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## Home Sweet Home: Domesticity in English and Scottish Insane Asylums, 1890-1914

Vesna Curlic, *The University of Western Ontario*

Supervisor: McKellar, Shelley, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in History

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## Abstract

This thesis considers the implementation of domestic aesthetics and activities in the insane asylum at the end of the nineteenth century. Doctors sought to bring elements of the Victorian and Edwardian home into the asylum as part of a modern, humane regime of mental healthcare, which I call “institutional domesticity.” I argue that this process was fraught with challenges. While implementation of domesticity was relatively successful in regard to asylum activities, like labour and employment, domesticity reached its limitations in the physical asylum space. Ultimately, this thesis demonstrates the ways in which all asylum actors, including patients, staff, community members, and the state, were able to interact with, respond to, and challenge domesticity in the asylum.

## Lay Summary

Insane asylums have long been haunted by images of cruelty and poor conditions for patients. This thesis examines a moment in history where doctors became aware of the poor reputation of asylums and began to experiment with ways to make the asylum more comfortable, including through the use of home-like decoration and activities (domesticity). This thesis considers the way doctors attempted to reform their institutions, as well as the ways that other individuals were able to influence this reform, especially patients. This thesis assesses the success of these new forms of treatment, which included implementing cultural recreation (like theatre, music, and writing) and labour (like gardening and cleaning). This thesis also examines the way that domesticity was implemented into the physical space of the asylum, through redecoration and the construction of new asylum buildings.

## Acknowledgements

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## INTRODUCTION

In the summer of 1908, Veronica L. was admitted to Crichton Royal Asylum in Dumfries, Scotland.<sup>1</sup> In her admission documents, doctors reported her as being “full of strange fancies,” depressed, paranoid, and “backward in [her] mental development.”<sup>2</sup> Though she was twenty-three years old, doctors suggested that she was closer to thirteen years old, in terms of behaviour and attitude. Veronica spent her first weeks at Crichton crying ceaselessly, because she despised being away from her family, especially her mother. Her case notes reported that she resented being institutionalised and believed that she was committed without her mother’s permission, which was not the case.<sup>3</sup> Her mother, in fact, was the one who petitioned the authorities to take Veronica to the asylum in the first place, fearing her daughter’s threats of suicide and self-harm.<sup>4</sup> During these initial days of her commitment, Veronica refused any offers of socializing with other patients or recreational activities, like reading. She refused to listen to the doctors and nurses who tried to cheer her up. She steadfastly maintained a belief that she could not get well at the asylum and wished to go home.<sup>5</sup>

By the end of her first month in the asylum, she reluctantly began to engage in some recreational activities, like writing and sewing. She seemed, doctors reported, “to take more interest in her surroundings.” Within six months, she was even more engaged in needlework and knitting, which the doctors saw as a promising sign. Nevertheless, her bad moods persisted. She continued to be “bad-tempered” at times and stomped her feet if angered. Medical staff commented that she often sought attention from the nurses and attendants, begrudging the fact

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<sup>1</sup> I have chosen to refer to patients by their first name and surname initial only, as is common practice in recent monographs on the history of psychiatry. For a discussion on the ethical implications of naming patients, see Wallis, *Investigating the Body in the Victorian Asylum*, p. 34.

<sup>2</sup> DGH1/5/1/1/61, Sheriff’s Warrants 1908.

<sup>3</sup> DGH1/5/21/4/13, Case Book Female Volume 13, Dumfries and Galloway Archives: 103.

<sup>4</sup> DGH1/5/1/1/61, Sheriff’s Warrants 1908.

<sup>5</sup> DGH1/5/21/4/13, Case Book Female Volume 13, Dumfries and Galloway Archives: 103.

that she had to share attention and space with other patients. Just over a year after her initial commitment, she was moved to a part of the hospital reserved for convalescent patients, where she had more privacy and more liberty. Here, her bad moods essentially halted. By the Fall of 1910, she was very close to recovery.<sup>6</sup> In October 1910, Veronica's sister Dorothy sent a letter to the asylum's administration, pleading that they keep her sister for a bit longer, despite the fact that she had fallen behind on her payments to the hospital. She rationalised her plea, telling the asylum that her brother was leaving for the army in the coming days which would distress Veronica. This upset, Dorothy argued, might cause Veronica to be violent to her, as she had been in the past. Veronica was, her sister reminded the asylum administration, a "handful."<sup>7</sup> Veronica was not discharged until December 9<sup>th</sup>, 1910, which suggested that Dorothy's request was accepted by the asylum's administration.

Veronica's experience in the asylum showcase a mentally ill woman who entered the asylum and immediately found herself homesick. She was unaccustomed to the challenges of institutional life and desperately wanted to go home. Though eventually she was able to adjust and begin participating in recreational activities at the asylum, she never enjoyed the communal nature of ward living. On the other hand, her sister's perspective painted a picture of a violent and difficult woman who posed an inconvenience to her family's lives. Veronica was trapped between an unwelcoming institution and an unwelcoming home. From Veronica's story emerge questions about the nature of the insane asylum at the dawn of the twentieth century, the relationship between the asylum's layout and patient comfort, and the seemingly-insurmountable gulf between institution and home.

Though Veronica's family did not struggle to commit her to the asylum, others found commitment to the Victorian asylum a lengthy process, due to increasing concerns over the

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<sup>6</sup> DGH1/5/21/4/13, Case Book Female Volume 13, Dumfries and Galloway Archives: 103.

<sup>7</sup> DGH1/5/35/4, Letter from a Patient's Sister, Dumfries and Galloway Archives.

course of the nineteenth century about patient treatment and wrongful commitment.<sup>8</sup> As early as 1811, administrators of English asylums provided a certificate of insanity for every person admitted to an asylum, which had the confirmation of a local doctor that the patient in question was “an idiot, lunatic, or person of unsound mind.”<sup>9</sup> By 1853, due to revisions to insanity legislation, two doctors separately certified a patient’s insanity. These two doctors could not be medical officers at the asylum where the patient was going to be committed, in an attempt to legitimize the commitment process. Additionally, doctors who intentionally falsified certifications were legally sanctioned. These new mid-century laws also required doctors to record testimonies from the patients’ family and friends to support his certification.<sup>10</sup> The nineteenth century was marked with fear that patients were being improperly committed by corrupt doctors and greedy family members who sought to control the patient’s inheritance.<sup>11</sup> These laws sought to legitimize the admission process to quell fears that people could be committed without being legitimately insane.

After certification and admission to the asylum, the medical staff of the asylum formally diagnosed the patient, as the first step towards beginning the treatment process. Doctors carefully observed the patient’s physical and mental state upon admission to the asylum, noting their psychiatric history, their physical appearance, any delusions they were experiencing, their ability to coherently answer questions, and if they were currently dangerous to others or suicidal. This information was recorded in a casebook, which was later updated with changes to the patient’s mental and physical state. The breadth of information taken down, initially and as the patient’s treatment progressed, was extensive. This was due to the fact that, despite

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<sup>8</sup> David Wright, “Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England,” in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, ed. Jonathan Andrews and Anne Digby (Amsterdam: Rodopi, 2004), 155.

<sup>9</sup> Wright, “Delusions of Gender,” 155.

<sup>10</sup> Wright, “Delusions of Gender,” 155.

<sup>11</sup> Sarah Wise, *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England* (London: Bodley Head, 2012) 68.



increasing legitimization of psychiatry as a medical field over the course of the nineteenth century, insanity remained an amorphous and ever-changing concept. In general, psychiatrists in the late nineteenth century agreed that some behaviours were inherently disordered, including delusions, hallucinations, and suicidal tendencies, all of which made a person a candidate for treatment in the asylum.<sup>12</sup> However, such defined behaviours were ever-changing and by the end of the nineteenth century, this ‘disordered’ behaviour category came to encompass many new ones.

Identifying the causes of insanity, however, was even more controversial. Conventional medical thinking in the late nineteenth and early twentieth centuries surrounding insanity was that it was caused by a combination of hereditary factors, environmental factors, and individual habits. Different physicians weighed these factors differently, even producing their own theories therein.<sup>13</sup> Some doctors sought to explain insanity through biological means, in line with the trends in somatic medicine of the nineteenth century. Of course, medical professionals examined the skull and brain in hopes of finding the “somatic seat” of insanity, but they also sought the cause for insanity in skin, the heart, bones, and body fluids, among others.<sup>14</sup> The most frequent iteration of biological theories took the form of ideas about the potential hereditary nature of insanity.<sup>15</sup> This, however, had dangerous implications. The suspicion that entire family lines could be corrupted by incurable mental disease produced fertile ground for the rise of eugenicist thought in the twentieth century.<sup>16</sup> Even in the nineteenth century, some who believed in a somatic cause went as far as to suggest a microbe that could cause insanity, which gained popularity with the general public after its publication in the *Times*. However, by

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<sup>12</sup> Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007), 2.

<sup>13</sup> Sidney Coupland, “The Causes of Insanity, with Especial Reference to the Correlation of Assigned Factors: A Study of the Returns for 1907,” *Journal of Mental Science* (hereafter JMS) 56, no. 252 (1910): 6.

<sup>14</sup> Jennifer Wallis, *Investigating the Body in the Victorian Asylum: Doctors, Patients, and Practices* (London: Palgrave Macmillan, 2017), 1-2.

<sup>15</sup> Coupland, “The Causes of Insanity,” 3.

<sup>16</sup> Edward Shorter, *A History of Psychiatry: from the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), 93-94.

1910, nationally-renown doctors were dismissing this theory, with one comparing it to the delusions of one of his patients.<sup>17</sup> Though the bacterial cause was dismissed, the relationship between the body and mind became increasingly prominent throughout the nineteenth century – first on the continent, then eventually in Britain. The understanding that the physical brain and nervous system impacted the experience of mental illness – which some have described as the “medicalization” of mental illness – eventually led to twentieth century developments like psychiatric drugs.<sup>18</sup> This, however, is beyond the scope of this research.

Other late nineteenth-century doctors were more concerned with social or moral causes of insanity. Some doctors believed modernity to be a contributing cause of insanity, because it revealed the weakest members of its society, who were unable to conform with the rigour and discipline of the modern world.<sup>19</sup> In one of many papers and speeches given on this topic in the early years of the twentieth century, Dr. T.B. Hyslop acknowledges the importance of “internal” factors like familial inheritance of disease or due to “the existence of some fundamental capacity which cannot be explained as a result of immediate ancestry.”<sup>20</sup> Nevertheless, he argued that sociological causes, such as the perceived downfall of the “British race,” pauperism, alcoholism, overwork, unemployment, and unions, all caused the human brain to enter an unnatural state, producing insanity.<sup>21</sup> Moral causes were similar, but had individual origins. Moral causes for insanity included over-work or over-study, domestic trouble, death of a relative, loss of employment, or impending marriage. These were all external stressors in an individual’s life which doctors could pinpoint as being simultaneous to the first signs of insanity.

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<sup>17</sup> Coupland, “The Causes of Insanity,” 6.

<sup>18</sup> Shorter, *A History of Psychiatry*, 85-86.

<sup>19</sup> Yanni, *The Architecture of Madness*, 3.

<sup>20</sup> Theophilus B. Hyslop, “A Discussion on Occupation And Environment as Causative Factors of Insanity,” *The British Medical Journal* (hereafter *BMJ*) 2, no. 2337 (1905): 941.

<sup>21</sup> Hyslop, “Causative Factors of Insanity,” 941.

With all these competing theories, medical professionals struggled to pinpoint fixed causes of insanity, which in turn influenced the treatment options available. While the popularity of biological theories for psychiatric disorders were on the rise among psychiatrists in the wider medical world, historians have argued that research on the subject was happening primarily in universities and institutes, rather than in asylums.<sup>22</sup> Thus, even when biological causes of insanity were proposed, the social or moral causes were the more dominant theories within the asylum. Unable to identify a concrete biological cause of insanity that might dictate treatment, physician superintendents of asylums focused on behaviour modification as treatment, seeking to tackle the social or moral causes of insanity. I argue in this thesis that, rather than prescribing a course of treatment which focused on a single somatic or psychosomatic cause, the asylum and its activities were designed to focus on an idealised version of the outside world, with all the benefits of civilized modernity without any of the stressors. Collective domestic activities like recreation and employment functioned as treatment in the asylum, in addition to more experimental, biologically-focused treatments. The physical space was also intended to be curative, with comfort and predictability at the forefront. Certainly, there were some treatments that are recognizable to modern sensibilities, but their popularity was limited. For example, treatments like psychoanalysis, though gaining some popularity by the turn of the century, did not gain mainstream use until the 1940s.<sup>23</sup> There was some interest in treatments like electroshock therapy, but its popularity in the nineteenth century was limited and ultimately, short-lived.<sup>24</sup> Instead, at the end of the nineteenth century, the dominant treatment for insanity was institutionalisation, which promised behaviour modification in a safe, healing environment.

