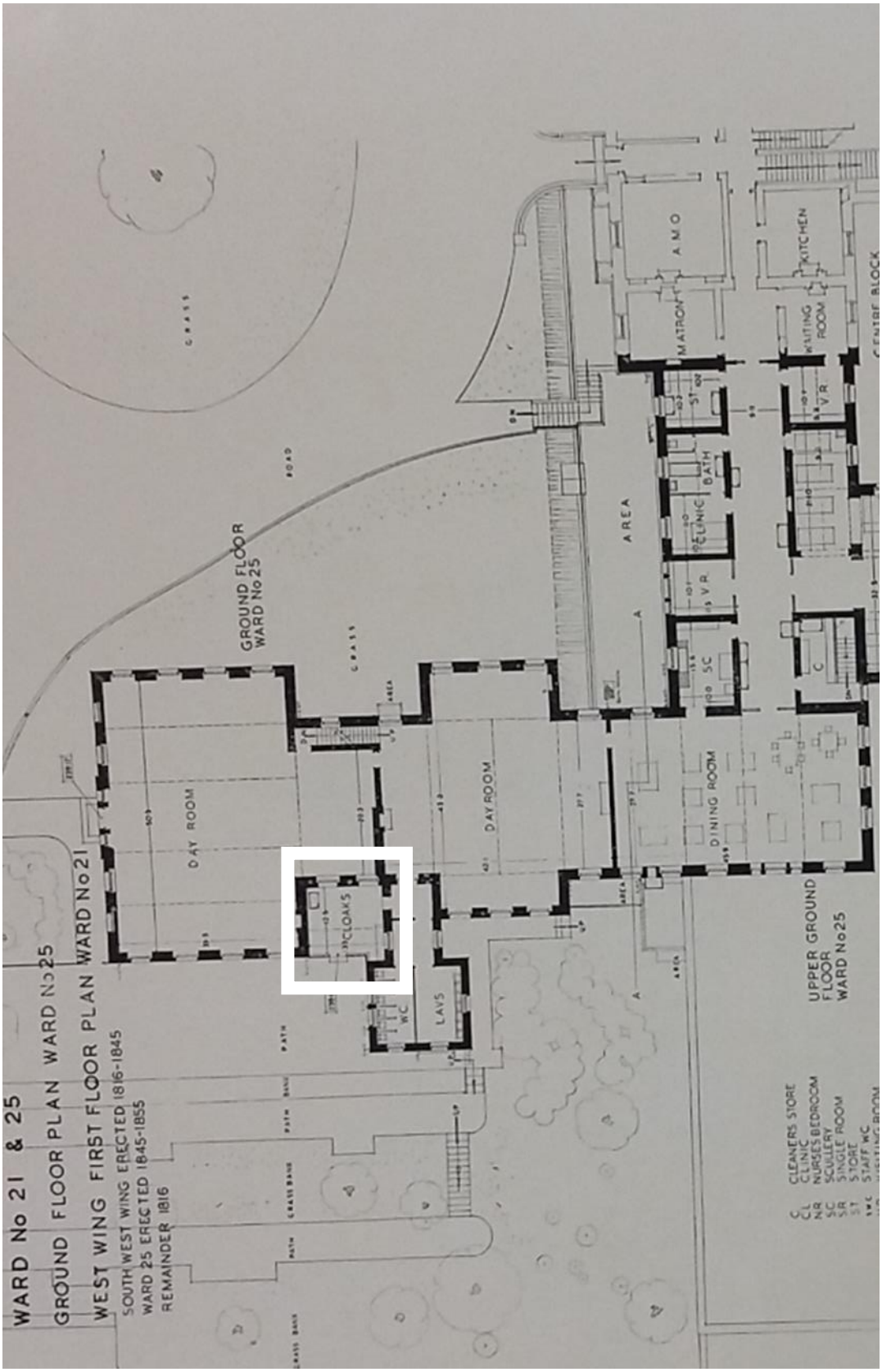

Figure 15. The cloakroom shown here fulfilled a similar function to the boot room discussed in Joseph B.'s casebook.

7.8 Conclusion

This chapter has examined the relationship between patient agency and asylum authority within its spatial setting. The built world of Lancaster Asylum was a physical manifestation of institutional authority; it facilitated the treatment and management of patients confined therein. In the fabric of Lancaster Asylum, we can see the changes in medical approaches to the treatment of insanity across the nineteenth century. Asylum designers facilitated the delivery of moral treatment programmes wherein patients' individuality was to be retained as far as possible. Single rooms, a variety of day spaces and small dormitories were created to facilitate the delivery of this regime. As institutional populations grew, however, larger spaces were necessary to permit the observation patients in an era of high patient to staff ratios. This shift can be seen in the Annexe at Lancaster Asylum, wherein moral management was facilitated by large dormitories and day rooms. Changes in institutional structures were thus wrought both by changing medical ideas about insanity, and the experience of the practical challenges of asylum management.[148] These changes in asylum design present only one institutional geography of the asylum as it was understood by designers, doctors and institutional managers.

Patients created an institutional geography distinct from that created and experienced by asylum designers, doctors, and other staff. This geography not only facilitated patient agency but was in itself evidence of the agentive power of the patients who created it. Whereas current work on asylum space tends to focus on its meaning to institutional designers, doctors, nurses and attendants, I have suggested that asylum space cannot be understood apart from the layer of meaning with which it was endowed by patients' use and misuse of that space. I have suggested that spaces associated with punishment such as the laundry, the workshop, the dormitory and the single room were given alternative meanings by patients who used these spaces, to gain privacy, to retain links to their pre-institutional selves, and to engage or avoid social interactions. These alternative associations were shaped as much by patients' pre-institutional experiences as by their knowledge of the asylum. In patients' ascription of new meanings to them, these spaces took on lives of their own, quite distinct from the functions which asylum designers had intended. In this way, asylum space was not only a mechanism for facilitating patient agency, but also provides evidence of

[148] Piddock, *A Space of Their Own,* pp. 49-76.

patients' agentive capacity in relation to institutional structures. Patients' use of asylum space created alternate institutional geographies, reshaping the environment of Lancaster Asylum.

8. Materiality and Agency

8.1 Introduction

The agency of county asylum patients cannot be understood in isolation from the material world in which those expressions of agency occurred. As Jane Hamlett points out, 'When examining the very poor or other marginalised groups, looking at what people did with things can help us understand how they exercised agency in their own right'.[1] In contrast to case notes, patients had direct access to objects. Things could be defaced, repurposed or altered, depending on how the patient interacted with them. Material culture therefore offers a more direct window into patients' responses to institutional life. This chapter continues to draw on case notes and other official documents such as inventories and annual reports, to offer context for patients' uses of objects. However, these are employed alongside analysis of objects themselves and photographs of institutional spaces to explore the material world of Lancaster Asylum. As discussed in the previous chapter, the intentions of asylum designers in creating a building which promoted the surveillance and control of patients could be subverted. The same disparity between theory and practice is evident in the wider material culture of the institution. Objects in Lancaster Asylum were intended to facilitate the cure of mental disorder and to create a 'technology of control'.[2] However, this was challenged by patients' appropriations and adaptations of objects.

In this chapter we will examine the ways in which patients changed the functions of institutional objects to exercise agency. We will begin, in Section 8.2, by exploring the intended functions of institutional objects from the perspectives of asylum designers. The arrangement of furnishings, decorative objects, work tools, and patient clothing was curated by institutional authorities to facilitate the delivery of moral treatment. Patients, however, used objects in ways that went beyond their original purpose, using them to resist, cope with, and engage with institutional life. Section 8.3 will explore how material culture approaches can be adopted to explore this gap between institutional intentions and patient uses of objects in practice. The subsequent sections will each focus on a different facet of the material culture in Lancaster Asylum to draw out the gap that emerged between the material world designed by asylum authorities and the material world created by patients. Section 8.4 will

[1] Jane Hamlett, *At Home*, p. 10.
[2] Hide, *Gender and Class*, pp. 55-8.

explore competing constructions of 'home' in the institution, highlighting the differing ways in which patients conceived of and used domesticity compared to institutional authorities. Section 8.5 will consider the ways in which asylum authorities and patients used objects to facilitate their endeavours; whereas asylum authorities used objects to deliver their treatment of patients, patients subverted 'curative' objects for a range of purposes. Section 8.6 explores the differing meanings of 'damage' in the context of the asylum, suggesting that what asylum managers saw as destructive reflected constructive behaviour used by patients to adapt or personalize institutional space. Section 8.7 will consider how uniforms became important to institutional efforts to control patients' bodies through their role in marking out patients' status, class, and preventing the transmission of communicable disease. While, for patients, uniforms represented a loss of individuality, customization was used to address this loss of self. The material world will be highlighted as a dynamic site through which the interplay of patient agency and asylum authority can literally be traced through successive layers of adaptation to institutional objects. The cyclical, productive relationship between agency and authority is nowhere more apparent than in the material culture of the asylum.

8.2 Material Cultures of Control

Great attention was paid to the decoration and design of Lancaster Asylum. This went beyond considerations of the suitability of interior design for confinement and extended to ensuring that rooms were tastefully decorated and comfortably furnished. As we saw in Chapter Seven, theories of moral treatment emphasized the importance of pleasant surroundings for soothing the disturbed minds of patients.[3] This was also part of a wider mode of thought in Victorian society which stressed the importance of environment in shaping behaviour.[4] The influence of this belief in the link between behaviour and environment can be seen in other institutions, but also in wider cultural phenomena including the development of recreational

[3] Digby, *Madness, Morality and Medicine*, p. 34.
[4] This can be seen in the discourses surrounding the construction of many nineteenth-century carceral institutions, not just asylums: Ignatieff, *A Just Measure of Pain*; Evans, *The Fabrication of Virtue*; Felix Driver, *Power and Pauperism*; J. Nicoletta, 'The Architecture of Control: Shaker dwelling houses and the reform movement in early-nineteenth-century America', *Journal of the Society of Architectural Historians*, 62(3) (2003), 352-87; Green, *Pauper Capital*.

parks,[5] and conventions of decorating the home.[6] As Deborah Cohen points out, wider social trends of middle-class consumption in this period were not just due to increased spending power; they also reflected a belief in the power of objects to influence the sensibilities of those experiencing them.[7] In the context of the asylum, this emphasis on the potential of the environment to influence behaviour was manifested in the drive to domesticate the institutional interior.[8] Asylums emphasized the importance of decorating wards, dayrooms and galleries in a pleasing way, that mimicked idealised versions of patients' homes. This was thought to minimize the appearance of institutionalization, exerting a calming effect by placing patients in familiar surroundings.[9] Domesticating the institution was also believed to have a 'civilizing' effect on patients. The creation of a home-like environment was believed to assist in the cultivation of the rational part of patients' minds.[10]

To achieve these goals, nineteenth-century asylums devoted significant resources to decorating their interiors. At Lancaster Asylum, the rooms were carefully and comfortably furnished.[11] As can be seen in Figure 16, decoration went far beyond providing what was required to ensure that patients were comfortable. In this image we see a billiards table that was provided for recreation for male patients. Miniature plants were dispersed throughout the room, and other decorative features like paintings, curtains and wallpaper were used to create a 'cheerful' atmosphere.[12] The floors, panelling, and seating were made from mahogany, a material associated with luxury.[13] Through the centre of the room were a number of pillars

[5] Hazel Conway, *People's Parks: The Design and Development of Victorian Parks in Britain* (Cambridge and New York, 1991).
[6] Jane Hamlett, *Material Relations: Domestic Interiors and Middle-Class Families in England, 1850-1910* (Manchester, 2010).
[7] Deborah Cohen, *Household Gods: The British and Their Possessions* (New Haven Conn, 2006), Chapter 2.
[8] Hamlett, *At Home.*
[9] Mary Guyatt, 'A Semblance of Home: Mental Asylum Interiors, 1880-1914', in Susie McKellar and Penny Sparkle (eds.), *Interior Design and Identity* (Manchester, 2004), pp. 48-71.
[10] Smith, *Cure Comfort and Safe Custody*.
[11] LA, HRL/2/10/2/1/1, Bills of quantities for building and decorating work on new buildings at Asylum May-July 1879; LA, HRL/2/10/2/1/2, Estimates for furniture (with drawings) for the new annexe 2 April 1883.
[12] E.g., LA, QAM/5/33, *Reports* (1884), p. 20.
[13] Jennifer Anderson, *Mahogany: The Costs of Luxury in Early America* (Cambridge MA, 2012).

carved in classical style and made from a material mimicking the appearance of marble. This dayroom was the epitome of middle-class Victorian domesticity.