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<sup>22</sup> Shorter, *A History of Psychiatry*, 69.

<sup>23</sup> Shorter, *A History of Psychiatry*, 113.

<sup>24</sup> Allan Beveridge and Edward Renvoizet, "Electricity and British Psychiatry in the Nineteenth Century," *Journal of Psychopharmacology* 4, no. 3 (1990): 145.

Because of these competing theories about causes of insanity, the personal beliefs of the doctors in the asylum could deeply influence a patient's diagnosis and subsequent treatment. Individual psychiatrists' views on the causes and treatment of insanity varied, which in turn shaped the asylums they ran. Among the medical staff in an asylum, arguably the most powerful figure was the physician superintendent. Part medical professional and part administrator, the physician superintendent had many disparate tasks from patient treatment to financial management of the asylum. At the asylum, in addition to the diagnosis of patients upon admission, physician superintendents managed all levels of staff employed within the asylum and took full responsibility for the medical care of asylum patients.<sup>25</sup> This involved daily (and sometimes nightly) visits to all parts of the asylum to supervise patients and staff, as well as responsibility for classifying and providing amusements for all patients during their stay at the asylum.<sup>26</sup> The physician superintendent did not do all of the work of caring for patients alone, of course. There was a small medical staff, including a senior medical officer who assumed physician-superintendent duties when needed, and a handful of junior medical officers of varying responsibility levels and experience levels who treated patients and conducted research at the asylum. Other administration-level asylum staff included a Steward who organized the domestic elements of the asylum and a Matron who organised the nurses and attendants.<sup>27</sup> In addition to managing these staff members, the physician superintendent often also maintained had a private practise, taught at local medical schools, and attended association meetings for the wider medical community.<sup>28</sup> In addition to this influence over the wider medical community, the individual personalities, educations, and beliefs of each physician-superintendent played a significant role in shaping the culture of the asylum. Because of this

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<sup>25</sup> Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker, and Kier Waddington. *The History of Bethlem* (London: Routledge, 2013), 589.

<sup>26</sup> Andrews et. al., *The History of Bethlem*, 589.

<sup>27</sup> Andrews et. al., *The History of Bethlem*, 588.

<sup>28</sup> Andrews et. al., *The History of Bethlem*, 589.

significant individual control over the asylum, it is vital to consider the histories of the physician superintendents at Bethlem Royal Hospital, Crichton Royal Institution, and Gartnavel Royal Asylum, which will form the evidentiary basis of this thesis.

Bethlem Royal Hospital was London's oldest and most well-known psychiatric hospital, but each of its physician superintendents brought unique perspectives on insanity to the institution. Percy Smith served for ten years as physician superintendent, from 1888 to 1898, then resigned to manage a full-time private practise.<sup>29</sup> He was an influential figure in the psychiatric community of his day. As a prolific contributor to *The Journal of Mental Science*, he wrote about the link between typhoid and insanity, experimental treatments for insanity like ovariectomies and hypnotism, and discussed changes to Lunacy legislation, among other subjects. Smith was a "well known and valued member" of the Medico-Psychological Association, the foremost British professional psychiatric community, and later became the president of the Neurological and Psychiatric sections of the Royal Society of Medicine.<sup>30</sup> Succeeding Smith, Theophilus Bulkeley Hyslop served as physician superintendent of the hospital until 1911. Born in Shropshire to a family with humble beginnings, Hyslop completed his medical education at the University of Edinburgh. In 1888, he accepted the Bethlem Hospital position of Assistant Medical Officer under Percy Smith and served as the acting Physician Superintendent each summer while Smith was on vacation. In his later years, Hyslop became obsessed with the idea that modernity and the conditions of modern urban life were a major cause of insanity.<sup>31</sup> This proliferated into some eugenicist ideas, wherein Hyslop believed that the English were the highest race in the evolutionary scale but feared that the race was being corrupted by alcohol, over-education, and female suffrage movements, as well as post-

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<sup>29</sup> W. H. B. Stoddart, "Obituary: Theophilus Bulkeley Hyslop, M.D., C.M., M.R.C.P.E., F.R.S.E.," *JMS* 79, no. 325 (1933): 424.

<sup>30</sup> "Honours for Dr. Percy Smith," *JMS* 63, no. 263 (1917): 622–23.

<sup>31</sup> Stoddart, "Obituary: Hyslop," 424.

impressionist art.<sup>32</sup> Hyslop himself was a talented artist, musician, and fiction writer, according to his contemporaries.<sup>33</sup> Following in Smith's footsteps, Hyslop opened a medical consulting practise upon his retirement from Bethlem. William Stoddart succeeded Hyslop, and much like his predecessors, Stoddart had worked at Bethlem Hospital in a junior medical position for years before his appointment as physician-superintendent. He was known by his peers to be lazy, casual in his demeanour, and a great lover of good food and wine.<sup>34</sup> He held the position of physician-superintendent for a relatively short period of time, from 1911 to 1914. Despite his relaxed personality, Stoddart was an important figure in Bethlem's history because he contributed to the acceptance of Freudian ideas and the use of psychotherapy by his staff, putting Bethlem at the forefront of this new shift in the field of psychiatry.<sup>35</sup>

Crichton Royal Hospital had a long history of notable superintendents, including its first appointee, W.A.F. Browne, who was among the most recognizable names in nineteenth century psychiatry. Browne served as physician superintendent at Crichton Royal Hospital from 1839 to 1857, and later became a medical inspector for the Scottish Commissioners in Lunacy. His treatise entitled *What Asylums Are, Were and Ought To Be*, published in 1837, advocated for asylums to resemble comfortable Victorian country houses and was a seminal piece of medical literature in the nineteenth century.<sup>36</sup> James Rutherford became the physician-superintendent of Crichton Royal Institution in 1883, a position he held for almost twenty-five years. The eldest son of a reverend, he completed his medical education at St. Andrews and University of Edinburgh, where he excelled.<sup>37</sup> Eulogized as one of the great moral reformers of psychiatry, his contemporaries pointed to his unique views of treatment, which included great amounts of

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<sup>32</sup> Andrews et. al., *The History of Bethlem*, 624.

<sup>33</sup> Stoddart, "Obituary," 425.

<sup>34</sup> Andrews et. al., *The History of Bethlem*, 624.

<sup>35</sup> Andrews et. al., *The History of Bethlem*, 624.

<sup>36</sup> W.A.F. Browne, *What Asylums Were, Are, And Ought To Be* (Edinburgh: Adam and Charles Black, 1837), 182.

<sup>37</sup> "James Rutherford, M.D., F.R.C.P.Ed., and F.F.P.S.Glas. (Obituary)." *JMS* 56, no. 233 (1910): 381

liberty and outdoor work for patients with mental illness, as well as the development of an open-door system and new parole methods.<sup>38</sup> “No man,” said his contemporaries upon his death in 1910, “had a kinder heart for the insane than Dr. Rutherford.”<sup>39</sup>

David Yellowlees joined Gartnavel Royal Hospital in 1874, after completing a medical education at the University of Edinburgh, and his arrival signalled a new phase in the history of the institution. During his 27-year tenure, the asylum stopped accepting pauper patients to focus on the under-acknowledged group of patients who were neither poor enough to be paupers nor wealthy enough to pay the high rates of board expected of private patients. With Yellowlees at the helm, the institution underwent multiple renovations, including the addition of a dining hall, the introduction of electric lighting, and the renovation of the wards.<sup>40</sup> He transformed a middling asylum into “a keen centre of psychiatric thought” through his energy, enthusiasm, and “radiant optimism.”<sup>41</sup> According to Sir George Savage, a prominent English physician, Yellowlees “was a true Scot, and his genial welcome and his humour did everyone good to meet him, for though strong in his views and willing to support them, he was not a man of one view.”<sup>42</sup> In 1902, Yellowlees retired from Gartnavel due to failing health and eyesight. At Gartnavel, he was honoured with a tremendous dinner ceremony upon his retirement and a medallion portrait hung in the Concert Hall at Gartnavel.<sup>43</sup> He continued to teach and write for many years until his death in 1921.<sup>44</sup> In his obituary in the *Journal of Mental Science*, it was stated that the British medical community had lost “one of the few remaining pioneers of the renaissance which occurred in British psychiatry during the later decades of the nineteenth century.”<sup>45</sup>

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<sup>38</sup> “Rutherford Obituary,” 381.

<sup>39</sup> “Rutherford Obituary,” 382.

<sup>40</sup> “Resignation of Dr. Yellowlees,” *JMS* 48, no. 200 (1902): 208.

<sup>41</sup> “David Yellowlees, M.D.Edin., Ll.D.Glasg. (Obituary),” *JMS* 67, no. 277 (1921): 270.

<sup>42</sup> “Yellowlees Obituary,” 271.

<sup>43</sup> HB13/2/228, “Amicitiae Memor,” NHS Greater Glasgow and Clyde Archives (1902): 7-8.

<sup>44</sup> “Resignation of Dr. Yellowlees,” 208.

<sup>45</sup> “Yellowlees Obituary,” 270.

The next physician superintendent of Gartnavel Royal Hospital was Landel Rose Oswald, a protégé of Yellowlees' who had received the position partially through merit and partially through patronage. Oswald, despite having a rough upbringing without "the opportunities that many another boy of his time had", was an excellent medical student and won the award for the most distinguished graduate award upon his graduation from Glasgow University Medical School in 1888.<sup>46</sup> Upon the recommendation of a close personal friend, Yellowlees hired the young Oswald as a Junior Physician at the Glasgow Royal Hospital. In 1895, Oswald received the appointment of the physician superintendent at Gartnavel's district asylum equivalent, Gartloch Hospital. In 1901, after Yellowlees' retirement, Oswald returned to Gartnavel as the hospital's physician-superintendent where he remained until his retirement in 1921 due to ill health. Contemporaries described Oswald as unapproachable and "unduly hard and impatient" at times, with rigorous working hours and high expectations of those around him.<sup>47</sup> However, he was effusively praised for his brilliant medical mind and the care he provided for his patients, who were "eternally grateful to him."<sup>48</sup> Oswald died, unmarried, at age sixty-seven, in 1928. This group of physician superintendents, drawn from three different asylums located in Britain and Scotland during the nineteenth century, were diverse in thinking and education, which carried over into their understanding of mental disease and their administering to the needs of patients with mental illness in their respective asylums.

The physician superintendents were certainly patriarchal figures within the asylum, ruling over a strictly-hierarchized staff, but they were not omnipotent. Over the course of the nineteenth century, asylum oversight bodies were created and strengthened, in response to longstanding cultural fears about asylums and insanity. The earliest iteration of an official oversight body in England was the Metropolitan Lunacy Commission, formed by the 1828

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<sup>46</sup> HB13/10/35, "Obituaries (Oswald)," NHS Greater Glasgow and Clyde Archives (1928), 1.

<sup>47</sup> HB13/10/35, "Obituaries (Oswald)," NHS Greater Glasgow and Clyde Archives (1928), 3.

<sup>48</sup> HB13/10/35, "Obituaries (Oswald)," NHS Greater Glasgow and Clyde Archives (1928), 4.



Madhouse Act, which was a local inspectorate that was tasked with inspecting asylums, releasing improperly confined patients, and overseeing stricter certification protocols.<sup>49</sup> By the mid-century, their roles were being reimagined and in England, they were replaced as part of the 1845 Lunacy Act. This act crystalized English visions of care for the insane until the end of the century. Scotland followed shortly after, with their own 1857 Lunacy Act, which came after a parliamentary inquiry.<sup>50</sup> The Board of the Commissioners in Lunacy in both England and Scotland were made up of six full-time Commissioners, three of whom were medical professionals and three of whom were legal experts.<sup>51</sup> They were tasked with inspecting all institutions where mentally ill people were housed, including private asylums, county asylums, and workhouses. This involved making judgements on patient certification and establishing standards of care across the nation.<sup>52</sup> The Medical Inspectors of the Commissioners in Lunacy had often spent their years as physician superintendents of many different asylums, and thus represented the convergence of practical experience and medical knowledge. For example, this was the case with W.A.F. Browne, who had been the physician-superintendent at Crichton Royal Hospital before then becoming a Commissioner in Lunacy. Each year, two Commissioners in Lunacy visited each asylum twice, usually in the first four months of the year and then again in the last four months. They produced extensive reports on individual asylums, as well as about the general state of lunacy care and spending. These reports are used heavily in this thesis, because the Commissioners in Lunacy represented an interesting midpoint between the state and the medical community, in a moment where those two actors were occasionally at odds. The voice of the Commissioners in Lunacy is also vital, because they are

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<sup>49</sup> Nicholas Hervey, "A Slavish Bowing Down: The Lunacy Commission and the Psychiatric Profession, 1845-60," in *The Anatomy of Madness Volume II: Institutions and Society*, ed. W.F. Bynum, Roy Porter, and Michael Shepherd (London; New York: Tavistock Publications, 1985), 101.

<sup>50</sup> Jonathan Andrews, "*They're in the Trade... of Lunacy, They 'Cannot Interfere' – They Say*": *The Scottish Lunacy Commissioners and Lunacy Reform in Nineteenth-Century Scotland* (London: The Wellcome Trust, 1998), 6.

<sup>51</sup> Hervey, "A Slavish Bowing Down," 103.

<sup>52</sup> Hervey, "A Slavish Bowing Down," 104.

one of the asylum actors with the most power to change the ideals of the physician-superintendents. While patients and lower-ranking staff could theoretically resist and accept changes to the asylum culture in mild ways, the Commissioners could strongly recommend a change and affect the reputation of an asylum if the physician-superintendent refused to comply, making them one of the most powerful actors in the asylum experience.

#### Defining Domesticity and Institutional Domesticity

Domesticity is a flexible concept encompassing aesthetics, material culture, behaviours, expectations, and norms. While fundamentally related to the home, domesticity was influential in all aspects of Victorian culture and society. I use domesticity to mean a particular set of middle-class ideologies that encompass gender expectations, comfort, and refuge. I will first define the origins of domesticity in the traditional sense, then consider the state of domesticity at the end of the nineteenth century more broadly. Finally, I will define the concept of ‘institutional domesticity,’ the particular iteration of domesticity that is implemented in the asylum and define the ways it differs from traditional domesticity in the Victorian home. It is vital to note that in this thesis, I refer frequently to “Victorian” domesticity, despite the period under examination including the Edwardian years. Many other historians have envisioned the late-Victorian and Edwardian periods as having a “cultural coherence,” and have thus considered 1901-1914 an extension of the late-Victorian period, as I do in this thesis.<sup>53</sup> Culturally, the Edwardian period maintained many functional similarities with the twilight of the Victorian period.

The concept of the nineteenth century middle-class has been a flexible and amorphous concept, defined by a variety of social, economic, political, and cultural criteria. Traditionally, the middle class has been defined as people that owned property and actively participated in

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<sup>53</sup> Lori Anne Loeb, *Consuming Angels: Advertising and Victorian Women* (New York: Oxford University Press, 1994), ix.

work, unlike the aristocracy. However, they abstained from physical wage labour, which differentiated them from the working classes.<sup>54</sup> Traditionally, historians using this economic definition have pinpointed the rise of the middle class as a result of economic and political change at the end of the nineteenth century, as a part of the industrial revolution.<sup>55</sup> However, the rise of the middle-class has also been defined by an emergence of a particular social and cultural structure, especially as it relates to gender relations. Iterations of what would later be recognized as middle-class domestic ideals began in the 1780s, with urbanization, economic development and religious turmoil meaning that “existing expectations about the proper roles of men and women were re-worked with a significantly different emphasis.”<sup>56</sup> While the eighteenth century embraced ‘domestic patriarchy’ – the active role of men in their own homes and families – the nineteenth century saw increased separation of ideas of public and private, along gendered lines.<sup>57</sup> By the 1830s and 1840s, the orthodoxy of domestic ideology was being established by popular prescriptive literature writers, like Sarah Stickney Ellis, Harriet Martineau, and John Loudon.<sup>58</sup> In the face of increasing division between the space where middle-class families lived and where they worked, writers on domesticity encouraged the home to be a safe refuge from the bustling politico-economic public sphere.<sup>59</sup> The home became a place of safety, comfort, and femininity, while the outside world became a chaotic, stressful, and distinctly masculine sphere.

By the end of the nineteenth century, however, the domesticity that existed throughout the early- and mid-Victorian period was in tatters. Gender and class expectations were changing, which threatened the fundamental basis of the separate spheres doctrine that

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<sup>54</sup> Simon Gunn, *The Public Culture of the Victorian Middle Class: Ritual and Authority and the English Industrial City, 1840-1914* (Manchester: Manchester University, 2000), 14-15.

<sup>55</sup> Gunn, *The Public Culture*, 15.

<sup>56</sup> Leonore Davidoff and Catherine Hall, *Family Fortunes: Men and Women of the English Middle Class 1780-1850* (London : Routledge, 2002), xvi.

<sup>57</sup> John Tosh, *A Man's Place: Masculinity and the Middle-Class Home in Victorian England* (New Haven: Yale University Press, 1999), 3.

<sup>58</sup> Davidoff and Hall, *Family Fortunes*, 180.

<sup>59</sup> Davidoff and Hall, *Family Fortunes*, 180-181.

underpinned Victorian domesticity. David Cannadine has argued that traditional class hierarchies were under attack in the late Victorian and Edwardian periods, due to a widening of the democratic process to the majority of men and the proliferation of social identities (like labourer) in politics.<sup>60</sup> These traditional class hierarchies underpinned the culture that allowed ideals of middle-class domesticity to flourish, suggesting that domesticity – real or prescriptive – was a likely casualty in the case of hierarchical class breakdown.

However, the greatest threat to the culture of domesticity was the challenges to gender roles at the end of the century. Specifically, the rise of early feminism and the “New Woman,” as well as the male flight from domesticity meant that gendered ideals of the middle-class home were under attack. Historians have suggested that the emergence of feminist thought as early as the 1850s began to degrade a key element of domestic ideals – the separation of public and private spheres.<sup>61</sup> By the 1890s, emerging feminist thought was solidifying into the cultural image of the “New Woman” – an amorphous target of equal measures of ridicule and praise at the end of the nineteenth century. The 1880s and 1890s saw increasing, if ultimately limited, numbers of middle-class women who challenged their financial and social position, seeking formal education and rejecting elements of traditional femininity.<sup>62</sup> These women entered universities, owned property, challenged the legal system, and were political activists.<sup>63</sup> Though the number of actual women who could fall into this “New Woman” category were generally limited, and the definitions of a “New Woman” were nebulous, the image became important in the British cultural imagination.<sup>64</sup> The flexibility of the New Women stereotype allowed it to be molded to whatever crisis the British press felt was most pressing on any given day. This

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<sup>60</sup> David Cannadine, *Class in Britain* (New Haven: Yale University Press, 1998), 106.

<sup>61</sup> Davidoff and Hall, *Family Fortunes*, xvii.

<sup>62</sup> Gillian Sutherland, *In Search of the New Woman: Middle-Class Women and Work in Britain, 1870-1914* (Cambridge: Cambridge University Press, 2015), 2-3.

<sup>63</sup> Sally Ledger, *The New Woman: Fiction and Feminism at the Fin de Siècle* (Manchester: Manchester University Press, 1997), 11.

<sup>64</sup> Sutherland, *In Search of the New Woman*, 5-6.

led, at least in part, to challenges to traditional domesticity, because women had taken themselves off the pedestal of nineteenth-century femininity through these new, proto-feminist demands – at least in the wider cultural imagination.<sup>65</sup> Some women’s refutation of the angel in the household image, and more importantly, the public outcry about it, suggested the end of the moment of domestic gender orthodoxy. Along with the advent of the “New Woman,” the late nineteenth century also saw the so-called male flight from domesticity. The male role in the home was fraught with tensions at the end of the nineteenth century, after a few decades where the home was cast as the comforting male refuge from the bustling outside world.<sup>66</sup> Historians have argued that a move away from patriarchal orthodox religion, the re-prioritizing of homosocial activities, and the adventurous spirit of colonialism all resulted in splintering between men and the home.<sup>67</sup> Men were, for the first time in the nineteenth century, openly discussing the disadvantages to their home lives, increasingly rejecting marriage and family, and embracing bachelorhood.<sup>68</sup>

It is upon this complicated tapestry of crumbling domesticity at the end of the nineteenth century that institutional domesticity flourished. Much like the public-private divide, institutional domesticity was often defined in terms of what it was *not*. Institutional domesticity sought, at all times, to balance the highest illusion of homeliness with the necessary institutional elements to maintain functioning of the institution. In the case of the asylum, this was particularly difficult, since patients were often threats to themselves or others. Their unpredictable behaviour meant that asylums needed some level of surveillance and security. It is within this contradiction – the surveillance in the home – that we find the questions at the heart of this thesis. The domesticity that was implemented in the asylum was not necessarily false, but it was explicitly constructed in ways that the domesticity in the traditional home was

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<sup>65</sup> Tosh, *A Man's Place*, 170.

<sup>66</sup> Tosh, *A Man's Place*, 7.

<sup>67</sup> Tosh, *A Man's Place*, 7.

<sup>68</sup> Tosh, *A Man's Place*, 172.

not. While domesticity in the home was influenced by societal expectations and directed by persuasive prescriptive literature, domesticity in the institution was a series of conscious decisions on the part of a small team of psychiatrists as a form of treatment for insanity.

There were three key elements of institutional domesticity. Comfort was the first, permeating the asylum in many ways, including decorations and spatial aesthetics. It also can be understood to permeate cultural pursuits in the asylum. Institutional domesticity was also built on the appearance of egalitarianism. That is to say, therapeutic domesticity required the shrouding of institutional hierarchies that normally characterised the patient-doctor relationship, especially in a space where patients were often incarcerated against their will. Above all, however, institutional domesticity required an illusion of liberty. Medical practitioners and state officials were intensely concerned with the idea that the asylum space should obscure as many elements of surveillance and incarceration as possible. Much of my argument is focused on these debates about liberty and the limits that it reaches in the face of day-to-day asylum practicalities, because this illusion of liberty was a necessary precondition for the implementation of domesticity in the asylum. Comfort, the imagined lack of hierarchies and the illusion of liberty are therefore the fundamental elements in defining institutional domesticity.

#### Gender, Class, and Geography in the Asylum

The three asylums of Bethlem Royal Hospital, Crichton Royal Hospital and Gartnavel Royal Asylum, located in different parts of England and Scotland, implemented aspects of domesticity in implicit and explicit ways, in different conditions, and to varying degrees. These three institutions represent a variety of class breakdowns, sizes, and geographic locations that are representative of psychiatric institutions more broadly at the end of the nineteenth century. Using a case study approach, these three asylums will allow me to investigate the implementation of domesticity in the asylum within various circumstances. For example, with

Crichton as the largest and Bethlem as the smallest in terms of patient population, they will demonstrate the ways that domesticity could be implemented on different scales and the impact a patient population could have on this implementation (see Table 1).