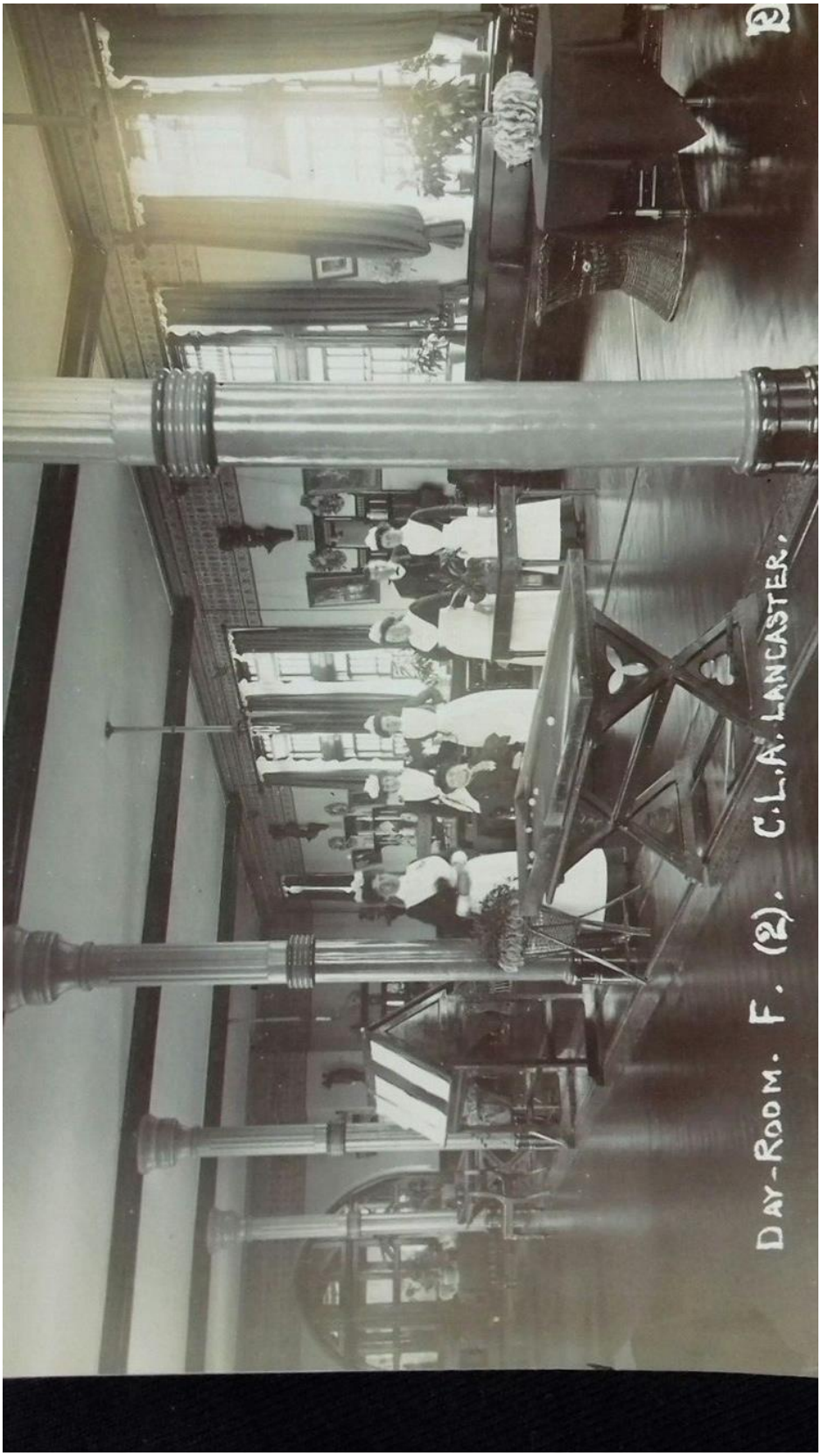

Figure 16. Day Room in Lancaster County Asylum, c. 1890s.

The question of how inmates responded to institutional surroundings presents significant challenges in relation to institutions like county asylums.[14] Hamlett grapples with the question of inmates' perceptions of their surroundings, arguing that the cultivation of domesticity in asylums did not always have the desired effect on patients. Some were too ill to engage with their surroundings, whilst others compared the asylum to their own homes and found it wanting.[15] The deployment of domesticity has also been investigated in the context of twentieth-century provisions for individuals with learning disabilities. John Welshman highlights the importance of 'homeliness' in the creation of hostels as part of care in the community initiatives. However, in practice, many local authority hostels lacked the appearance of a family home, suggesting that there was a gap between the ideals expressed by health care authorities, and the hostel interiors experienced by service users.[16]

The imposition of a specific kind of domesticity in the asylum has been considered, by some, as evidence of endeavours to control inmates' behaviour and inculcate middle-class values and standards amongst patients.[17] In county asylums, where most patients were 'paupers', the intention of asylum designers to create a homelike environment through middle-class fashions may have been misplaced. Even acknowledging the range of social classes which the catch-all term 'pauper patient' can mask, in Lancaster Asylum it was predominantly working-class individuals who occupied spaces like the dayroom depicted above. The idea that the asylum was to feel home-like, therefore, was not always borne out in practice. Louise Hide has viewed the decoration and arrangement of asylums as a 'technology of control', arguing that architecture, material culture, work routines, exercise, amusement programmes and religious instruction were all put in place to regulate behaviour, reinforce gendered and classed identities, punish and reward patients, and ultimately to cure and reform them.[18] Hide's analysis moves beyond unsophisticated social control accounts of institutional materiality, acknowledging the opportunities for patient agency presented by the material world. She argues that it was possible for the insane to exercise agency in some areas of

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[14] Yanni, *The Architecture of Madness*.
[15] Hamlett, *At Home.*
[16] John Welshman, 'Inside the Walls of the Hostel, 1940-74', in Pamela Dale and Joseph Melling (eds.), *Mental Illness and Learning Disability Since 1850, Finding a Place for Mental Disorder in the United Kingdom* (London, 2006), pp. 200-23.
[17] Scull, *Museums of Madness.*
[18] Louise Hide, 'From Asylum to Mental Hospital: Gender, Space and the Patient Experience in London County Council Asylums, 1880-1910', in Hamlett, Hoskins and Preston (eds.), *Residential Institutions*, pp. 56-68.

asylum life such as complaining about food, refusing to work, or adapting their clothing.[19] Indeed, Hamlett also highlights the potential of the material world for facilitating patient agency, suggesting that patients could resist the imposition of middle-class norms by damaging their surroundings.[20] This allowed patients who did not feel at home amidst a manifestation of domesticity influenced by the middle-class home, or, at least, the upper-working-class parlour, to register their discontent.[21] There were patients, however, who derived pleasure from the decoration of the asylum.[22] Patient responses often depended on their experiences of domesticity prior to their confinement, as well as their mental states once they were in the asylum.

The ability of patients to exercise agency through the material world depended on their capacity to alter or misuse the objects which they encountered. Rebecca Wynter's study of Staffordshire County Gaol and Lunatic Asylum argues that, despite the design of institutional material cultures as technologies of control, gaps in institutional surveillance meant that the intentions of authorities could be subverted by inmates' uses of objects.[23] Indeed, patients' appropriations of institutional objects meant that, despite being deprived of personal possessions, they could negotiate the material world, exchanging or making objects, and colonising or personalising institutional space; making homes within the institution.[24] Studies of prisons[25] and concentration camps[26] have also highlighted the importance of the material world to inmates' strategies of resistance and coping mechanisms. In institutional contexts, even the most mundane objects could take on significance as 'powerful expressions of human agency'.[27] Patients in Lancaster Asylum were similarly able to re-purpose institutional objects to support agentive behaviours. This is interesting, in and of itself, for what such actions can tell us about patient responses to life in the asylum. However, this chapter will not just focus on how patients subverted institutional material cultures to exercise agency but will also explore how patient agency changed the material world of the

[19] Hide, *Gender and Class*.
[20] Hamlett, *At Home*, p. 7.
[21] Hamlett, *At Home*, p. 36.
[22] Hamlett, *At Home*, p. 36.
[23] Rebecca Wynter, '"Diseased Vessels and Punished Bodies": A Study of Material Culture and Control in Staffordshire County Gaol and Lunatic Asylum, c.1793-1866' (Unpublished PhD Thesis, University of Birmingham, 2007).
[24] Hamlett, *At Home*.
[25] E.g., Casella, *The Archaeology of Institutional Confinement*, pp. 84-143.
[26] E.g., Myers, 'Between Memory and Materiality', 231-45.
[27] Bergqvist Rydén, 'When Bereaved of Everything', 1-20.

asylum. Thus, the redesign, re-purposing or rejection of institutional material culture will be highlighted as both a mechanism and a manifestation of agency.

8.3 Methodology

Material culture offers useful insights into the experiences of institutional populations who did not leave their own written records. However, interpreting material culture requires its own methodology. As with buildings, objects do not contain a meaning to be 'read',[28] they are not merely receptacles containing meanings for the researcher to simply unearth. In relation to material culture, the historian's job is to detect and decipher the meanings which are embedded into objects and their context. This chapter will demonstrate the potential of cross-referencing objects, photographs and textual sources to appreciate the many potential meanings that objects could have to individuals in the past. However, contextualizing objects using case notes and other documentary sources should not preclude taking 'things' seriously. There is, in fact, an increasingly widespread call for researchers to privilege the object and move away from written sources altogether.[29] Privileging the object and abandoning the written record could serve the aims of scholars interested in doing medical history 'from below' especially well. As Sarah Pennell has suggested, objects provide us with access to the experiences of those people in the past who did not leave behind textual evidence of their lives.[30] However, the way in which objects from the asylum make their way into the historical record does not exclude the narratives of the 'dead white men' which Pennell sees as peculiar to written sources.[31] We do not encounter objects from Lancaster Asylum in an unshaped form, but as part of a museum collection which results from the particular interests and priorities of the curators of these objects.[32] The methodology of this chapter, therefore, remains committed to taking seriously the objects with which patients interacted, whilst also acknowledging the need for context.