	1890	1895	1900	1905	1910
Crichton Royal Hospital	687	1006	727	781	799
Gartnavel Royal Asylum	484	485	413	411	410
Bethlem Royal Hospital	249	229	188	99	171

**Table 1** Total population of certified patients per year (excludes voluntary boarders)

All three of these hospitals share the designation of Royal institution. Royal asylums or hospitals were among the oldest institutions in Britain and were generally established by funds from the local parish, as well as private donations. Some, like Crichton Royal Hospital, were established due to a single donation from an individual benefactor.<sup>69</sup> Historically, Royal asylums were better funded institutions, and thus tended to be at the forefront of new therapeutic advancements, with well-known doctors at their helm.<sup>70</sup> Royal asylums usually had space for both private and pauper lunatics within their walls, with the exception of Gartnavel, which stopped accepting new pauper patients in 1889. Pauper lunatics could not afford the cost of psychiatric care, and those who found themselves in Royal asylums – rather than poorhouses or strictly pauper asylums – had their rates paid by their parish, from the ‘poor rates’ fund. Private patients, on the other hand, could pay their own fees or rather, had family and friends who paid their fees for them. Private patients encompassed a wide range of social classes and

<sup>69</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), xxiii.

<sup>70</sup> Chris Philo and Jonathan Andrews, “Introduction: Histories of Asylums, Insanity and Psychiatry in Scotland,” *History of Psychiatry* 28, no. b1 (2017): 6.

should not be automatically assumed affluent, since many private patients struggled to pay the high rates of board.

In fact, at the end of the nineteenth century, Commissioners in Lunacy envisioned a new role for these Royal asylums. In Scotland, Commissioners in Lunacy became concerned with the demographic of patients who were neither rich enough to afford the “opulent” accommodation of strictly private care, nor were they poor enough to qualify for pauper status. This “poorer class of private patients” had no satisfactory institutional care in the eyes of the Commissioners, since the few attempts to have private asylums with low rates of board were essentially unsustainable – “practically impossible to make adequate provision for persons requiring asylum treatment at the rates of board which were charged there and at the same time to allow of a profit for the proprietors.”<sup>71</sup> By the 1890s, Scottish Commissioners in Lunacy claimed that these low-cost private institutions had all shut down and began to propose the idea that Royal Asylums might be the solution for this demographic of poorer private patients. Since they were initially designed as charitable institutions, Commissioners saw this as “acting in the spirit of their founders.”<sup>72</sup> The Commissioners also pointed to the accessibility of Royal Asylums, since they are distributed conveniently around the country in both rural and urban areas. In the vision of the Commissioners, this demographic of patients paid “equal to or somewhat above the rate charged for pauper lunatics, but no so much above it as to obtain accommodation in the better class of private asylums,” which was roughly £25 to £50 per year.<sup>73</sup>

At this cost, the Commissioners argued, it was almost impossible to find asylum accommodation, which they suggested led to the “pauperising” of patients who would not usually have that title. Family and friends of a patient tried desperately to save their loved ones

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<sup>71</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), xlvii.

<sup>72</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), xlvii.

<sup>73</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), xlvii.



from the “stigma of pauperism,” which was significantly more feasible if the rates of board were lowered to take into account the poorer demographic of patients and their families.<sup>74</sup> The stigma of pauperism was much more than just a social stigma. Claiming pauperism also meant relinquishing certain rights, like the right to vote or to make a will.<sup>75</sup> Throughout the Commissioners’ reports in the 1890s and early 1900s, the urging for low rates of board for this poor private patient from the Royal Asylums persisted as a common theme. Royal asylums and their Physician Superintendents were congratulated on their charitable nature if they managed to have a significant number of these types of patients. The 1890s marked a turning point for the royal asylum as a concept, broadening its definition to include a wider range of socio-economic backgrounds, despite the seemingly simple dichotomy of private vs. pauper patients. The concern that the Commissioners have over poor private patients and the opening up of the royal asylum provide vital context to understand the attempts at reproducing domestic ideals in the asylum, especially since class majorly impacted the nature of domesticity beyond the asylum’s walls.

	1890		1895		1900		1905		1910	
	Pauper	Private	Pauper	Private	Pauper	Private	Pauper	Private	Pauper	Private
Crichton Royal Hospital	M.194 F. 193 387	M.148 F.152 300	M. 325 F. 325 650*	M. 176 F. 180 356	M. 141 F. 155 296	M. 204 F. 227 431	M.147 F.169 316	M. 221 F. 244 465	454	345
Gartnavel Royal Asylum	M. 124 F. 49 173	M. 138 F. 173 311	M. 82 F. 36 118	M.174 F. 193 367	M. 2 F. 2 4	M.183 F. 226 409	M. 1 F. 0 1	M. 180 F. 230 410	1	409
Bethlem Royal Hospital	178 (No gender)	M.45 F.26 71	M. 96 F. 133 229	M.55 F.82 137	M. 31 F.20 51	M. 39 F. 60 99	M.47 F.77 124	M.24 F.23 47		

**Table 2** Numbers of certified patients, broken down by gender and classification (when available)

<sup>74</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), xlvii.

<sup>75</sup> Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Basingstoke: Palgrave Macmillan, 2014), 29.

*\*In 1892, Crichton accepted a significant number of lunatics from nearby Lanarkshire, while new parish hospitals were built. They remained there for many years, explaining the sudden increase in pauper patient population.<sup>76</sup>*

Alongside class, gender was the other great organizer of the Victorian and Edwardian asylum, as well as being one of the great influential elements of domesticity. The extent to which gender influenced women's admission to asylums has been greatly debated in the historiography. Some have suggested that insanity was a term used to control deviant female behaviour, like sexuality, cursing, and noisy conduct.<sup>77</sup> More recently, historians have argued that gender was not a significant factor in the admission of insane people into the asylum, countering earlier claims about the medicalization of women's behaviour in the Victorian era.<sup>78</sup> This revelation countered earlier suggestions that women were disproportionately confined in asylums by their male relatives and spouses, whereas the realities of empirical evidence demonstrated that all family members participated in the certification and confinement of their ill relatives.<sup>79</sup> As seen in Figure 2, there is some indication that women were overrepresented in the asylums I am examining, but the rates do not suggest the "overwhelming dominance" that feminist historians have argued existed.<sup>80</sup>

Nevertheless, asylums were largely gender segregated, with some activities such as concerts and theatrical productions being places of hetero-social mingling. Men and women alike were frequently employed in the asylum, which I will discuss in depth in Chapter One. However, this employment was assigned along strict gender divisions. While men worked in the gardens and the grounds, women were generally employed in more traditionally feminine activities like the kitchens, the laundry, and the sewing room.<sup>81</sup> In cases where the gender-

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<sup>76</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), xxiii.

<sup>77</sup> Jonathan Andrews and Anne Digby (eds.), Introduction to *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodpoi, 2004), 29.

<sup>78</sup> Wright, "Delusions of Gender," 149.

<sup>79</sup> Wright, "Delusions of Gender," 169.

<sup>80</sup> Anne Shepherd, "The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums," in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, ed. Jonathan Andrews and Anne Digby (Amsterdam: Rodpoi, 2004.), 223.

<sup>81</sup> Shepherd, "The Female Patient Experience," 241.

segregated nature of the wards was threatened, anxiety ensued. For example, one of the major reasons cited for the construction of a new Recreation Hall at Bethlem was the fact that the current concerts and theatrical shows were held on a temporary stage in one of the women's wards. The hall, despite being an enormous financial burden to the hospital, was explicitly intended to avoid male patients and attendants entering the female wards.<sup>82</sup>

Even beyond the patients, the asylum was a large patriarchal institution, with almost exclusively men at the helm. The physician-superintendent, which was frequently imagined as a pseudo-father figure to patients, had extensive control over the goings-on of the asylum, and many of his high-ranking medical officers were also men.<sup>83</sup> With only one exception found in the records of the case study asylums examined here – the appointment of medical officer Dr. Margaret Dewar to the ladies' division at Crichton Royal Hospital in 1895 – women usually could only hold the Matron position at their highest, which was still a low-ranking administrative position.<sup>84</sup> Thus, for both patients and staff, the asylum was an incredibly gender-segregated space, in ways that the 'outside world' was not necessarily.

Once the patient was certified and admitted, their experiences were still largely impacted by external factors. The geography of the asylum, for one, was vital to the patient experience. As I will discuss later in this thesis, space was necessary for constructing liberty and domesticity in the asylum. Among the various factors that contributed to the particular confluence of ideals and norms that defined Victorian culture, the shift from rural to urban communities was foremost. Certainly, therefore, the importance of physical geography extended to the medical world and the asylum. By the halfway point of Queen Victoria's reign, the majority of the population was concentrated in towns and cities.<sup>85</sup> The move towards urbanisation, scholars have suggested, meant that urban Victorians began to romanticise rural

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<sup>82</sup> *Bethlem Royal Asylum Annual Report* (1895), 43.

<sup>83</sup> "Yellowlees Obituary," 270.

<sup>84</sup> *Thirty-Eighth Annual Report of the Scottish Commissioners in Lunacy* (1896), 60.

<sup>85</sup> W.J. Keith, 'The land in Victorian literature,' in Mingay, *The Victorian Countryside*, p. 138

landscapes, “for refreshment and renewal, as a haven from the wearying pace of city life.”<sup>86</sup> In general, Victorian contemporaries and historians alike have argued that urbanisation was essential to the increase in asylum populations, since domestic space became more valuable as urban populations swelled.<sup>87</sup> However, when combined with the increasing perception of rural space as healing, the geographic location of the asylum becomes increasingly more important. The three asylums that form the basis of this thesis present a range of geographical locations, ranging from distinctly rural to concretely urban. Located in Dumfries, Scotland, Crichton Royal Institution was the most rural of the three institutions. This allowed it to be constantly evolving and expanding, including the acquisition of new cottages for high-paying private patients and the creation of a new building called the “Third House,” which began construction in 1898.<sup>88</sup> Gartnavel was found, after its 1843 move, on the outskirts of Glasgow, making it a semi-urban and semi-rural space. Bethlem, in its nineteenth century incarnation, was in bustling central London, in the building which today houses the Imperial War Museum. The place where the asylum was located impacted the patients’ experience with the space, as did the organization within the asylum in regard to patients’ gender and class.

Bethlem was moved to a new location in 1815, after its previous location at Moorfields became overcrowded. Its new location was in Southwark and quickly became known for its extremely modern and civilized architectural style, including a portico and a looming dome.<sup>89</sup> The dome became iconic, inspiring the name for the institution’s magazine, *Under the Dome*. The front side, pictured below, faced a bustling street and meant that the asylum’s workings were visible to the average passerby, in some cases.<sup>90</sup> The asylum was comprised on one single,

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<sup>86</sup> W.J. Keith, ‘The land in Victorian literature,’ in Mingay, *The Victorian Countryside*, p. 138

<sup>87</sup> Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective*, Vol. 3 (Berkeley: University of California Press, 2019), 216-217.

<sup>88</sup> Gillian Allmond, “Liberty and the Individual: The Colony Asylum in Scotland and England,” *History of Psychiatry* 28, no. 1 (2017): 31.

<sup>89</sup> Yanni, *The Architecture of Madness*, 19.

<sup>90</sup> Yanni, *The Architecture of Madness*, 19.

long building, with wings stretching from either side of the dome. Many were critical of the design of the new Bethlem Hospital. The spaces where the patients lived were perpetually dark and gloomy, and the stylish portico blocked the sun from many of the rooms, which led some to suggest that the architect had prioritized the doctors' desire for magnificence and public status over the needs of patients.<sup>91</sup> However, James Lewis, the architect who designed Bethlem's new building, was well-versed in a range of architectural practises, and had begun his career as a country house architect before moving on to institutional architecture of hospitals, schools, and of course, asylums.<sup>92</sup>



**Figure 1** Photograph of Bethlem Royal Hospital, c. Early 20th century <sup>93</sup>

Glasgow Royal Hospital was initially built in 1815, with the renowned architect William Stark at its helm. In the process of designing the building, Stark was largely concerned with patient surveillance, an illusion of liberty, and comfort, which he believed would modify the

<sup>91</sup> Yanni, *The Architecture of Madness*, 19.

<sup>92</sup> Peter Leach, "Lewis, James (1750/51–1820), architect," *Oxford Dictionary of National Biography*, 2004, <https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-37672>.

<sup>93</sup> 09/HPC-07, "Album of photographs of hospital exterior and interior at St George's Fields" from the Bethlem Museum of the Mind Archives

behaviour and conduct for insane patients.<sup>94</sup> By the 1840s, the hospital had been suffering from overcrowding for years and in 1843, a new building was opened on the outskirts of the city.<sup>95</sup> This new location was chosen due to its privacy and its large grounds of sixty-six acres. The design of the new asylum was informed by extensive travel undertaken by the architect, Charles Wilson, who chose to visit many of the most famous asylums in England and France to assess the practises and challenges of existing asylum architecture.<sup>96</sup> The asylum was divided into two major buildings, the East House and the West House. The West House contained the ward for male and female private patients, as well as the physician's house. It was decorated with fashionable décor and resembled, in many ways, a modern Victorian mansion. Patients in the West House had their own rooms, their own suites, and dayrooms.<sup>97</sup>



**Figure 2** Gentleman's quarters in the West House, Gartnavel Royal Hospital <sup>98</sup>

<sup>94</sup> Ann Snedden, "Environment and Architecture," in *Let There Be Light Again: A History of Gartnavel Royal Hospital From its Beginnings to the Present Day*, ed. Jonathan Andrews and Iain Smith (Glasgow, 1993), 25-26.

<sup>95</sup> Snedden, "Environment and Architecture," 30.

<sup>96</sup> Snedden, "Environment and Architecture," 30.

<sup>97</sup> Snedden, "Environment and Architecture," 31.

<sup>98</sup> Snedden, "Environment and Architecture," 45.

Originally, the East House contained the wards for male and female pauper patients, which surrounded the part of the house containing the kitchen and wash-houses. By the 1890s, Gartnavel had essentially stopped accepting pauper cases, and the space was renovated. Though the patients living in East House were still technically private patients, they were paying lower rates of board and thus, their space was sparser.<sup>99</sup> While the layout of the asylum seemed modern upon its inception, inspired by world-renown asylums, it was considered dated and institutional by its own directors by the late 1880s.<sup>100</sup>



**Figure 3** The 1874 Plan for Gartnavel Royal Hospital <sup>101</sup>

The comment by Gartnavel directors about the dated and institutional nature of their asylum was inspired by a new system of asylum layout that had become popular recently – the cottage

<sup>99</sup> Snedden, “Environment and Architecture,” 31.

<sup>100</sup> Snedden, “Environment and Architecture,” 34.

<sup>101</sup> Snedden, “Environment and Architecture,” 43.

system. Gartnavel's Scottish contemporary, Crichton Royal Institution, exemplified this modern and home-like system of asylum architecture. Crichton was opened in 1839, with an endowment Dr. James Crichton and his wife, Elizabeth Crichton. By the end of the nineteenth century, the asylum was being transformed into a colony style asylum, patients were being housed in smaller, home-like cottages, which was the most popular and modern style of the late nineteenth century.<sup>102</sup>

Ultimately, the physical space of these three asylums represent a wide spectrum of asylums at the end of the nineteenth century. All had been built to be modern in the eyes of their respective architects and represented changing visions on asylum architecture, but only Crichton had maintained its modernity by the end of the century, regularly receiving praise from the Commissioners in Lunacy. Similarly, all three asylums represented a range of locations, ranging from urban to rural. The physical location of the asylums not only impacted the ability of the asylum to expand, but also affected their ability to be self-sufficient. Crichton, as the most rural of the bunch, was also nearly entirely self-sufficient at the end of the century, with its own farm to produce the majority of its own food, laundry, butcher, tailor, and other services.<sup>103</sup> In terms of gender, class, and location, these asylums are similar enough to be comparable, while maintaining their own individual character, which allows them to be representative of the implementation of domesticity in the asylum.

## Historiography

The investigation into domesticity in the English and Scottish lunatic asylum contributes to questions in two disparate historiographies: the history of psychiatric institutions and the history of the Victorian home. Both of these historiographies touch on questions of space,

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<sup>102</sup> Snedden, "Environment and Architecture," 34.

<sup>103</sup> James Carmont, *The Crichton Royal Institution, Dumfries* (Leicester: De Montfort Press, 1896), 39.



comfort, and communities, which are also centered in my own research. In asking question about the nature of domesticity in the asylum, this thesis marries these two disparate historiographies and produces new insight on the permeable walls between the institution and the home. Due to its contradictory institutional nature and pseudo-domesticity, the lunatic asylum occupied a strange place between the realms of public and private sphere. The long-standing historiography on Victorian domesticity is intensely concerned with the separation (or lack thereof) between the imagined public sphere and the imagined private sphere. Many Victorians imagined their world divided into two separate domains, with a feminized private sphere and a masculine public sphere. This divide was created and reinforced by nineteenth century prescriptive literature, which coached men and women on behaviour, manners, and expectations of their disparate spheres. Powerful cultural texts like Coventry Patmore's *The Angel in the House* and Sarah Stickney Ellis' *The Daughters of England*, as well as the emergence of the popular genre of the conduct book, idealised the feminine activities of housekeeping, servant management, and effortless marriage maintenance. The construction of norms of femininity in the nineteenth century placed women's labour distinctly in the domestic, private sphere while men were left to control the public sphere of politics and economy. This persistent – yet fundamentally simplistic – vision of Victorian gendered culture became deeply influential in the historical understanding of nineteenth century Britain.

The concept of “separate spheres” as the divide between a feminine private sphere and a public masculine sphere has been frequently reimagined by historians of the Victorian home and eventually allowed historians to critically engage with the ever-changing relationship of gender, class, and age in and out of the home. Some have accused early historians of using the concept of separate spheres uncritically. In a seminal historiographical article from the late 1980s, Linda Kerber describes the varied and occasionally “sloppy” ways in which the term

“separate spheres” had been used by historians throughout the previous few decades.<sup>104</sup> She argues that in the 1960s and early 1970s, when historians first began utilizing the metaphor of separate spheres, the domestic women’s sphere was generally cast as a negative tool of subordination and oppression.<sup>105</sup> Later, from 1975 onwards, women’s historians began recasting the private sphere as a space bearing empowering, uniquely feminine culture and friendship, albeit a culture still formed largely around domesticity and distinct from the public sphere.<sup>106</sup> In this vein, Patricia Branca worked to complicate the effortless ‘angel in the household’ image constructed in Victorian prescriptive literature. She pointed out that most middle-class women had to maintain an illusion of effortlessness while undertaking difficult household labour, servant management, and household accounting.<sup>107</sup> Branca’s argument served to complicate the historical imagination of the domestic sphere by revealing its inherent illusionary nature. Martha Vicinus’ classic *Suffer and Be Still: Women in the Victorian Age* (1972) and its follow-up, *A Widening Sphere: Changing Roles of Victorian Women* (1977) are both edited collections which succinctly demonstrate the state of thought on separate spheres in the 1970s. By and large, the essays in these collections, especially the latter, consider extraordinary women who made it into the public sphere – scholars, property owners, and actresses. In the introduction to *Suffer and Be Still*, Vicinus describes the aim of the collection as understanding the ways in which the Victorian woman increasingly broke away from “the model of the perfect lady” through political activism, education, and employment.<sup>108</sup> Nevertheless, these cases were rare, and this work ultimately demonstrates the enduring cultural power of separate spheres. While Branca’s argument complicated the vision of women’s roles

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<sup>104</sup> Linda K. Kerber, "Separate Spheres, Female Worlds, Woman's Place: The Rhetoric of Women's History," *The Journal of American History* 75, no. 1 (1988): 17.

<sup>105</sup> Kerber, "Separate Spheres," 11-13.

<sup>106</sup> Kerber, "Separate Spheres," 14-17.

<sup>107</sup> Patricia Branca, *Silent Sisterhood: Middle Class Women in the Victorian Home* (London: Croom Helm, 1975), 144.

<sup>108</sup> Martha Vicinus, *Suffer and be Still: Women in the Victorian Age* (Bloomington: Indiana University Press, 1972), xiv.

in the domestic sphere, Vicinus' vision considered the ways that individual women were able to gain power in the traditionally public sphere. Both forms of these arguments served to complicate the idea of separate spheres, either by reimagining the domestic sphere or illuminating stories of women who were able to enter the public sphere.

These evolving relationships between gender and domesticity eventually set the stage for further developments in the literature during the 1980s. In the 1980s, there was a crystallization of historical understandings of private and public as intertwined. As a seminal text on English middle-class domesticity, Leonore Davidoff and Catherine Hall's 1987 *Family Fortunes: Men and Women of the English Middle Class 1780-1850* is a self-proclaimed example of this historical moment.<sup>109</sup> They suggested that "[p]ublic was not really public and private not really private despite the potent imagery of 'separate spheres.'"<sup>110</sup> This turn deconstructed the prescriptive associations of men with the public sphere and women with the private sphere, allowing for critical gendered analysis across the spheres. Another example of a product of this turn is the 1992 publication of James Hammerton's *Cruelty and Companionship: Conflict in Nineteenth-Century Married Life*. In this monograph, Hammerton considers the influence of the public gaze on marriage, arguing that this eventually led to more legislation on "the darker side of conjugal life."<sup>111</sup> He considers men in the home and their role in the distinctly private sphere world of marriage, and the role of the public gaze in private lives, which is a product of the 1980s critical approach to gender and domesticity. In 1993, Amanda Vickery declared that if "there had always been separate spheres of gender power, and perhaps there still are, then 'separate spheres' cannot be used to explain social and political developments in a particular century, least of all to account for Victorian class formation."<sup>112</sup>

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<sup>109</sup> Davidoff and Hall, *Family Fortunes*, xvii.

<sup>110</sup> Davidoff and Hall, *Family Fortunes*, 33.

<sup>111</sup> James A. Hammerton, *Cruelty and Companionship: Conflict in Nineteenth-Century Married Life* (London; New York: Routledge, 1992), 2.

<sup>112</sup> Amanda Vickery, "Golden Age to Separate Spheres? A Review of the Categories and Chronology of English Women's History," *The Historical Journal* 36, no. 2 (1993): 413.

She concluded this after tracing the emergence of the domestic middle-class woman all the way through to its seventeenth century iteration, suggesting that these reoccurring patterns of gendered labour divisions transcended the Victorian moment. Though separate spheres maintained its position as a powerful ideology, the period following the publication of *Family Fortunes* interrogated the gulf between the ideology and the reality.

This shift ultimately resulted in a specific interest in the male relationship to domesticity, including John Tosh's 1999 *A Man's Place: Masculinity and the Middle-Class Home in Victorian England*. In this monograph, Tosh explains the evolving male relationship with domestic values over the course of the nineteenth century, from the ascendancy of "masculine domesticity" to its climax and eventually, reactions against it.<sup>113</sup> It is an early example of the turn towards studies of masculinity as a gendered construct in the field of Victorian domestic studies. More recently, examining both masculinity and femininity as key elements of domestic ideology has allowed for domesticity to be examined outside of the traditionally feminized family home, further challenging and re-navigating the definition of separate spheres. Amy Milne-Smith's 2011 *London Clubland: A Cultural History of Gender and Class in Late Victorian Britain* removes domesticity from the context of the traditional home by examining the homosocial space of gentleman's clubs as an alternative home resulting from the male flight from traditional domesticity at the end of the nineteenth century. She demonstrates the power of the domestic ideology beyond the reaches of the home. By following in the historiographical footsteps of Milne-Smith, my project considers how domesticity was a powerful organizing force outside of the home at the end of the nineteenth-century. As the asylum is a non-traditional home space, it had its own relationship to domesticity and therefore, gender and class.

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<sup>113</sup> Tosh, *A Man's Place*, 196.

Of course, attached to the question of domesticity and gender norms is the question of consumption and material goods. An early addition to this subfield of the study of domesticity was Lori Loeb's 1994 *Consuming Angels: Advertising and Victorian Women*. In this monograph, Loeb considers the way that women were instrumental to the commercial life of the late nineteenth century, using an extensive body of Victorian advertisements. She suggests that advertisements constructed and idealised femininity and motherhood through their images, seeking to make middle-class women commercial actors. In 2006 Deborah Cohen's *Household Gods: The British and their Possessions* reimagined the relationship between Victorians and the objects that cluttered their homes. In particular, she examines the relationship between Victorian morality and material goods, as well as the way in which decoration was used to showcase personality (as opposed to the earlier 'character'). More recently, Jane Hamlett considered the ways in which physical space could mold social relationships within a home, in the 2010 monograph *Material Relations: Domestic Interiors and Middle-Class Families in England, 1850-1910*. All of these selected texts showcase the importance of material culture and domestic aesthetics in influencing the people who engaged with them, which has been an important consideration for this research project.