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[28] Cf. Whyte, 'How Do Buildings Mean?', 153-77.
[29] Henry Glassie, *Material Culture* (Bloomington, IN: 1999), p. 48.
[30] Sarah Pennell, 'Mundane materiality or should small things still be forgotten? Material culture, micro-histories and the problem of scale', in Karen Harvey (ed.), *History and Material Culture: A Students Guide to Approaching Alternative Source*, p. 174.
[31] MacKinnon and Coleborne, 'Seeing and Not Seeing Psychiatry', in Coleborne and MacKinnon (eds.), *Exhibiting Madness in Museums*, pp. 3-13.
[32] See Chapter Three, pp. 65-6.

One way in which context can be provided is through casebooks, which can shed light on how patients misused or appropriated objects. The importance of this context can be explained by looking at an 'example object' from the collection: a chamber pot. When we encounter a chamber pot in the Lancaster Asylum collection, without reference to casebooks it could easily be interpreted unproblematically as a domestic item provided to patients by the asylum authorities. We might even read the chamber pot as an instrument of control or regulation. Chamber pots were provided to patients at night time so that they did not have to leave the room to use the lavatory. This would have been particularly important for ensuring that patients were kept in one place to be easily observed during the night time by a much smaller staff of attendants and nurses. We might unproblematically accept the chamber pot in the light of this interpretation of asylum domestic culture as part of a technology of control.

When viewed in the context of case notes, however, we see that chamber pots were very frequently used as makeshift weapons by patients. This appropriation of asylum property as a tool to facilitate resistive behaviour only becomes apparent through cross-referencing the object encountered in the museum collection with the references made to it in the case record. However, this cross-referencing should not preclude us from taking the object seriously. Analysis of the object itself can thus shed some light on why patients responded to them and re-purposed them in the ways that they did. The chamber pots in the Lancaster Asylum collection are porcelain, they are very large and extremely heavy.[33] The size and weight of the chamber pots go some way towards explaining why they feature so prolifically in case notes as a weapon. As this example illustrates, it is both possible and desirable to take objects seriously in their own right, whilst still providing context from textual sources.[34]

Photographs provide further insight into ways that objects were used. Photographs of how dayrooms, wards, galleries and other interior spaces were decorated can be useful for understanding how objects were arranged in asylum space. A range of images will therefore be referred to throughout the chapter to examine how objects were intended to be used in the asylum. In addition to photographs of the asylum interior, casebook photographs are also particularly useful in interpreting how patients responded to asylum clothing. Many of these images show how patients adapted their uniform dress, which again can be set in the context

[33] Lancashire Museum, Preston, Lancashire, LMH.
[34] Richard Grassby, 'Material Culture and Cultural History', *Journal of Interdisciplinary History,* 35(4) (2005), 591-604.

of comments made about such customization in case notes. Photographs themselves, however, are also subject to a number of methodological issues. Susan Sontag has argued that we are inclined to accept photographs as authoritative and trustworthy records of reality, and indeed that much of the value we place on photography derives from our faith in its apparent objectivity.[35] Yet photographs are far from objective, they are the result of particular preoccupations, of specific political, social and intellectual environments.[36] Photographs of rooms within the asylum used throughout this chapter must be treated as idealized versions of reality.

Through bringing together objects, photographs and casebooks, this chapter will explore the multiple ways in which patients' experiences interacted with the material world. Readings of contemporary medical textbooks, or a focus on asylum objects in isolation from their context yields understandings of material culture as part of a technology of control. However, by cross-referencing objects, photographs and casebooks, this chapter will suggest that objects had a multiplicity of meanings and purposes to both patients and staff in Lancaster Asylum that cannot be understood apart from the contexts in which those meanings and purposes were constructed. Material culture in the asylum was integral to attempts to control and manage patient behaviour, but it was equally essential to patients' attempts to exercise agency. The physical world of the asylum thus provides important insights into the relationship between agency and authority within the institution.

8.4 Home or Institution?

Casebooks demonstrate that patients frequently broke domestic objects in Lancaster Asylum. In the sample of casebooks used for this study, a total of 453 incidents occurred in which institutional objects were broken by patients.[37] The items most commonly targeted by patients were domestic objects – medical objects were rarely targets of patient damage. The

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[35] Susan Sontag, *On Photography* (Hamondsworth, 1979); Susan Sontag, *Regarding the Pain of Others* (London, 2004); pp. 29-37; Rawling, '"She Sits all Day"', 99-110; Rawling, 'Visualising mental illness'; Ludmilla Jordanova, 'Portraits, Patients and Practitioners', *Medical Humanities,* 39(1) (2013), 2-3; Susan Sidlauskas, 'Inventing the medical portrait: photography at the "benevolent asylum" of Holloway c.1885-1889', *Medical Humanities,* 39(1) (2013), 29-37.

[36] Jordanova, 'Portraits, Patients and Practitioners', pp. 2-3.

[37] For further details of the sample of casebooks used in this study see Chapter Three, pp. 55-63.

focus of patients was largely on items which were in place to create a feeling of homeliness within the institution. The number of incidents in which domestic objects were broken by patients suggests that the asylum's efforts to cultivate a home-like atmosphere were not successful. I suggest that breakages of domestic objects demonstrate patients' frustration with institutional life and dissatisfaction with their surroundings. Such actions were a means of rejecting the middle-class décor that had been chosen to make them feel more at home.

The types of objects which were most frequently broken by patients can shed some light on what damaging property meant to patients. Table 1 shows that window panes were by far the most frequently targeted object in Lancaster Asylum. This targeting of windows was not unique to Lancaster, Hamlett also notes the large number of broken windows in Hanwell and Long Grove Asylums.[38] There are several possible reasons for the frequency with which patients smashed windows, the most obvious being that they were relatively easy to access and to break. The perceived cost of glass may also go some way to explaining this trend. Glass was an expensive item, and the amount of glass in an institution the size of Lancaster Asylum represented a significant cost.[39] It appears that patients attempted to manipulate this by deliberately targeting windows when engaging in property damage. Indeed, the significance of window-breaking as a mechanism of protest has been observed in other institutional settings and in relation to broader working-class protests. David Green sees window breaking in London workhouses as a key way in which inmates resisted the institution.[40] Isobel Armstrong has also discussed the significance of window-breaking in Chartist protests.[41]

[38] Hamlett, *At Home,* p. 30.
[39] Henrie Louw, 'Window-Glass Making in Britain c.1660-c.1880 and Its Architectural Impact', *Construction History,* 7, (1991), 61-2.
[40] Green, 'Pauper Protests', 151-56.
[41] Isobel Armstrong, *Victorian Glassworlds: Glass Culture and the Imagination 1830-1880* (Oxford, 2008).

Object Damaged	Number of incidents
Windows	210
Plants	23
Crockery	19
Pictures	5
Ornaments	4

Table 2. Objects Most Frequently Broken by Patients in Lancaster Asylum

Breaking objects enabled patients to express dissatisfaction with their surroundings. On one occasion, Louisa C. 'Threw a cup of tea at a nurse because the cup was chipped' suggesting that she was dissatisfied with the quality of the object.[42] Ann S. was said to go about 'upsetting furniture and pulling down pictures', again directing destructive tendencies against domestic and decorative objects.[43] The tastes of those who decorated and furnished Lancaster Asylum were potentially very different from the tastes of its working-class patients. The fact that so many incidents of destructive behaviour were directed against decorative or domestic items may well be explained in this context. Even in cases where patients broke objects apparently at random, the fact that patients showed such disregard for the objects demonstrates the failure of the asylum's mission to use domesticity to 'civilise' the minds of the insane. Incidents in which objects were broken could be interpreted as a manifestation of patient frustration, as a way in which individuals were directing their anger towards the physical aspects of the institution. Mary B., for example, was said to be: 'In a state of continual ill-temper, and dissatisfaction at detention with exacerbations of acute excitement, cursing, swearing and stamping every day and occasionally breaking glass'.[44] Damaging the institutional interior directed Mary's anger about detention against the fabric of the building that detained her.

[42] LA, HRL/4/12/3/12, 30 Jun 1885-5 Dec 1886, p. 89.
[43] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 86
[44] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 65.

Damaging the physical world of the institution also represented a concerted effort to be difficult, to incur costs to the asylum and perhaps to be so destructive as to make patients' detention untenable. This method of displaying dissatisfaction with being kept in the asylum against their will was common with patients throughout the period. Even in the early twentieth-century, this tactic continued to be used to resist detention. The case notes of Joseph Francis J. demonstrate the continuity of this behaviour into the twentieth century: 'Today smashed a panel of glass in a door as a protest against his detention here and his not being allowed to go to service at the R. C. chapel'.[45] Many patients damaged property as a way to provide a 'consequence' for the failure of Asylum staff to meet their requests. Richard T. smashed windows in the asylum when his request for tobacco was not fulfilled: 'Two days after admission he wilfully broke a square of glass in a window because he had not got tobacco and threatened to break all the windows in the house'.[46] This incident is particularly interesting because it demonstrates that some patients perceived property damage as a way of gaining leverage. Richard broke just one pane of glass, however, he then threatened to break more, presumably if his request continued to be denied. The initial breakage thus appears to have been intended to demonstrate to the asylum authorities that Richard was willing to go through with his larger threat to break 'all the windows in the house'.[47] Thus, in a situation where patients found themselves in an inherently unequal power relationship, threatening to damage property may well have been perceived as one of the only 'bargaining chips' available to them. When patients destroyed asylum property, they were not just expressing frustration at their detention or at their requests for certain privileges or items being denied.[48] They were also engaging in behaviour which they believed provided them with an effective means of resistance.

Damaging property challenged the authority of the asylum; it not only incurred costs to the institution but was extremely disruptive and highly visible. Such challenges to institutional authority could not go unanswered and patients were punished in consequence of this behaviour. Occasionally, disincentives were focussed on the patient's body. For example, Michael M., was given a 'shower bath, blister to nape, seclusion and low diet for two days'

[45] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23410.
[46] LA, HRL/4/12/2/4, 21 Jul 1868-8 Dec 1870, p. 197.
[47] LA, HRL/4/12/2/4, 21 Jul 1868-8 Dec 1870, p. 197.
[48] Similar strategies have been highlighted in Mandler (ed.), *Uses of Charity*; Green, *Pauper Capital*, pp. 158-59.

after breaking a number of items in the asylum.[49] Following his window-breaking, Richard T. was also given a shower bath.[50] Patients' bodies were also targeted in less direct ways, through punishments that controlled their movement in the institution and their access to objects. Destructive patients were moved to other wards or placed in seclusion to discourage them from damaging property in future. Demotion to 'worse wards', which were more sparsely furnished, prevented patients doing any further damage to institutional objects by limiting their contact with domestic furnishings. On wards for 'turbulent' patients, there were fewer items to destroy, and as such, patients' ability to damage property was limited. Single rooms also contained very few objects other than a bed for the patient to sleep on. Furthermore, padded single rooms further limited patients' capacity to damage the asylum by preventing contact with walls, paintwork, and wallpaper. The ways in which the asylum sought to reassert its authority when patients damaged institutional objects directly corresponded with the ways in which patients asserted agency through the material world – objects and space were used to more tightly control patients' bodies and behaviour.[51] Often, this served only to propagate further incidents of destruction; the walls of padded rooms, for example, were frequently torn and ripped by those confined therein.[52] Asylum authority and patient agency thus operated in a self-perpetuating cycle in relation to the material world.