My research project draws on the literature on the history of psychiatry as much as it does on the history of domesticity, which has also undergone major shifts since the mid-century. Concerning the literature of psychiatric history, my focus on liberty and domesticity in the asylum engages with enduring questions about the so-called progress narrative and social control, while simultaneously innovating the approach to these questions. Until the early 1960s, historiography on psychiatry generally saw care of the mentally ill as moving on an upwards trajectory, progressing from barbarity to humane treatment. Michel Foucault's 1961 publication *Folie et déraison* was among the first to problematize the traditional progressive narrative of psychiatry. Instead, he argued that this "Whiggish" history fundamentally miscast the

nineteenth century asylum as moral and humane, when it instead produced a state of surveillance as oppressive as physical restraint. Similarly, Irving Goffman's text *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* was also published in 1961 and explores the patient's experience in what he calls "total institutions." Goffman takes on a similar rhetoric to Foucault, examining the power dynamics between asylum staff and patients, and arguing that routines in the asylum were purposefully constructed to insidiously implement total control over the patients.

The concept of social control in the asylum inspired generations of scholars, who added their own element to this narrative of social control, which sought to de-emphasize the therapeutic element of the asylum. Andrew Scull's 1979 *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* cast insidious motives on the asylum, with a Marxist twist. He suggested that economic developments of this period would assure that family members could not afford to support mentally ill family members, and asylums were created in response to this. In his vision, asylums served to either transform people back into productive members of capitalism or otherwise served as convenient storage for the mentally ill away from society.<sup>114</sup> A few years later, Anne Digby pursued similar themes in the 1985 monograph *Madness, Medicine and Morality: A Study of the York Retreat, 1796-1914*. By focusing on one single institution, she is able to rigorously test Foucault's assertions against the lived experiences of patients in the asylum. Ultimately, she presents a vision of Foucauldian asylum social control that accommodates the particular nature of the York Retreat. Some historians, however, saw more continuities than ruptures between Whiggish interpretations of the asylum and Foucauldian ones. Roy Porter's 1987 *Madmen: A Social History of Mad-Houses, Mad-Doctors & Lunatics* is indicative of a move away from the Foucauldian interpretations of madness. To complicate Foucault's vision of a great confinement of mad

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<sup>114</sup> Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979), 14.

people at the start of the nineteenth century, Porter examines madness in the Georgian period, suggesting that there were more continuities between the eighteenth and nineteenth centuries than Foucault and Scull suggested.<sup>115</sup> Porter agrees that the eighteenth century was ‘a disaster for the insane’ but spends much of the monograph undermining the Foucauldian idea of a great confinement and adding nuance to the vision of the eighteenth century as the precursor to Victorian reformist attitudes. Porter ultimately presents an argument that is halfway between an embracing of the social control narrative and a rehabilitation of the asylum.

Other historians have proposed alternative interpretations of the asylum, which complicate the idea that social control in the asylum was all-encompassing. Ellen Dwyer is an early example of this trend, with her 1987 monograph *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums*. Dwyer examines two asylums in New York, but her focus on the social role filled by asylums, her generally positive view on the care they provided to patients and idea of the asylum structure as familial would launch the history of psychiatry away from the simplicity of the social control narrative. Dwyer’s moderate vision has continued to be proliferated in the historiography. Among British historians, the asylum’s relationship to social control has only recently begun to be rehabilitated. As recently as 2014, Jane Hamlett’s *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian and Edwardian England* examines asylums, lodging houses and schools in the nineteenth century and argues that domestic material culture in the institution was sometimes a means of control, but sometimes was a source of comfort and individuality for those who were institutionalized.<sup>116</sup>

In fact, the Anglo-Scottish comparison I employ here is certainly also not unprecedented in the history of Victorian domesticity in the psychiatric institution. Gillian Allmond’s 2017

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<sup>115</sup> Roy Porter, *Madmen: A Social History of Madhouses, Mad Doctors & Lunatics* (Stroud: Tempus, 2004), 275-276.

<sup>116</sup> Jane Hamlett, *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian and Edwardian England* (Hampshire: Palgrave Macmillan, 2015), 21-22.

article “Liberty and the individual: the colony asylum in Scotland and England” unravels the differences between Scottish and English acceptance of the ‘village asylum,’ a system of unattached villas in a wide stretch of land, which she argues expresses significant cultural differences in the priorities of English and Scottish medical communities. She sees herself as “[challenging] the historiographical orthodoxy” that views the late nineteenth century as a moment where the field of psychiatry distanced itself from the physical asylum space. She argues that, while Scottish medical professionals embraced this villa system due to their prioritisation of patient liberty, English psychiatric professionals prioritised security and hygiene.<sup>117</sup> In many ways, my project builds on this article by engaging in a similar scope of comparison, unpicking the equalizing terminology of “British” and challenging existing notions about the un-therapeutic nature of the asylum space.

The history of psychiatric institutions lends itself to the particular genre of single-institution texts, and the three case study institutions have received varying levels of historiographical attention. Glasgow Royal Asylum has been treated by an edited collection published for its 150<sup>th</sup> anniversary in 1993 and a follow-up published in 1996. This edited collection brings together historians’ perspectives on all elements of institutional life, both therapeutic and administrative. In particular, the chapter on “Environment and Architecture” by Ann Snedden is useful to my project, because of the light it sheds on the ever-shifting physical space of the asylum. Crichton Royal Hospital has not been examined in an overarching institutional monograph, though the collection of patient art assembled by the physician superintendent W.A.F. Browne was examined by historian Maureen Park, as part of a broader historiographical desire to access the specific experiences and inner lives of institutionalised patients.<sup>118</sup>

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<sup>117</sup> Allmond, “Liberty and the Individual,” 29.

<sup>118</sup> Maureen Park, *Art in Madness: Dr. W A F Browne’s Collection of Patient Art at Crichton Royal Institution, Dumfries* (Dumfries: Dumfries and Galloway Health Board, 2010), see especially Introduction and Chapter One.



Certainly, the institution that has received the most monograph-length attention is Bethlem Royal Asylum. Bethlem serves as a case-study in countless texts but is the main subject of a few notable histories. The 1996 text *Masters of Bedlam: the Transformation of the Mad-Doctoring Trade* brought together heavyweights of the field Andrew Scull, Charlotte Mackenzie, and Nicholas Hervey. This text largely examines the experiences of medical professionals at Bethlem over the course of the nineteenth century, but these experiences are closely intertwined with the development of the institution at large. Shortly after, another bevy of historians tackled Bethlem's notorious history in the 1997 *The History of Bethlem*. This text is co-authored by Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker and Keir Waddington. It takes an in-depth and complete look at the entire history of the institution, from its opening to nearly present-day. More recently, there was the 2003 publication of *Presumed Curable: An Illustrated Casebook of Victorian Psychiatric Patients in Bethlem Hospital*. By using photographs and daguerreotypes of patients at Bethlem as their major source, Colin Gale and Robert Howard unveil a fascinating wealth of material culture sources and centre the oft-forgotten patient experience in their institutional history. By pulling together disparate institutional histories and marrying them with an emerging historiography which reconsiders the therapeutic nature of the asylum, this project connects questions of physical space, outside community, and professional legitimization in the heyday of the psychiatric institution.

Ultimately, this thesis investigates the cultural impact of domesticity on the asylum, directed primarily by the medical practitioners and the ways in which staff, patients, families and the state enforced, re-enforced and challenged these ideas and behaviours. In Chapter One, I will interrogate the attempts to implement recreation and labour in the asylum as forms of therapeutic domesticity. I will examine the ways in which gender and class influenced the implementation of these activities, especially labour, as well as exploring the ways in which patients were able to exercise agency in these domains. In the realm of cultural pursuits, patients

and staff interacted closely. In these moments of levity, brought about by theatre and music in the asylum, I will assess the impact of recreation on institutional hierarchies and patient agency. In the literary culture of the asylum especially, asylum administrators provided patients with a platform for their opinions and experiences.

In Chapter Two, I will assess the attempts to implement institutional domesticity into the physical environment of the asylum. These attempts generally took one of two forms. First, I will examine attempts to change the impermanent scenography of the traditional asylum space. In doing so, I will examine attempts at renovation and redecoration in standard ward-style asylum buildings and the ways in which administrators battled against inherently institutional visual cues. Additionally, I will consider the ways that medical staff sought to control the movement of patients within the asylum, through the use of locked doors and physical restraints. In each of these scenarios, institutional domesticity faced challenges and reached its limitations, often due to the inherently institutional nature of the asylum and the practicalities of daily life. The implementation of institutional domesticity into the physical space of the asylum also took the form of a new system of villa-style houses, which were nearly physically identical to a Victorian or Edwardian home. Even in these spaces, which were pinnacles of homeliness, the realities of asylum life created challenges and barriers to institutional domesticity. In understanding doctors' attempts to implement domesticity in both the activities and the space of the asylum, this thesis reveals the ways in which all asylum actors were able to engage with, mold, and challenge domesticity. Ultimately, this thesis does not assess the impact this new form of medical thinking had on patients. Rather, it considers the mutable nature of the institution. This thesis considers the patients insofar as they are actors who influenced the implementation of domesticity in the institution, despite the fact that many patients were incarcerated against their will. Ultimately, however, this is an investigation into the nature of the institutional space and its relationship with domesticity.



## Chapter One - Domesticating the Mind: Recreation and Employment in the Asylum

“Satan finds some mischief still for idle hands to do,” Dr. David Bower, physician superintendent at Springfield House Asylum, suggested in an 1882 article in the *Journal of Mental Science*, on the subject of bored patients in the asylum.<sup>119</sup> The medical staff at asylums sought to create predictable, calming environments to promote patient healing. However, the risk of boredom loomed, threatening the recovery of patients and the general peace of the asylum. Asylum staff of all ranks were tasked with continually balancing patient experiences between that of healthy amusement and destructive boredom. To make the day as predictable yet engaging as possible, staff managed patients’ daily activities on carefully planned itineraries. The daily routine in the asylum varied from institution to institution, but in general, it was centered on three main meals – breakfast, a mid-day dinner (the largest meal) or lighter luncheon, and in the evening, dinner or the lighter option, tea. This was punctuated by a regimented schedule of outdoor sports, games, and work to keep patients busy.<sup>120</sup> Physician Superintendent James Rutherford described the ideal routine for a patient at Crichton Royal Institution: wake at 5:30 a.m. with the attendants; both attendants and patients work together to clean the institution until 7:30 a.m., when they had breakfast; attend chapel at 8:30 a.m.; various working groups begin at 9 a.m.; dinner at 1 p.m.; recommence work at 2 p.m.; return for tea at 6 p.m. After this and before 10 p.m. bedtime, patients might partake in various amusements offered at the asylum.<sup>121</sup> The evening amusements often took the form of concerts, theatre, conversation groups, and other class-appropriate leisure activities. Occasionally, this routine

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<sup>119</sup> David Bower, “Employment in the Treatment of Mental Diseases in the Upper Classes,” *JMS* 28, no. 122 (1882): 182.

Dr. Bower is in fact, quoting Isaac Watts, a well-known eighteenth-century hymn writer. This line comes from Watts’ poem “How Doth the Little Busy Bee.”

<sup>120</sup> Bower, “Employment,” 187.

<sup>121</sup> James R. Dunlop, “The ‘Open Door’ System,” *JMS* 27, no. 119 (1881): 479.

was broken with trips into nearby towns, excursions to local sporting events, or drives in the countryside, but it remained largely the same.<sup>122</sup> This routine changed little day-to-day but was centered on regular engagement with recreation and labour, which were key components of therapeutic domesticity.

The implementation of recreation and work in the asylum was not a new practise by the end of the nineteenth century. As early as the eighteenth century, asylum administrators had begun to think about treatment differently, largely as a result of the intellectual environment produced from the Enlightenment.<sup>123</sup> These early therapists theorized that insanity resulted from disordered patterns of reasoning and suggested that distraction from these irrational patterns might be a key element of healing patients. This was part of a larger shift towards moral therapy, a treatment system intended to be kinder, more modern, and more enlightened than the confinement of past centuries.<sup>124</sup> At the more cutting-edge institutions at the end of the eighteenth century, female patients worked in the kitchens, polished furniture, and mended clothing, while male patients chopped wood and churned butter.<sup>125</sup> A century later occupational treatment, through the dual pillars of employment and recreation, had become an essential part of asylum therapeutics. This form of therapeutic treatment was believed to distract chronically ill patients from their delusions and gave them less time to brood on the misfortunes that were thought to cause their insanity in certain cases.<sup>126</sup> Simultaneously, occupational therapy served to physically tire the patient, so they had less energy for destructive behaviours. Excess energy was believed to manifest in destructive behaviour like tearing clothing or linens, breaking windows or decoration, masturbation, violence, and even suicide.<sup>127</sup> Labour and recreation had

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<sup>122</sup> Bower, "Employment," 187.

<sup>123</sup> Anne Digby, *Madness, Morality, and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), 34.

<sup>124</sup> Digby, *Madness, Morality, and Medicine*, 33.

<sup>125</sup> Digby, *Madness, Morality, and Medicine*, 42.

<sup>126</sup> Bower, "Employment," 183.

<sup>127</sup> Bower, "Employment," 183.

become entrenched parts of asylum treatment and this reinforced the context of institutional domesticity in asylums at the end of the nineteenth century.

Employment, in particular, was steeped in class expectations. A patient's pre-asylum socio-economic status deeply influenced the kind of work they were able to do within the asylum. The work that needed doing in the asylum was often menial and unskilled work, like polishing furniture, farming, or gardening, which some administrators, if not many patient families, deemed inappropriate for patients who paid private patient fees. At Royal asylums, physician superintendents particularly struggled to assign work, as there tended to be both private and pauper patients housed there. Nevertheless, psychiatrists emphasized that employment was particularly important to patient treatment, in a way that recreation alone could not satisfy. Labour gave patients a sense of accomplishment and provided patients a sense of purpose in their institutionalised lives.<sup>128</sup> For men, outdoor labour was particularly important, due to the physical benefits it provided men. The Commissioners in Lunacy frequently praised the implementation of outdoor physical activity as means of treatment in the asylum. In fact, in some cases, Commissioners even felt that extensive time working outdoors counteracted the disadvantages of less-than-ideal indoor spaces, like the "defective and antiquated character" of Crichton's Second House for male pauper lunatics.<sup>129</sup> Despite the tricky nature of assigning labour in the asylum, it was a key element of the process of treatment.

I will argue that many asylum administrators were deeply committed to the implementation of labour as part of treatment in the asylum. For private patients, this took the form of overcoming class-based expectations of what was and was not appropriate work, which administrators were willing to compromise for the therapeutic benefits of employment. Asylum administrators also demonstrated significant creativity in assigning work to private patients, to maximize the number of patients who benefitted from labour. For pauper patients, I will argue

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<sup>128</sup> Bower, "Employment," 183.

<sup>129</sup> *Thirty-Eighth Annual Report of the Scottish Commissioners in Lunacy* (1896), 61.

that asylum administrators recognised the value of pauper labour, and in turn, patients were able to access otherwise inaccessible comforts and luxuries. This mutually beneficial relationship suggested that employment was one environment where the implementation of institutional domesticity was successful, despite some challenges.

Recreation was a well-established method for staving off the monotony of asylum life and keeping patients away from destructive tendencies. Sometimes, recreation took the form of sports and exercise. Sports like cricket and tennis were especially important, since they were generally believed to instill an understanding of discipline and obedience, which could help an insane patient recover their sanity.<sup>130</sup> However, cultural recreation served a particularly interesting role within the asylum. In wider society, “rational recreation” was booming. This was the largely middle-class belief that culture could be mobilized through philanthropic efforts to moralize and rationalize the poor.<sup>131</sup> Similar beliefs about rationality and morality were applied to the insane, making cultural recreation a particularly interesting element of therapeutic domesticity.

In examining cultural recreation in the asylum, I will argue that, in the late nineteenth century, the construction of recreation-specific buildings in asylum settings demonstrated an increasing value placed on musical and theatrical recreation within the institution. The direct involvement of staff in the production of cultural recreation in the asylum – through staff-led orchestras and theatrical troupes – allowed for unique moments of levity and a relaxation of strict asylum hierarchies. This kind of patient-staff interaction allowed for strict asylum hierarchies to be re-framed as more gentle and familial hierarchies, contributing to an overall sense of domesticity. Additionally, cultural recreation was one of the rare occasions in the asylum when patients could be forces of production. In producing cultural recreation, patients

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<sup>130</sup> Hide, *Gender and Class in English Asylums*, 117.

<sup>131</sup> Peter Bailey, *Leisure and Class in Victorian England: Rational Recreation and the Contest for Control, 1830-1885* (London: Routledge & Kegan Paul, 1978), 132.

could assert their agency, which in turn promoted a sense of liberty and normalcy within the asylum. Beyond performative recreation like theatre and music, I will examine the proliferation of institutional magazines at the end of the nineteenth century. I will suggest that these were also successful places for patients to seek out agency and a sense of liberty, through their contributions to the cultural record of the institution. Institutional magazines, too, were a setting where strict patient-staff hierarchies were relaxed, and patients could form communities together, contributing to an illusion of de-institutionalisation in the asylum. Ultimately, in examining both employment and recreation in the asylum, I will argue that they were a major priority for medical professionals and asylum administration at the end of the nineteenth century. I will also suggest that recreation and labour were two settings where the implementation of domesticity was relatively successful. Both recreation and labour allowed patients a unique sense of agency and personal value which produce the sense of liberty necessary for institutional domesticity. Additionally, recreation shrouded and relaxed asylum hierarchies, which was necessary for institutional domesticity to flourish as a form of treatment within the asylum.

### Employment in the Asylum

The asylum confronted its complicated status as a liminal place between public and private spheres most clearly in its assignment of work. Labour was a defining feature of both gender and class in wider society. Victorian society often defined class by the type of work one engaged in, with the burgeoning Victorian middle class often defining themselves against the working class through their employment and labour.<sup>132</sup> In terms of gender expectations, too, employment was a firm definer of the masculine public sphere and housework a component of the feminine domestic sphere. Despite the fact that labour in the wider world was part of the public sphere,

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<sup>132</sup> Gunn, *The Public Culture*, 14-15.



in the asylum it was a function of therapeutic domesticity. Much of the work done in the asylum, like cleaning and gardening, mimicked domestic tasks more than it mimicked traditional wage labour. Considering the role of employment as a defining characteristic of gender and class in the wider Victorian world, it was no surprise that Commissioners in Lunacy recommended employment “in healthy and congenial occupation either in the shape of industrial work or otherwise as may be best suited to the position and habits of the patients.”<sup>133</sup> Patients were expected to conform, at least to some extent, to their gender and class expectations in the work that they performed, though, as will be demonstrated, there was a degree of flexibility in certain cases.

The work of patients contributed significantly to the continued functioning of the asylum, by providing free labour for cleaning, housekeeping, grounds-keeping, or food production. Though it may appear that patients were simply employed as a way to cut costs, physicians were convinced of the patient behavioural and therapeutic value of labour. First, the employment of patients was believed to minimise boredom in the asylum, which in turn curtailed mischief and destruction.<sup>134</sup> There was a prevailing belief among doctors that the insane were “a class of people who are prone to do evil as the result of their mental aberration” unless they were properly occupied.<sup>135</sup> Certainly, patient labour was beneficial to the asylum and it occupied patients during waking hours. It helped to break up the monotony of the daily routine in the asylum for patients and for staff. Doctors genuinely believed that labour benefitted a patient’s mental well-being, as they believed it distracted patients from their misfortune and in turn, raised their low spirits.<sup>136</sup> Beyond its mental benefits, doctors felt that employment had therapeutic value for a patient’s physical health due to fresh air and exercise, for those who worked outside. Commissioners in Lunacy praised Crichton for its rural

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<sup>133</sup> *Thirty-Eighth Annual Report of the Scottish Commissioners in Lunacy* (1896), 61

<sup>134</sup> Hide, *Gender and Class in English Asylums*, 112.

<sup>135</sup> Edward D. O’Neill, “The Systematic Employment and Training of the Insane,” *JMS* 42, no. 177 (1896): 275.

<sup>136</sup> O’Neill, “The Systematic Employment,” 275.

environment, noting that “the large extent of land in the possession of the institution constitutes a therapeutic agent of the highest value” because of the variety of work it provided for patients.<sup>137</sup> However, labour also provided a sense of purpose and accomplishment to patients, which doctors felt could not be replaced by recreation.<sup>138</sup> In the wider Victorian world, productivity and labour were believed to be important elements of self-improvement, and this naturally translated into the asylum as well, where insanity was seen as a temporary flight from civilization. Work was believed to promote healing in patients who could recover, but even for those who were deemed incurable, it gave meaning to their lives in the asylum.<sup>139</sup> All in all, a patient’s willingness and ability to work was one of the many indicators that doctors used to assess a patient’s progress towards sanity.

The implementation of work “best suited to the position and habits of the patients” was notably more complicated for private patients than it was for pauper patients. While labour as a form of treatment for pauper patients was a long-established tradition by the end of the nineteenth century, asylum administrators faced more challenges in finding appropriate work for private patients, especially at Royal asylums with their mixed-class populations.<sup>140</sup> Private patients, with their middle- or upper-class status, did not perform outdoor, manual labour, in most cases. Much of the patient work in asylums involved menial, unskilled labour, like farming for men and ward cleaning for women. Some asylum physician superintendents eschewed labour for private patients altogether, but many argued that labour was necessary for treatment because it was purposeful and productive in ways that physical recreation could not replicate.<sup>141</sup> As will be demonstrated, physician superintendents consistently prioritized the implementation of employment as part of therapeutic domesticity, in spite of significant challenges. In doing

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<sup>137</sup> *Thirty-Eighth Annual Report of the Scottish Commissioners in Lunacy* (1896), 61.

<sup>138</sup> Bower, “Employment,” 183.

<sup>139</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 82.

<sup>140</sup> Bower, “Employment,” 183.

<sup>141</sup> Bower, “Employment,” 183.

so, they contorted some pre-existing class expectations for patients and used extreme creativity to find gainful, semi-appropriate employment for private patients.

The deep commitment of physicians to the implementation of employment in the asylum as part of institutional domesticity meant that private patients often worked in domains that were unfamiliar to them. Private male patients especially were expected to work in variations of outdoor labour which would challenge non-asylum class structures. For example, male private patients often worked in the gardens of the asylum. Middle- and upper-class men were involved in gardening to the point that most of the care for Crichton's forty acres of gardens was done by private patients and was supplemented by paid servants.<sup>142</sup> At Gartnavel, too, gardening was an important part of male labour. In 1901, it was reported that 151 patients were employed at Gartnavel, out of 425 total patients, with the breakdowns as follows:

<b>Task</b>	<b>Male</b>	<b>Female</b>
Housework	28	31
Gardening	20	0
In workshops (trades)	13	0
In kitchen/laundry	0	23
Sewing/knitting	0	36
Total	61	90

**Table 3** Patient employment at Gartnavel Royal Asylum, 1901<sup>143</sup>

This breakdown was typical for working private patients, with the vast majority of men working in gardens or in ward cleaning. However, historians have suggested that ward cleaning was perceived by male patients as demeaning and feminizing.<sup>144</sup> Usually, male patients worked in menial ward cleaning for the first few weeks after their arrival, as part of an initial observation

<sup>142</sup> *Thirty-Sixth Annual Report of the Scottish Commissioners in Lunacy* (1894), 51.

<sup>143</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 81.

<sup>144</sup> Hide, *Gender and Class in English Asylums*, 116.

period, and those who were able often eagerly sought the assignment of other tasks.<sup>145</sup> A few “mentally superior” patients were additionally engaged in “congenial pursuits” beyond those listed, but the vast majority of the private patients at Gartnavel were involved in these manual or domestic tasks.<sup>146</sup> Nevertheless, the Commissioners in Lunacy praised this implementation of employment, despite the fact that it challenged the private patients’ pre-asylum status. The Commissioners praised Dr. Yellowlees for his efforts to find work for private patients and argued that it would be unfair to deprive rich patients from the therapeutic value of work simply because they were rich, since poor patients received so much value from their employment.<sup>147</sup> The Commissioners and the medical administrators were in agreement that the therapeutic value of employment was worth compromising class expectations of the outside world, and suggested a deep commitment to the implementation of institutional domesticity.