8.5 Objects of Cure or Weapons of Resistance?

Material culture was not only central to moral treatment in its capacity to cultivate a domestic aesthetic but was essential for facilitating the routines of domestic life and the productive employment of patients. For the institution to emulate the domestic situation of the family home, patients were provided with all the items necessary for daily household routines.[53] It was considered essential that patients were trusted to control their behaviour in a setting that emulated the family home, which entailed allowing patients access to everyday household objects. Examples of this can be seen in relation to patient dining, which, in order to emulate wider social practices allowed patients access to plates, teacups, knives and forks; objects

[49] LA, HRL/4/12/1/19, 15 Jun 1855-27 May 1857, p. 52.
[50] LA, HRL/4/12/2/4, 21 Jul 1868-8 Dec 1870, p. 197.
[51] Cf. Foucault, *The History of Sexuality*, pp. 95-6.
[52] E.g. Mary Amelia M., 'tore the walls of a padded room to bits also her bed mattress', LA, HRL/4/12/3/19, 23 Oct 1894-6 Apr 1896, p. 168.
[53] Hamlett, *At Home,* p. 36.

which clearly posed a potential risk in cases where patients were prone to injure themselves or others. Similarly, patients' rehabilitation was believed to be promoted through the insertion of productive work into their daily routine. Various occupations were available in the asylum depending on patients' gender. Many of these jobs required tools or equipment.

Asylums had a duty of care to patients; one of their main functions was the preservation of the lives of individuals prone to self-injury or suicidal impulses.[54] However, due to the importance that moral treatment attached to the necessity of trusting patients to exercise self-control, and to the civilizing influence of domestic interiors and routines, asylum authorities could not simply prevent all patients from accessing items like cutlery, crockery and work tools. Thus, a tension emerged wherein Lancaster Asylum staff had to simultaneously allow patients access to potentially dangerous objects, whilst also policing how those objects were used and by whom. Potentially hazardous objects were carefully regulated by the institution. For example, when meals were served, cutlery was counted when it was given out and when it was collected back in to ensure that patients could not secrete potentially dangerous objects to less supervised spaces.[55] Similarly, work tools were monitored through inventories, and patients who were believed to pose a significant risk were prevented from working in jobs that required the use of such items.[56]

The asylum's efforts to regulate potentially hazardous objects, however, was not always successful. Often, these objects were misused by patients to facilitate agentive behaviour. Many types of patient agency were dependent on the ability of patients to appropriate asylum objects, to use as tools to facilitate their actions. Patients who sought to escape had to overcome physical barriers by picking locks or breaking windows. Similarly, incidents of violence very often required weapons to be employed for maximum impact. Coping with institutional life often entailed personalization of asylum space which, again, required objects to be gathered, altered and arranged for decorative purposes. Even patients who engaged with life in the asylum could display their engagement through gestures involving material goods.

Patients' repurposing of asylum objects was particularly prolific in acts of resistance. Examples of this can be seen in how patient escape attempts were facilitated by misuses of

[54] York, 'Suicide, Lunacy and the Asylum', pp. 128-39.
[55] LA, QAM/5/38, *Report* (1841), p. 18.
[56] LA, QAM/5/38, *Report* (1841), p. 17.

objects provided by the asylum. Some patients accessed tools by taking them from the workshops in which they were employed. Thomas R. stole a chisel from the joinery workshop to escape: 'Cut his road through the wooden paling in New End yard by means of a chisel he had secreted from the joiners and made his escape'.[57] Not all patients were employed during their time in the asylum, and as such many individuals had to improvise tools out of everyday objects.[58] Thomas C. W.'s case notes describe the manufacture of tools: 'when he can collects material to make into picklocks and other instruments'.[59] Some patients did not manage to secure items necessary to pick the locks of their room, instead making creative use of furniture to escape.[60] John D. was apparently unable to open the door of his room, so sought an alternative route out of the institution: 'Some days ago reared his bedstead on end and made his way through the ventilator into the corridor'.[61] John's method of getting out of his room highlights how patients made use of ordinary domestic items to facilitate escapes.

In cases of escapes, objects that patients stole, made, or appropriated were essential to facilitating patients' plans. Other resistive behaviours were less dependent on objects, but still made use of them to make actions especially impactful. For example, in incidents of violence many patients used only their own bodies as weapons. However, there were a significant number of violent acts in which domestic objects were incorporated. Weapons often included objects that were provided to patients by the asylum as decorative or functional domestic items. Ornaments, vases, chamber pots, crockery and cutlery all feature prominently as having been re-purposed by patients for violent ends. On some occasions, domestic objects appear to have been used simply because they were at hand at the time that an incident unfolded. Acts of violence which occurred in dormitories frequently involved chamber pots as weapons, possibly because they were a movable item in an area which had very few such things. They were also easy to grab in a dormitory given that they were close by and, as mentioned earlier, although heavy, were not too difficult to lift and wield. It is also possible that they were used because their contents made them especially unpleasant for the victim. When Edward D. threw a chamber pot at an attendant, his case notes recorded not only the

[57] LA, HRL/4/12/1/11, 28 Jul 1840-26 May 1842, p. 98.
[58] Cf. Fiona Starr, 'An Archaeology of Improvisation: Convict Artefacts from Hyde Park Barracks, Sydney, 1819-1848', *Australasian Historical Archaeology*, 33 (2015), 37-54.
[59] LA, HRL/4/12/2/2, 12 April 1865-2 Feb 1867, p. 61.
[60] Tools for lock-picking were amongst assemblages from Alcatraz Prison: Conlin Casella, *The Archaeology of Institutional Confinement*, pp. 99-100.
[61] LA, HRL/4/12/2/9, 4 Feb 1879-13 May 1880, p. 241.

use of the object as a weapon but also remark that as well as throwing it at the attendant, the patient also 'emptied the content on his head'.[62]

Several incidents in which domestic objects were used as weapons highlight the premeditation that went into such acts. Isabella M., for example, attacked a patient using a 'mutton chop bone' that she had saved from dinner.[63] She did not attack the other patient in the Dining Hall, but smuggled the bone out and waited until she was on the stairs to commence her attack. Animal bones have been discussed in archaeological studies of institutions mainly as evidence of inmates' diet, however, the above incident suggests that such objects may also have been used as weapons.[64] The importance of weapons to fighting and violence in Lancaster Asylum can also be seen in the fact that several patients appear to have armed themselves with objects that could be used in conflicts. It appears that, for some patients, carrying around items that could be used as weapons was an important pre-emptive measure, perhaps even an act which could be understood as an attempt at self-defence. We can see this in cases like that of Nancy M. whose case notes describe her as having been extremely prone to fighting. The doctors noted that Nancy. 'carried cups about in her pockets for aggressive purposes as required'.[65] Even the most everyday items, like tea cups, could be turned to the purpose of self-defence by resourceful patients.

As well as re-purposing domestic items and work tools, patients made objects to facilitate acts of resistance. An example of the invention of such items can be seen in the case of William M. who assaulted another patient using a knife that was 'of his own make'.[66] Evidence from casebooks suggests that there may well have been an illicit market in manufactured weapons in Lancaster Asylum. In 1911, Thomas B. H. was caught with items in his possession which indicated that he had been selling weapons to his fellow patients: 'Found to have several small knives of recent manufacture, a file, some buttons and a sum of 14/- odd in his possession. It is believed he has been selling the knives'.[67] Although this was the only reference that explicitly mentioned a trade amongst patients, the fact that William M. was making knives as early as 1865 may point to the possibility of a longer history of a

[62] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23550.
[63] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 176.
[64] Cf. Eleanor Conlin Casella, 'Every Procurable Object: A Functional Analysis of the Ross Factory Archaeological Collection', *Australasian Historical Archaeology,* 19 (2001), 25-38.
[65] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 137.
[66] LA, HRL/4/12/2/2, 12 Apr 1865-2 Feb 1867, p. 47.
[67] LA, HRL/4/12/2/28, 18 Aug 1908-18 Feb 1911, no. 23693.

black-market trade in Lancaster Asylum. Such evidence highlights the proliferation of the use of weapons amongst patients, and it also points to the extent to which patients' acts of violence were premeditated – to source, purchase and secure a weapon would suggest a great deal of forethought.

Trade in contraband necessitated the creation of hiding places for the items being traded, and the money or goods accumulated as profit. Such hideaways have been observed in studies of other carceral institutions. Goffman discusses the ways in which patients found personal or secret storage locations to hide illicit goods or personal effects throughout the psychiatric hospital in which his study was based.[68] Eleanor Conlin Casella also discusses how patients managed to maintain access to forbidden objects in prisons through their concealment of such items in hiding places.[69] Hamlett has also examined the importance of such hiding places for smuggling personal objects into Common Lodging Houses, especially identifying mattresses as a common hiding place.[70] Such practices are also evident in patient behaviour in Lancaster Asylum. One frequently mentioned hiding place was patients' mattresses in which items could be concealed from staff observation.[71] Other patients hid items upon their person, making use of pockets in clothing to do so. Items intended to be used as weapons were also concealed in patients' clothing to ensure they were close to hand when necessary, as seen in relation to Nancy M's arsenal of teacups.[72] This tactic could also be a way of preventing other patients from finding a 'stash' of personal or prohibited belongings.[73] This may have been an especially important consideration for patients who were trying to hide items which had been stolen for their fellow inmates. Bernard C., for example, was a particularly prolific thief: 'Much given to thieving and concealing all manner of things about his person'.[74]

The existence of an illicit trade in weapons points to a black market economy in Lancaster Asylum.[75] The illicit trade in knives, which made one patient a sum of 14 shillings

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[68] Goffman, *Asylums*, pp. 248-54.
[69] Conlin Casella, '"Doing Trade"', pp. 214-5.
[70] Hamlett, *At Home*, pp. 129-30.
[71] LA, HRL/4/12/2/2, 12 April 1865-2 Feb 1867, p. 61.
[72] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 137.
[73] Goffman, *Asylums*, pp. 253-4.
[74] LA, HRL/4/12/2/9, 4 Feb 1879-13 May 1880, p. 253.
[75] Trading goods has been considered a significant mechanism of inmate resistance in carceral institutions, see, Vergil Williams and Mary Fish, *Convicts, Codes and Contraband: The Prison Life of Men and Women* (Cambridge, MA, 1974); Casella, '"Doing Trade"', 209-

(as well as several other items that appear to have been traded in kind), also points to the fact that many patients managed to find ways to both bring money into the Asylum, and to make money while they were a patient.[76] This explains, perhaps, how those patients who made requests for certain goods to be provided to them (discussed in Chapter Five) may have paid staff for items such as tobacco or newspapers. Furthermore, it explains how those patients who ran away and went into the local town to visit a pub (Chapter Four), were able to afford to do so, as well as how those who evaded capture completely might have been able to support themselves after their escape. Thus, we see that in addition to the material culture that was created for patients by the asylum, there was clearly also a separate (but linked) patient-generated material culture that shaped patients' capacity to exercise agency in the institution, and, in some cases, beyond its walls.

Having considered the ways in which asylum objects could become tools for resistance, it is worth noting that not all appropriations of asylum objects were resistive. Indeed, in some cases patients' re-purposing of domestic objects were not just tolerated, but actively encouraged. Patients' misuse of objects to improve their ability to look after themselves appears to have been a use of asylum property that was sanctioned by institutional authorities. This sanctioning of patient appropriations of property appears to have occurred because it made the jobs of staff easier. This can be seen in cases in which patients made use of objects to improve their ability to get around independently of staff assistance. Nancy M., for example, was unable to walk unassisted and managed to overcome this by 'pushing a chair before her'.[77] Similarly, John L. was assisted in moving about the asylum by his fellow patient James H. who used a wheelbarrow to move him from place to place.[78] Thus, when it made the work of staff members easier, the misuse and re-purposing of objects by patients was apparently permissible. Some patients also attempted to use asylum objects as favours or mementos to give to staff in expression of their gratitude for asylum treatment. Jane F.'s case notes describe such behaviour: 'stuffs rags, odds and ends in pockets of the Medical Officer as keep sakes'.[79] In such instances, these behaviours appear to have been tolerated because of their apparent association with patient gratitude. Despite the fact that such actions still

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21; Conlin Casella, *The Archaeology of Institutional Confinement,* pp. 79-81; Peter Davies, 'Destitute Women and Smoking at the Hyde Park Barracks, Sydney, Australia', *International Journal of Historical Archaeology,* 15(1) (2011), 82-101.

[76] Cf. Suderland, *Inside Concentration Camps,* pp. 135-9.

[77] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 137.

[78] LA, HRL/4/12/2/9, 4 Feb 1879-13 May 1880, p. 208.

[79] LA, HRL/4/12/3/25, 9 Jan 1900-8 Mar 1901, p. 114.

undermined the intended uses of asylum objects, they were condoned because they did not disrupt asylum authority but reinforced it.

8.6 Damage or Decoration?

Many individuals used, or misused, asylum objects to adjust or adapt to institutional life. Actions towards objects that were interpreted as destructive or disruptive by asylum authorities could hold different meanings for patients who intervened to alter the material world to make the institution feel more like a home. One particularly common way in which patients adapted asylum objects was in relation to the decoration and personalization of institutional space. Elizabeth S. arranged a number of items around her bed in the dormitory: 'Collects rubbish about her bed which nurse removed in her absence and for this she threatened to thrash the nurse'.[80] The way in which this behaviour is discussed in the case notes highlights how asylum authority and patient agency could come into conflict in relation to material culture. The material arranged around Elizabeth's bed was evidently important to her, this is evident in her reaction when the objects were removed. Her case notes, however, dismiss the collection of objects as 'rubbish'. The nurse removed the objects without consulting the patient, presumably because items strewn around beds in dormitories were potentially a hazard. They also most certainly interrupted the carefully cultivated middle-class domesticity of the room. Such conflicts over personalisation reflect, perhaps, the differing interpretations of domesticity held by asylum authorities and patients. As discussed above, the middle-class interiors of institutions like Lancaster Asylum were unlikely to convey the type of domesticity with which working-class patients were familiar.[81] Elizabeth's arrangement of items, dismissed as 'rubbish' by asylum authorities, could, from her perspective, have been an effort to make institutional space feel more personal, perhaps even more like home.

Indeed, interventions that asylum authorities interpreted as attempts to damage or deface institutional objects or spaces held quite different meaning for patients. One such incident can be seen in the case notes of Thomas C. W.:

[80] LA, HRL/4/12/3/6, 18 Dec 1874-4 Oct 1877, p. 131.
[81] Hamlett, *At Home,* p. 36.

> Attention was directed a few days ago to the door of his single bedroom it bore marks of having been cut with some sort of knife till in some parts it was cut through. A search was made and several pieces of sharpened hammer head tied to a strip of flannel and other implements were found about his bed and person beside large quantities of old papers, notebooks containing medical prescriptions, absurd writings and miscellaneous rubbish.[82]

The carvings on the back of Thomas' door were seen as a destructive act in his case notes, however, they could equally be understood as graffiti.[83] This interpretation is especially likely when we consider the other items found in Thomas' room including old papers, notebooks and other writing materials. The damage done to property in this case seems to have been less concerned with the destruction of asylum objects, and more with personalizing them, or leaving a mark on the institution.[84] Cocroft *et. al.* argue that spontaneous graffiti could also be a means of 'subverting a hated structure'.[85]

Adapting asylum objects also served as a mechanism of self-expression, a means of maintaining connections to pre-institutional identities. For example, Sarah W. made items of needlework which she wanted to send to her friends.[86] Similarly, Mary M. sewed decorative items which incorporated the names of people she knew from her home town: 'Won't occupy herself, except in doing what she considers fancy work working names of Dublin people she knew in thread on pieces of rag'.[87] The creation of decorative items could be seen, not just as a way of occupying time in the Asylum, but also as a means of self-expression. For Sarah W., sending needlework to her friends may have allowed her to maintain friendships and networks outside the institution. For Mary M., embroidering the names of people she had known prior to her admission may be understood as a way of recording her story, or remaining connected to her pre-institutional self. Similar uses of embroidery by female inmates have been explored elsewhere, highlighting their function as a medium of story-telling, self-expression, and even resistance. Lorina Bulwer, an inmate of a workhouse in Norwich, created embroideries which give a remarkable account of her life and her

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[82] LA, HRL/4/12/2/2, 12 April 1865-2 Feb 1867, p. 61.
[83] W. Cocroft, D. Devlin, J. Schofield, and R. J. C. Thomas, 'The Art of War', *British Archaeology*, 86 (2006), 44-7.
[84] Cf. Myers, 'Between Memory and Materiality', 231-45.
[85] Cocroft, et. al., 'The Art of war', p. 47.
[86] LA, HRL/4/12/3/25, 9 Jan 1900-8 March 1901, p. 159.
[87] LA, HRL/4/12/3/11, 25 Sept 1883-27 Jun 1885, p. 264.

experience of the workhouse. Her stitched words proclaim her anger at her incarceration and offer up objections to her situation.[88] Agnes Ritcher, a patient in Hubertusberg Asylum, Germany, in 1895 created a jacket from the asylum clothes with which she had been provided which incorporated complicated and difficult to decipher lettering which told her story.[89] Rather than demonstrating adherence to gender norms, these women used embroidery as a means to tell their own stories and to create a platform for their voices.[90]

8.7 Uniform or Clothing?

Patient clothing was another aspect of the asylum's material culture that was particularly important to asylum authority and to patients' expressions of agency. Although it could be deployed as a technology of control, clothing could also be adapted by patients. Uniforms were a particularly important element of control in several nineteenth-century institutions, particularly workhouses and prisons.[91] Several studies of the dress of inmate populations have seen uniforms as a means of making inmates compliant with a controlling regime, or as a tool by which feelings of guilt and shame might be cultivated.[92] Uniform and physical appearance have continued to be understood as a means to classify and punish convicts in studies focussing on overseas penal colonies. Clare Anderson discusses the different ways in which the authorities in British penal colonies in South and Southeast Asia used uniforms to identify convicts and classify them according to their status and sentence.[93] Joy Damousi has argued that gender influenced the responses of inmates to institutional dress, noting that issues of appearance and dress had a particular impact on women.[94]

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[88] 'Sampler' by Lorina Bulwer, Norfolk Museums Collection, NWHCM: 2004.824.1, http://norfolkmuseumscollections.org/collections/objects/object-548002897.html [accessed 12 December 2017].
[89] Gail A. Hornstein, *Agnes's Jacket. A Psychologist's Search for the Meanings of Madness* (New York, 2009)
[90] Rozsika Parker, *The Subversive Stitch. Embroidery and the Making of the Feminine* (London and New York, 2010), p. 19.
[91] Vivienne Richmond, *Clothing the Poor in Nineteenth-Century England* (Cambridge, 2013).
[92] Foucault, *Discipline and Punish*; Ignatieff, *A Just Measure of Pain*; Norman Longmate, *The Workhouse: A Social History* (London, 2003); M. Maynard, *Fashioned from Penury: Dress as Cultural Practice in Colonial Australia* (Cambridge, 1994).
[93] Anderson, 'Fashioning Identities', 152-74.
[94] Joy Damousi, '"What punishment will be sufficient for these rebellious hussies?" Head shaving and convict women in the female factories, 1820s-1840s', in I. Duffield and J.

Social control analyses, however, do not adequately account for clothing practices in English asylums. During the nineteenth-century, the nascent psychiatric profession did not recommend the imposition of uniforms on patients, seeing this as detrimental to recovery.[95] Patients admitted to institutions like Lancaster Asylum were given a set of clothing on admission to ensure that communicable diseases were not brought in to the institution. To economize in the provision of clothing, bulk-purchasing was common which meant that all patients wore similar garments, thus a uniform-like effect was created.[96] Patients in Lancaster Asylum therefore, did not have to wear a uniform. However, they were also not allowed to wear their own clothes. Uniforms were not intended as a technology of control in the asylum, indeed uniforms were widely discouraged by the asylum profession. Yet, that is not to say that clothing did not *become* an important means through which the asylum asserted its authority as these institutions developed.

The use of strong dress - garments with which patients were restrained – can be seen as a significant manifestation of asylum authority through clothing. Strong dress provided an alternative to handcuffs or chains in dealing with difficult or violent patients in a period when mechanical restraint had been rejected. Strong dress was used in cases where patients were particularly destructive of clothing, and in some cases, it was used when patients were particularly violent, doing harm to others and themselves.[97] Though the use of secure dress persisted throughout the period, it was deployed in a limited fashion. Indeed, only 16 cases in the sample used in this study mention the use of secure dress. Although this is likely an underestimate of its use, given that records of mechanical restraint were kept separately from the casebooks, it points to the fact that after 1840, restraint in any form was considered undesirable. As Wynter points out, however, the fact that it was used less made it even more stigmatizing, marking out patients who were forced to wear it as exceptionally badly behaved.[98]

Bradley (eds.), *Representing Convicts: New Perspectives on Convict Forced Labour Migration* (Leicester, 1997), pp. 204-17.

[95] J. Mortimer Granville, *The Care and Cure of the Insane. Being the Reports of The Lancet Commission on Lunatic Asylums 1875–6–7 For Middlesex, the City of London and Surrey*, (London, 1877), vol. II, p. 173.

[96] Wynter, "'Good in all respects'", p. 46.

[97] LA, HRL/4/12/2/24, 17 Feb 1905-21 Dec 1905, p. 195.

[98] Wynter, "'Good in All Respects"', p. 51.

Strong dress was used most often in cases where patients persistently damaged their clothing. For some patients, damaging clothing represented an act of resistance to their detention. Alice W., for example, resisted getting dressed and undressed, which was part of a wider pattern of resistant behaviours that she deployed in response to her detention. Her case notes state: 'within the last few days she has become more obstinate only does a little sewing, refuses to do what she is requested to do, does not dress or undress herself willingly, refuses to come to her meals, appears to have some delusion about her detention'.[99] Alice's refusal to comply with clothing was thus part of a range of tactics she adopted in relation to the 'delusions' she had about her detention. Henry H. even more explicitly used clothing to resist his detention: 'Takes off his clothes and says he does so because he desires his liberty.'[100] Such uses of clothing parallel inmate resistance in other institutions. Seth Koven, for example, has argued that individuals in workhouses destroyed clothing to resist institutional authority and force the workhouse officials to pay for replacement garments.[101] Asylum's use of strong dress to assert its authority over patients who damaged clothing was thus a response closely linked to the behaviour it sought to address.[102] Destruction to clothing was controlled by the enforcement of more punitive standards of dress. This highlights, again, the reciprocal relationship between the agency of patients and the authority of the asylum.

The destruction of clothing by patients, however, sometimes had quite a different purpose. In several cases, damage to uniforms can be understood along the same lines as examples of patient graffiti – as a method of personalizing or customizing uniforms. Elizabeth M. S. tore her clothing to make a pattern around the border of her apron, thus customizing her asylum dress. Her case notes recorded that she, 'tears edges of her clothes and makes fringes to the borders'.[103] Even though a previous note in her case record stated simply that she had been 'destroying all [of] her clothes', the subsequent entry suggests that this was not simply a matter of damaging her dress.[104] The deliberate fraying of the edges of her garment suggests the production of a pattern. What one doctor interpreted as destructive

[99] LA, HRL/4/12/1/21, 22 Jan 1859-8 Jun 1860, p. 202.
[100] LA, HRL/4/12/2/7, 28 Jul 1875-26 Jun 1877, p. 162.
[101] Seth Koven, *Slumming: Sexual and Social Politics in Victorian London* (Princeton, NJ, 2004), p. 69.
[102] Cf. Foucault, *The History of Sexuality*, pp. 95-6.
[103] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 171.
[104] LA, HRL/4/12/3/15, 15 May 1889-15 Aug 1891, p. 171.

behaviour, another explained as constructive behaviour – an attempt to alter her dress through customization of the fabric.

Jane Hamlett and Lesley Hoskins have explored how asylum dress could be used by patients to reclaim their individuality within the asylum. Their study of Brookwood County Asylum demonstrated how adapting asylum uniforms and retaining small personal effects allowed patients to retain a sense of identity through dress.[105] Similarly, the jacket which Agnes Ritcher wore during her stay in Hubertusberg Asylum highlights the centrality of clothing to patient identity. This was an item Agnes had made herself out of clothing she had been given by the institution. She adapted the ill-fitting asylum garment to make a tight-fitting, tailored jacket which not only demarcated her individuality, but also told her story and experience of madness through the stitching.[106]

Not all alterations to their appearance made by patients were viewed in a negative light. Indeed, many asylum doctors viewed appropriate attention to appearance as a sign of recovery, considering that it showed evidence of an increased amount of self-respect.[107] Such positive changes may not have been mentioned in casebooks, given that they did not necessarily require management. In fact, when describing patients who were unproblematic, it was more common for doctors to make very general comments such as, 'goes on well' or 'continues to improve'. Very rarely was casebook space devoted to describing the specific evidence of such improvements. Therefore, we must look to other sources if we are to understand how patients expressed their identities through clothing in cases where such expressions were viewed positively. The photographs of patients within casebooks are frequently a far richer source of information in this regard. Although not without their own set of methodological issues, asylum photographs can provide an interesting window into the ways in which patients customized their appearances.[108] It is important to bear in mind when considering clothing as depicted in casebook photographs, that these images were approved by asylum doctors. Any customization of clothing that was seen as negative, as challenging

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[105] Hamlett and Hoskins, 'Comfort in Small Things?', 93-114.
[106] Hornstein, *Agnes's Jacket*.
[107] Richmond, *Clothing the Poor*, p. 292.
[108] For more on the methodological issues of utilizing asylum photographs see, Tagg, *The Burden of Representation*; Mark Jackson, 'Images of Deviance: Visual Representations of Mental Defectives in Early Twentieth Century Medical Texts', *British Journal for the History of Science*, 28(3) (1995), 319-37**;** Rawling, 'Visualising mental illness'; Sidlauskas, 'Inventing the medical portrait', 29-37.

gender norms, or reinforcing patients' insanity may well have been disallowed from the photography studio. We should also recall that medical portraiture did not exist in a vacuum and was heavily influenced by wider trends in portrait photography.[109] As such, we might expect that dressing up and posing for photographs was influenced by patients' experience of photography outside the institution. This may mean that the personal adornments we see in the casebook photographs were not part of patients' everyday attire but were attempts to look their best.

[109] Jordanova, 'Portraits, Patients and Practitioners', 2-3.

Figure 17. Selina P. (left), Margaret M. (centre), Joseph R. (left).

Nevertheless, the photographs give some insight into how patients presented their 'best' face in the institution. For many patients this meant customizing clothes by making adding various adornments. This can be seen in Selina P.'s photograph which shows the addition of a lace collar and a brooch made from flowers (Fig. 17). The lace collar is likely to have been made by Selina during the leisure time that women spent sewing. Selina was employed in the dairy, thus it is unlikely that this was the product of the time she spent employed there.[110] Since women were expected to sew for their main 'productive' occupation in many cases, as well as during their leisure time, it might well be that sewing for leisure was more closely linked to the production of such decorative items rather than the mending or production of regular asylum clothing. Similarly, her brooch is probably an item made during leisure time spend doing crafts. Selina thus customized her uniform by adding items to it that she had made herself.

Margaret M. (Fig. 17) customized her uniform simply by wearing the items with which she had been issued in a slightly altered fashion. We can see from her photograph that she chose to wear the bonnet with which women were provided, even though many women did not. Margaret also appears to wear a blanket reconfigured as a shawl, again using asylum provided fabrics to create a slightly altered appearance.[111] Joseph R., on the other hand, apparently did very little to alter his uniform. What is most individual in Joseph's appearance is his carefully groomed beard. This decision to cultivate facial hair must be read as a conscious one, since, based on photographs of other male patients, asylum residents were allowed to shave. Joseph's beard is also carefully shaped, it is not simply the result of overgrowth but the work of careful styling and cultivation.[112] As such we might see Joseph's decision to grow a beard as an expression of his subjectivity, perhaps linked to wider social currents in Victorian society whereby beards were closely linked to notions of manliness and masculinity.[113] Joseph's expression of masculinity was evidently considered appropriate by asylum doctors, since he was photographed with his beard. However, where patient adaptations to their appearance challenged Victorian gender norms, it was viewed as

[110] LA, HRL/4/12/3/8, 11 Oct 1879-9 Mar 1881, p. 47.
[111] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 90.
[112] LA, HRL/4/12/2/16, 25 Jul 1888-31 Mar 1891, p. 225.
[113] Christopher Oldstone-Moore, 'The Beard Movement in Victorian Britain', *Victorian Studies*, 48(1) (2005), 7-34.

evidence of insanity.[114] Sarah Y.'s case notes described how she, 'Parts her hair at the side like a boy and refuses to have it done otherwise'.[115] Sarah's hair styling challenged Victorian gender norms, perhaps explaining why doctors felt that such behaviour was noteworthy to record in her casebook.[116]

Personalization of appearance not only allowed patients to reassert their individuality in the asylum, but also to continue to participate in social life outside the institution. Continued interest in fashion could present patients with a means of continuing to participate in the world outside the institution.[117] Pride in self-presentation could also allow some patients an element of self-respect, or perhaps even a sense of control in an institution where the rhythm of daily life was dictated by the Asylum timetable. Margaret M. refused to work unless 'all her clothes are changed daily'.[118] This preoccupation with, and insistence upon, extremely high standards of personal hygiene seems to indicate that Margaret wished to maintain her individuality, self-respect, and to distance herself from the stigma of asylumdom through the maintenance of high standards of personal appearance. Indeed, asylum clothing appears to have been viewed by many patients as evidence of the taint of institutionalization and a number of individuals rejected asylum clothing because of the stigma it denoted. Elizabeth B. asserted her objections to asylum clothing on the basis of their connection with patient status: 'Anxious to have good clothes and be an officer here…. objects to food, clothes, being associated with patients etc.'.[119] Rejecting patient clothing in this way could therefore be a way of rejecting patient status, and in some cases maintaining a connection to the outside world. Indeed, wearing one's own clothes was very closely associated in the minds of many patients with obtaining discharge. Jane B.'s case notes describe this belief succinctly noting that she was difficult 'to dress in patients clothes as she wants to go away'.[120]

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[114] Quintin Colville, 'Jack Tar and the Gentleman Officer: The Role of Uniform in Shaping the Class- And Gender-Related Identities of British Naval Personnel, 1930-1939', *Transactions of the Royal Historical Society,* 13 (2003), 105-29.
[115] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 64.
[116] For further discussion of the influence of gender on psychiatric thought see, Showalter, *The Female Malady*; Busfield, *Men, Women and Madness*; Jane Ussher, *Madness of Women: Myth and Experience* (Hove, 2011).
[117] Wynter, '"Good in All Respects"', p. 46.
[118] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 90.
[119] LA, HRL/4/12/3/6, 28 Dec 1874-4 Oct 1877, p. 130.
[120] LA, HRL/4/12/3/25, 9 Jan 1900-8 Mar 1901, p. 43.

Clothing was not, however, used merely to demarcate patient status, but also to differentiate between individuals of different status within the asylum. Private patients, for example, were allowed to wear their own clothes, thus marking out their membership of a higher social class.[121] Similarly, patients were distinguished from staff through the uniforms worn by nurses and attendants which clearly displayed their status within the asylum and thus reinforced their authority over the patients. Such hierarchies could, however, be disrupted; in several instances patients' uses of clothing destabilized the authority of asylum staff. Phoebe H.'s case provides an example of such uses of clothing: 'impersonates nurses and goes about the wards in a cap and print dress'.[122] There were also more subtle gradations to the institutional hierarchy than the staff/patient split, and some patients appear to have sought to communicate through their clothing. Joseph R. for example (Fig. 17) was a 'trusted patient'. This meant that he was allowed privileges within the institution that were forbidden to others because, based on his long-term behaviour, he was not a risk to himself, to others, or in terms of attempting to abscond. Due to his trusted status, Joseph was given extra responsibilities and more freedom than other individuals. He was trusted to carry messages between staff on different wards in the Asylum as his main occupation, meaning that he had a remarkable degree of free movement around the institution.[123] His status as a trusted patient was evidently a source of great pride to Joseph, who customized his uniform to reflect his privileged position. His case notes state that he 'Adorns his clothes with two-penny, half-penny ornaments in which he takes much pride'.[124] This behaviour was clearly seen as noteworthy, but perhaps more as an eccentricity than evidence of insanity. Nonetheless, although Joseph was allowed to wear his 'medals' during his day-to-day activities, they were removed for his casebook photograph.

Clothing was an important tool in facilitating patient agency, but it remained significant as a tool for controlling patient behaviour, making it a site of great tension. The clothing with which patients were provided may well have been rejected and damaged by them, but the institution responded to such behaviour through the deployment of strong dress, as discussed above.[125] Clothing was thus modified in response to patient agency. In cases of escape, clothing was a particularly important part of the Asylum's efforts to re-establish

[121] Wynter, '"Good in All Respects"', pp. 45-6.
[122] LA, HRL/4/12/3/33, 21 Mar 1908-3 Sep 1909, p. 169.
[123] LA, HRL/4/12/2/16, 25 Jul 1888-31 Mar 1891, p. 225.
[124] LA, HRL/4/12/2/16, 25 Jul 1888-31 Mar 1891, p. 225.
[125] Wynter, '"Good in all Respects"', p. 51.

control over the patient. In some cases, caution cards were given to run-aways which patients had to carry to inform staff that they were a 'flight risk'. In more extreme cases, however, clothing itself was a key institutional response to escapees. This is demonstrated in the case notes of John B. which state: 'Yesterday slipped away from walking party but was shortly afterwards brought back. Ordered to have on white clothes in future'.[126] It appears, based on casebook evidence, that the Asylum authorities dressed persistent runaways in white clothing to mark them out as a 'flight risk'.

This white uniform not only served to make risky patients visibly to staff, especially if they made their escape at night time, but also marked out patients to their fellow residents. It simultaneously controlled, classified and punished.[127] Given that asylums were not intended to punish the individuals which they housed, but rather to care and cure for them, the use of uniforms in classifying patients was (theoretically) limited. In practice, however, the use of strong dress for destructive patients and the deployment of white clothing for persistent runaways clearly demonstrates that institutional authority was re-asserted over the bodies of patients through their clothing. Patient agency, particularly where that agency was resistive, was thus responded to through interventions in the material world, making the objects that surrounded the patient more rigorously controlling. The relationship between agency and authority in the institution was thus productive, generating changes in institutional practices in Lancaster Asylum.

8.8 Conclusion

Objects were central to how patients exercised agency, and to how the Asylum asserted its authority. The material world of the institution provides an interesting theatre in which the interaction between patient agency and asylum authority can be examined. It reflects many of the aspects of this relationship that have been highlighted in the preceding chapters. When patients were confronted with a particular type of décor, or a particular style of clothing, they could adapt, alter or intervene with it to make it their own. Patient uses of objects frequently went beyond how the asylum intended these items to be deployed, and they often facilitated rather than limited expressions of agency. However, just as patients could negotiate the

[126] LA, HRL/4/12/2/16, 25 Jul 1888-31 Mar 1891, p. 255.
[127] Maynard, *Fashioned from Penury*, p. 21; Richmond, *Clothing the Poor*, p. 284; Anderson, 'Fashioning Identities', pp. 165-7.

material world provided by the asylum authorities to exercise agency, the Asylum could also reassert its authority over patients through the material world. We see these attempts at re-establishing authority very clearly through patient clothing. In cases where patients destroyed their clothes, the asylum responded by placing them in strong dress, placing the body of the patient under a very particular kind of restraint.[128] Patients who attempted to escape had to carry a caution card and, in some cases, to wear white clothing which clearly and publicly declaimed their misbehaviour. Material culture, then, was clearly important to the re-establishment of asylum authority in opposition to patient agency. We thus once again see the symbiotic and reciprocal nature of patient agency and asylum authority embodied in institutional objects. Asylum authority produced some patients' attempts to re-assert agency, which in turn required the reassertion of asylum authority, which produced yet further manifestations of patient agency. The cyclical nature of this relationship is clearly visible through the materiality of Lancaster Asylum.

[128] Wynter, '"Good in all Respects"', p. 41.

9. Conclusion

This thesis has explored the various ways in which patients in Lancaster Asylum exercised agency in the institution. It has been demonstrated that, despite the inherently controlling nature of psychiatric medicine in this period, patients could exercise agency over their lives in the asylum. Through complex and often overlapping strategies of resistance, accommodation and engagement, patients navigated the institution. The strategies that patients adopted were shaped by the structures of institutional life, medical authority, and the broader social, cultural, and economic structures of nineteenth and early-twentieth century society. Equally, the structures of institutional life were affected and, at times, altered by patient agency. Patient agency, therefore, operated at two interrelated levels in Lancaster Asylum. Firstly, patients' day-to-day agentive behaviours allowed them to negotiate the terms of their confinement and materially alter their lives in the institution. Secondly, patients' day-to-day actions, and the responses that those actions elicited from asylum authorities, cumulatively impacted the development of the institution.

Key to understanding patient agency in the asylum is the framework of agency suggested by this thesis. I have argued that where current scholarship on the asylum has addressed the question of whether patients could exercise agency in the institution, it has equated agency with resistance.[1] A similar collapsing of agency and resistance can be seen in studies of the inmates of other carceral institutions, including prisons and workhouses.[2] I have suggested that this is not an idiosyncrasy in histories of psychiatry or of the institution, but the product of the continued usage of a fundamentally flawed definition of agency that operates in the field of social history.[3] This definition hinges on an understanding of agents as rational, self-conscious, and articulate; a definition that disbars a whole host of marginalized social groups, including asylum patients, from any claim to historical agency.[4] This is not merely a relic of histories that were 'modernist, essentialist, masculinist, or Eurocentric'[5], but also the result of the marshalling of history to galvanize marginal groups to resist their

[1] Green, 'Pauper Protests', 137-59; Clark, 'Wild Workhouse Girls', 389-409; Crossman, 'The New Ross Workhouse Riot of 1887', 135-58.
[2] MacLeod, 'Hegemonic Relations', pp. 533-57.
[3] Ahearn, 'Language and Agency', pp. 115-6.
[4] Maynes, 'Age as a Category of Historical Analysis', pp. 114-24.
[5] Conlin Casella, *The Archaeology of Institutional Confinement*, p. 72.

oppressors.[6] This has resulted in resistance being romanticized, and other mechanisms of agency being dismissed as docility.[7]

The definition of agency adopted in this thesis has, therefore, included patient resistance, coping mechanisms and active engagement in its analysis of patients' responses to the institution. Chapter Four discussed patients' strategies of resistance in the asylum which included tactics through which patients rejected their detention or at least components of the institutional regime. Patients resisted their detention through complaining to authorities inside and outside of the institution about their situation, through refusing to participate in medical interviews or physical examinations, running away and occasionally through violence to members of staff. These mechanisms of resistance overtly challenged institutional authority, which often meant that asylum authorities sought to decisively, sometimes even violently, quash such behaviour. This meant that unless such mechanisms of resistance went undetected – as in cases where patients successfully escaped – their efficacy in allowing patients to achieve their goals was limited. Other mechanisms of resistance focused on specific elements of the institution including work, food, or treatment by attendants. Patients could refuse to work, complain about food quality and make official complaints about incidents in which attendants had used violence or excessive force. These targeted forms of resistance could be more successful, particularly when patients drew on their knowledge of their rights in the asylum and institutional mechanisms of complaint. Yet, despite their success rates, these mechanisms of resistance necessitated a tacit acknowledgement of institutional authority. Thus, despite their intention to resist their treatment in Lancaster Asylum, such instances of targeted resistance actually resulted in the affirmation of institutional authority.

Discussion of patient coping mechanisms as agency in Chapter Five explored how patients sought to make their lives within Lancaster Asylum more comfortable by modifying aspects of their confinement rather than resisting it. Patient coping mechanisms afforded them privileges, benefits or perks in the institution, which mitigated some of the deprivations of confinement. These behaviours paralleled the ways in which 'colonized' patients in Erving Goffman's *Asylums* 'worked the system' to maximise their comfort in the psychiatric hospital. As with Goffman's patients, many of the coping strategies adopted by Lancaster

[6] Ahearn, 'Language and Agency', p. 115.
[7] Abu-Lughod, 'The Romance of Resistance', pp. 41-55.

Asylum patients rested on their knowledge of the institution which allowed them to identify ways in which to manipulate opportunities available within the institution to their own advantage.[8] Benefits were obtained by patients who were able to participate in, and thereby control, the construction of their institutional identity, those who requested certain medical treatments, certain wards, or work assignments. By gaining access to these benefits, patients derived a degree of power within the institution, and at times this was not just power over their own lives but also over other patients. This demonstrated that power relations within the asylum were not hierarchical, filtering down from the superintendent, through ranks of medical officers, attendants, auxiliary staff, to be exercised *over* patients. Instead, I suggest that patients' ability to manipulate cracks in institutional authority demonstrated that institutional power structures in asylums were heterarchical. This also highlights that patient coping mechanisms, despite being half-measures that were not aimed at outright resistance, could be more effective in affording patients agency. This further problematizes the conflation of agency and resistance, underlining the value of the approach to agency suggested by this thesis.

The importance of patients' active engagement with the asylum further undermines models of agency focused only on resistance. Patient engagement was frequently based on their perception of the asylum in terms of the treatment it offered and in terms of the other options that were available to them outside of the institution. Building on scholarship which has highlighted the intersection of medical and lay understandings of disease, I suggest that the engagement of many patients with life in Lancaster Asylum was based on their belief in the curative power of the institution. Due to the coincidence of lay and medical understandings of insanity and its treatment, some of the patients who entered Lancaster Asylum did so willingly, and once admitted engaged wholeheartedly with treatments offered therein in efforts of attain a cure. Such patients were key to maintaining order within the institution, often acting to uphold institutional regulations and monitor the behaviour of other patients, taking on quasi-staff roles. Patient engagement also had a secondary function, that of bolstering the confidence of doctors in Lancaster Asylum through affirming the efficacy of their treatment. This confirms the suggestions made by Regina Morantz-Sanchez and Charles Rosenberg that patients could affect the self-image of medical professionals, and their

[8] Goffman, *Asylums*, pp. 197-203.

confidence in their ability to treat disease.[9] Due to its function in supporting institutional authority, active engagement was not only permissible but positively encouraged by asylum authorities at Lancaster and could afford patients a significant degree of agency in the institution.

Patient agency was further facilitated and limited by the spatial and material world of Lancaster Asylum. An examination of the built environment of Lancaster Asylum and the material culture contained within it in Chapters Seven and Eight highlights the ways in which patients shaped the development of the institution. Exploring the physical world of the asylum illuminated a contrast between theory and practice in asylum life. Asylum designers organised institutional space and the objects within it to facilitate the delivery of treatment in the institution, the physical world was used to structure patients' experiences and to control their movement. However, the reality of day-to-day life in the asylum changed the uses of space and objects by patients. Increases in patient numbers, lapses in staff observation, and lack of funding to repair or maintain certain rooms or buildings produced opportunities for alternative uses and meaning to be attached to the physical world. Patients' uses, and misuses, of asylum space created an institutional geography that was entirely distinct to staff's experiences of space. This geography allowed patients to cope with institutional life, or to resist their confinement entirely. Patient appropriation of objects in the asylum could also facilitate agency. Patients used objects to challenge institutional constructions of domesticity, as tools to facilitate acts of resistance, or to assert their individuality and subjectivity. Patients interactions with the physical world of Lancaster Asylum altered its meaning, and rather than functioning to maintain asylum authority as intended, it took on a life of its own, providing as well as limiting opportunities for patient agency.

The ways in which patients exercised agency were shaped both by institutional structures and by the wider social and cultural context of nineteenth-century Lancashire society. Working-class patients appropriated tactics of resistance that were used in wider working-class protests in this period such as window breaking, and organising strikes.[10] Coping mechanisms were also shaped by patients' pre-institutional lives. Some patients sought to maintain links to their pre-institutional identities after being admitted to the asylum

[9] Morantz-Sanchez, 'Negotiating Power', 287-309; Rosenberg, 'The Therapeutic Revolution', pp. 3-26.
[10] Armstrong, *Victorian Glassworlds*; Navickas, *Protest and the Politics of Space and Place*; Walton, *Lancashire*, pp. 239-82.

by continuing to work in their own trade. This method of coping with their new patient status was facilitated by the arrangement of institutional spaces of work at Lancaster, which allowed patients who worked in the laundry or in the workshops to physically, as well as mentally, distance themselves from institutional life. Receptivity to medical treatment in the asylum was also shaped by broader trends in working-class medicine. Patients who had subscribed to medical aetiologies of insanity prior to their admission were receptive to institutional treatment and supported medical authority. Similarly, the arrangement and decoration of patients' homes influenced their understanding of 'domesticity', affecting whether patients responded positively or negatively to the institutional interiors of Lancaster Asylum.[11] The ways in which patients responded to institutional life were, of course, individualistic and varied from person to person depending on their circumstances, their mental state, and their previous life-experiences. However, it is clear that certain broader trends in patients' responses to institutional life were affected by extra-institutional social structures.

The agency of asylum patients, however, was more highly circumscribed than that of their working-class counterparts in mainstream society. Members of the institutional population were not only subject to constraints of their economic, social and cultural milieus, but also to the constraints of asylum authority. The ways in which patients exercised agency were profoundly shaped by the nature of medical authority in the asylum. Medical authority is inextricably linked with control over the body of the patient, and as such, patients' bodies became important sites and tools for resistance. Some patients refused to submit to physical examination, and others used their bodies to behave violently towards nurses and attendants. The centrality of classification to medical control in the institution also shaped patient agency, as they attached their own meanings to wards and institutional space, finding ways to occupy the areas that they preferred and thereby producing an alternative institutional 'classification'. The ways in which patients exercised agency were thus often affected by institutional structures.

Equally, asylum structures were affected by patient agency. This is not to overstate the role played by patients in the development of Lancaster Asylum; clearly parties such as local magistrates, the Commissioners in Lunacy, successive Superintendents and medical officers all played major roles in shaping the development of the institution. However, current literature also goes too far in understating the role of the patient. This thesis has

[11] Hamlett, *At Home.*

shown that patients' responses to confinement and their interactions with institutional structures in Lancaster Asylum did alter their shape. I have suggested that the relationship between patient agency and asylum authority in Lancaster Asylum was symbiotic, cyclical, and self-perpetuating. The relationship between these two forces drove institutional developments. The resistance of patients occasioned alterations to the built world, patients who smashed windows were placed in shuttered rooms and patient escapes led to the development of white uniforms to mark them out. Patients' input in medical interviews allowed them to control their psychiatric identity, but also provided asylum doctors with the material they needed to administer treatment and develop their knowledge of mental disorder. Engagement with doctors demonstrated patients' faith in their capacity to cure, perhaps allowing the doctors who treated them greater self-confidence in their abilities.

I hope not only to have augmented accounts of the asylum which consider the roles of doctors, magistrates, reformers, architects, and other elites, but to have suggested the importance of other actors in the history of psychiatry who have been neglected due to current mobilizations of theories of personal and historical agency. I have not explicitly considered the perspectives of nurses and attendants, although through examining their contact with patients I have suggested that those responsible for the day-to-day management of the insane had significant impacts on the ways in which medical authority functioned in the institution. Attendants and nurses have received significantly less attention in current scholarship than doctors, reformers, patients' and their relatives. This thesis has demonstrated the importance of nurses and attendants as representatives of institutional authority and highlighted the centrality of relationships between attendants and patients in shaping life in the institution in both positive and negative ways.

Further research into the roles of attendants would also potentially facilitate additional contextualisation of asylums within the local communities who provided the bulk of staff employed therein. Pre-existing relationships between patients and attendants were significant in shaping patient experiences in the institution; patients occasionally lived in the same neighbourhood as their attendant or had known them as friends prior to their admission to Lancaster. Such local networks inevitably shaped the ways in which patients related to the institution, and although further research is needed, this thesis has suggested that asylum authorities may have used these networks to manage patients' transition from the community to the institution, and back home again.

Indeed, this thesis suggests that the role of local Lancastrians in the institution may also have been significant in shaping its development, although the discussion of this could not be fully developed in the scope of this project. Local people acted to return patients who ran away, they worked in the Asylum's laundries, kitchens and workshops, on the Asylum farms, built the structures of the institution and provided its furnishings. They were also frequently those whose patients' agentive behaviour sought to reach – potential allies or adversaries – being targeted with letters of complaint thrown out of windows, violence from working patients, the envisaged audience when patient threatened to publish exposes in newspapers. These groups have received little, if any, attention in current scholarship in relation to their role in the development of psychiatry and the institution. Moving towards broader definitions of agency facilitates the consideration of actors such as these, whose roles in the development of institutions like Lancaster have been under-studied because narrow, binary frameworks of power and domination cannot conceive of their role in the historical process.

The main contribution that this thesis has made, therefore, to existing scholarship lies in the framework for approaching patient agency offered herein. The approach that has been taken to casebooks is somewhat novel, particularly the use of patient casebooks to access evidence of patient agency rather than focusing on the somewhat more ephemeral question of 'patient experience'.[12] In particular, the combination of textual, medical records with an analysis of institutional architecture and material culture used in this thesis highlights the possibility of doing 'medical history from below' in a way that incorporated the voices of those who did not leave behind written records of their own construction.[13] The originality of the research undertaken here, however, lies in the way that agency has been approached. This has clear implications within the social history of medicine, wherein a broader definition of agency would facilitate investigations of the ways in which 'non-decision making' actors impacted medical encounters, medical spaces, and, indeed, the development of medicine over time. I would also suggest that, more generally, the framework of agency offered here may begin a conversation through which social historians might begin to think more critically about what it is we mean by agency, and who it is we afford agency to.

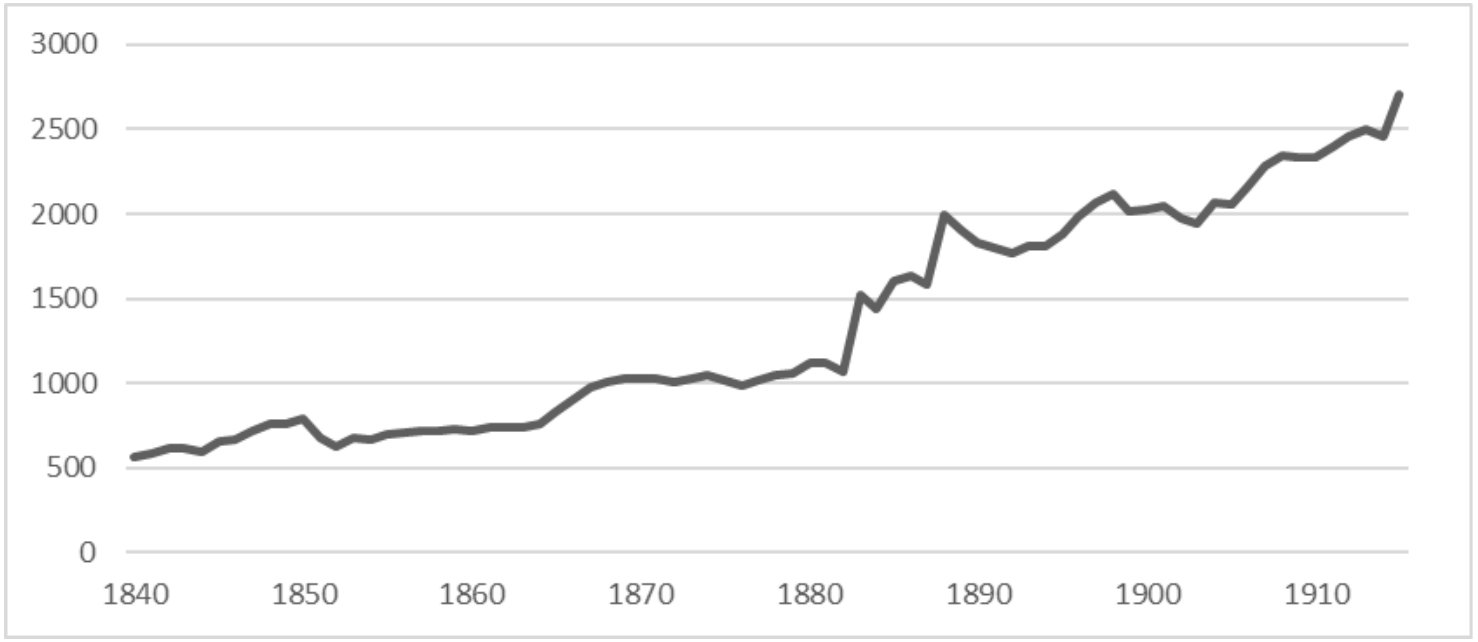
[12] Joan Scott, 'The Evidence of Experience', *Critical Inquiry,* 17(4) (1991), 773-97.
[13] Hamlett, *At Home,* p. 10.

Through examining the links between patient agency and asylum authority this thesis has illuminated the agency of the patient, not just in relation to their ability to influence their day-to-day lives in the institution but also as agents in the historical trajectory of Lancaster Asylum. Patients' ability to shape practices in Lancaster was not always conscious, or deliberate, but also resulted from the relationship between patient agency and institutional authority, which frequently produced changes in the institution. The conclusions that are drawn from this research have implications not only for understanding the historical development of Lancaster Asylum, but can also, perhaps, make contributions to contemporary debates on the relationship between patient choice and psychiatric paternalism. Through understanding that patients have a long history of contributing – albeit in unseen ways – to the development of the treatment of mental disorders, perhaps it can become possible to include patients in discussions about the compulsory administration of psychopharmacological drugs to treat mental illness,[14] in-patient stays, and the use of physical restraint in residential psychiatric facilities.[15]

Patients in Lancaster Asylum were certainly able to exercise agency in their treatment within the institution, often despite the institutional structures within which they were confined. They could resist their detention, their treatment, the imposition of a patient identity. They could also adopt strategies to make asylum life more comfortable, to minimize the deprivations imposed by their confinement. Others actively sought out asylum treatment, engaging with medical authority within the institution, often driven by the very real suffering they were experiencing as a consequence of their mental disorders, physical illnesses, or poverty. These behaviours had implications for asylum authorities, whose responses to patient behaviour created an institution which functioned in a manner that was not entirely of their creation. The asylum thus emerges from this analysis as a negotiated entity, a product not only of medical professionals, governments, reformers, nurses and other staff, but also of patients.

[14] www.criticalmhnursing.org (accessed 03/12/2018).
[15] www.theguardian.com/society/2018/oct/02/physical-restraint-used-on-50-more-nhs-patients-with-learning-disabilities (accessed 01/11/2018).

Patient Population in Lancaster Asylum, 1840-1915.



Source: LA, QAM/5/1-45, *Reports* (1841-1888); LA, CC/LAR/1-2, *Reports* (1889-1890); LA, CC/HBR/1-45, *Reports* (1891-1938).

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HRL/4/12/1/13	27 Jul 1843-7 Apr 1845.
HRL/4/12/1/14	12 Jun 1845-24 Jul 1847.
HRL/4/12/1/16	13 Jan 1849-4 Mar 1852.
HRL/4/12/1/18	12 Nov 1853-9 Jun 1855.
HRL/4/12/1/19	15 Jun 1855-27 May 1857.
HRL/4/12/1/21	22 Jan 1859-8 Jun 1860.
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HRL/4/12/1/24	31 Jul 1863-7 Apr 1865.

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HRL/4/12/2/24	17 Feb 1905-21 Dec 1905.
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HRL/4/12/2/28	18 Aug 1908-18 Feb 1911.
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HRL/4/12/3/8	11 Oct 1879-9 Mar 1881.
HRL/4/12/3/11	25 Sep 1883-27 Jun 1885.
HRL/4/12/3/12	30 Jun 1885-4 Dec 1886.
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