However, great efforts were made to assure that these somewhat unsavory, labour-intensive tasks were couched in a palatable, class-appropriate context for private patients – a luxury that pauper patients were not afforded. In his 1882 article advising the implementation of work for private patients, Dr. David Bower suggested that above all, the work performed by private patients should not appear menial.<sup>148</sup> He argued that, as long as the work seemed productive and appeared to need some skill, labour for upper-class patients would not be perceived as derogatory.<sup>149</sup> The prevalence of gardening for private male patients, above most other tasks, is an example of the attempt to infuse what was essentially menial labour with middle- and upper-class propriety. The choice to promote gardening for male private patients was a conscious one. Gardening, unlike farm work or other physical labour, had deeply artistic and romanticised connotations in the late Victorian period. Gardening was an emerging as form

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<sup>145</sup> Hide, *Gender and Class in English Asylums*, 104.

<sup>146</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 82.

<sup>147</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 82.

<sup>148</sup> Bower, “Employment,” 186.

<sup>149</sup> Bower, “Employment,” 187.

of art rather than labour in the nineteenth century and was perceived as a masculine, moral form of occupation.<sup>150</sup> Elite men were thinking about and discussing their gardens on the pages of a slew of new periodicals in the nineteenth century, and while the actual work was done by their poorly-paid staff, there was an enduring sense of respectability surrounding gardening.<sup>151</sup> The association between morality, masculinity and gardening made it the natural and respectable choice for male private patients. The gardens that private patients tended were distinctly separate from the farms and vegetable gardens that pauper patients looked after. Private men worked in separate ornamental gardens, which did not produce vegetables or fruit, meaning that their work was purely artistic and aesthetic. These ornamental gardens were geographically and functionally distant from the farms and agriculture where pauper patients completed their labour.<sup>152</sup> At Crichton asylum, this gardening work did wonders for the patients in “appearance and behaviour,” according to the physician-superintendent, James Rutherford. Doctors clearly believed in the therapeutic value of work and were willing to compromise non-asylum class expectations to assure that all patients had access to the therapeutic value of work. However, they did not abandon class expectations all together, and sought to couch work in class-appropriate terms.

This is not to say that male patients accepted their assignment of labour without issue. If gardening was made voluntary, physician superintendents found that only a handful of private patients would choose to spend their days in the garden.<sup>153</sup> It had to be made mandatory, with a specific gardening attendant to oversee the work of the private patients with “encouragement, kindness, and firmness.”<sup>154</sup> This caused patients to eventually take interest in their work and the product of it, attracted to the sense of accomplishment it gave them, according to cases

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<sup>150</sup> Brent Elliott, *Victorian Gardens* (London: B. T. Batsford, 1986), 10 and Thomas Carter, *The Victorian Garden* (London: Bell & Hyman, 1984), 9-10

<sup>151</sup> Carter, *The Victorian Garden*, 7.

<sup>152</sup> *Sixty-Seventh Annual Report of Crichton Royal Hospital* (1906), 13.

<sup>153</sup> Bower, “Employment,” 184.

<sup>154</sup> Bower, “Employment,” 184.

where gardening for private patients was implemented.<sup>155</sup> This suggests that patients in the asylum could become accustomed to performing tasks outside of their usual, pre-asylum realm of occupations. Class expectations regarding activities became somewhat flexible in the asylum, but only within particular limits and in particular contexts. Whenever possible, physician superintendents sought to employ creative approaches to patient work, to maximize the number of private patients who could work.

This commitment to finding appropriate work for private patients sometimes took unusual forms, especially in accommodating private female patients in roles beyond the limits of domestic labour. In 1901, the Commissioners praised Dr. Rutherford, the superintendent of Crichton Royal Asylum, for his employment of some private patients outside of the realm of manual labour. They highlighted a working female private patient, who was trained as a Swedish masseuse and a gymnastic instructress before her commitment to the asylum. As part of her work, the masseuse provided massages to other patients who needed the treatment as well as training nurses in the techniques of massage. Every morning, she also led a gymnastics class for other patients. The Commissioners commented on the “interesting and, for an asylum, novel sight ... of some twenty of the lady patients in the First house [sic] performing with evident enjoyment a varied series of drill and gymnastic evolutions under the direction of the instructress.”<sup>156</sup> The Commissioners praised Dr. Rutherford for his embrace of this innovative type of work, and mentioned that it was characteristic of his administration. The praise was rooted in the intersection between healthy physical exercise for patients and the existence of work that was suitable for the patient’s class, beyond the domestic work usually reserved for private female patients.

In another show of the innovative lengths to which physician-superintendents would go to facilitate work for private patients, there was a case at Bethlem where a female patient was

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<sup>155</sup> Bower, “Employment,” 184.

<sup>156</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 65.

employed in the wards as a caretaker for the patients.<sup>157</sup> While it was not unusual for pauper patients to work in the wards as ward cleaners, it was certainly unexpected to see one patient caring for others. The Commissioners in Lunacy had pushed for the introduction of more female companionship in the wards, and this unusual employment scheme was a response to that call. This unnamed private patient worked in the wards dedicated to the most difficult patients, who had the least optimistic prognoses, and was supposed to be a positive influence the difficult patients. It is easy to imagine the emotionally and physically challenging work that the patient engaged in, in her role as a caretaker for these incurable patients. Certainly, the female patient was a probationer, suggesting that she was near discharge and therefore nearly sane.<sup>158</sup> Nevertheless, it was not unheard of for probationers, who seemed perfectly sane and were discharged on a temporary basis, to have relapses into insanity and commit suicide or harm another. In such cases, doctors defended themselves by arguing that a patient might seem perfectly normal within the confines of patienthood, but that it was essentially impossible to know how a seemingly-sane patient would react to the unpredictability of the outside world.<sup>159</sup> With little detail given about the female probationer, it is impossible to imagine how sane she was or how qualified she was for quasi-nursing work, but it is easy to imagine the unpredictability and challenges that came with caring for the least promising patients in the asylum. Her case was not the only one where a patient fit for discharge was retained in the asylum for longer than necessary, to work. Historian Louisa Hide traced multiple cases of patients being retained as workers in asylums well past their intended discharge date, because their labour had become indispensable to the wards.<sup>160</sup> Private patients, especially those who were nearing recovery, were often entrusted with care for their fellow patients, as part of a larger commitment to finding suitable work for middle- and upper-class patients.

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<sup>157</sup> *Bethlem Royal Asylum Annual Report* (1893), 64

<sup>158</sup> *Bethlem Royal Asylum Annual Report* (1893), 64.

<sup>159</sup> *Bethlem Royal Asylum Annual Report* (1891), 44.

<sup>160</sup> Hide, *Gender and Class in English Asylums*, 112.

Private patients often worked in odd and sometimes downright experimental jobs around the asylum, in an attempt to reconcile the therapeutic benefit of employment with the strict expectations of class. The implementation of labour for private patients was much more difficult than it was for pauper patients, who were believed to more easily adapt to the unskilled and manual labour around the asylum. However, the benefits of work were believed to outweigh any potential consequences. This resulted in private patients doing manual work or work they would not usually do in the outside world, as well as a consistent commitment to finding creative ways for private patients to work in the asylum. Employment represented a moment of convergence between Commissioners, doctors, and staff, where institutional domesticity was successfully implemented, even in the face of class-based challenges and an apparent dearth of appropriate work.

The implementation of work for pauper patients did not have to overcome the same challenges as private patient work, since it was a well-established part of asylum therapeutics by the end of the nineteenth century. However, I will suggest that asylum administrators and medical officers showed sustained appreciation for the labour that pauper patients did in the asylum, both through their explicit acknowledgement of this work and a constant financial commitment to facilitating pauper work. I propose some ways in which labour was an opportunity for patient agency, which contributed to an overarching sense of liberty in the asylum. The harmonious benefits that employment conferred on administrators and patients suggests that it was a successful implementation of institutional domesticity.

Often, medical administrators were explicit about their awareness about the value of pauper work. When Gartnavel stopped accepting new pauper patients in 1888, physician superintendent David Yellowlees quickly realised the economic loss the institution was suffering. In his 1897 annual report, he admitted that the removal of pauper patients helped raise the “social tone of the Institution” but recognized that it was “by no means an unmixed



good.”<sup>161</sup> Among the losses, he counted the fact that pauper patients did valuable manual work around the asylum, free of charge, which would now be completed by paid employees. Though he does not specify in the report what work he means, he explained that it was work that private patients could not be expected to perform.<sup>162</sup> This implies that it was likely agricultural labour, which was widely believed to be inappropriate for private patients.<sup>163</sup> Both Crichton and Gartnavel had space for a hospital farm, which largely employed male pauper patients.<sup>164</sup> In fact, the majority of employed male patients at Gartnavel in 1886 worked on the farm.

*Table 17.—Showing the Average Numbers Employed in the EAST House.*

	Males.	Females.	Total.
With Farm and Garden Attendants, Cleaning in the Wards and Assisting Attendants, . . . . .	66	...	66
In the Steward's Stores, . . . . .	32	27	59
In Laundry, . . . . .	2	18	20
“ Kitchen, . . . . .	...	26	26
At Needlework, and also Assisting Attendants, . . . . .	...	30	30
With the Blacksmith, . . . . .	1	...	1
“ Carpenter, . . . . .	1	...	1
“ Engineer, Stoker, and Coal Porter, . . . . .	10	...	10
“ Mason, . . . . .	2	...	2
“ Painter, . . . . .	2	...	2
“ Tailor, . . . . .	4	...	4
“ Shoemaker, . . . . .	1	...	1
“ Upholsterer, . . . . .	4	...	4
Mat Maker, . . . . .	1	...	1
Total more or less employed, . . . . .	126	101	227
Unemployed, except in taking exercise or in amusements; and Invalids, } . . . . .	81	42	123
Average Daily number in East House, } M. F. T. Private, 79 80 168 } Pauper, 128 54 182 }	207	143	350

**Figure 4** Gartnavel Royal Asylum Patient Employment Breakdown, 1886<sup>165</sup>

Despite being relegated to the poorest members of the asylum community, the farm at Gartnavel produced vital food and goods to the asylum and to the wider community, including pork, lamb, eggs, and wool.<sup>166</sup> In 1886, sixty-six male pauper patients<sup>166</sup> worked in the farm and gardens at

<sup>161</sup> *Eighty-Fourth Annual Report of the Gartnavel Royal Asylum* (1897), 11.

<sup>162</sup> *Eighty-Fourth Annual Report of the Gartnavel Royal Asylum* (1897), 11.

<sup>163</sup> Bower, “Employment,” 186.

<sup>164</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), 53.

<sup>165</sup> *Seventy-Third Annual Report of the Gartnavel Royal Asylum* (1886), 27.

<sup>166</sup> *Seventy-Third Annual Report of the Gartnavel Royal Asylum* (1886), 29.

Gartnavel, which was roughly average compared to the years preceding years.<sup>167</sup> That same year, the total value of the goods produced at the farm and the gardens was £1,061.<sup>168</sup> Even after all the costs of farm and garden upkeep was deducted, there was still £244 of profit remaining for the asylum.<sup>169</sup> This was not an insignificant profit – it could pay for the annual salaries of between five and fifteen attendants or nurses, dependent on their experience level.<sup>170</sup> Additionally, the food that these asylum farms and gardens produced staple foods in the asylum diet. The largest meal of the day in the asylum, the mid-day dinner, was comprised of five or six ounces of meat (usually beef or mutton, with fish, steak, and rabbit saved for special occasions), between half and three-quarters of a pound of vegetables (usually potatoes, with cabbage, parsnips, and carrots making weekly appearances), and a pudding or tart.<sup>171</sup> Many of these ingredients were produced in significant quantities in the asylum gardens and from the farm. Pauper patients were significant contributors to the financial life in the asylum, and medical superintendents acknowledged the value of their work. When Gartnavel stopped accepting pauper patients in 1888, the asylum lost a wealth of free labour that was a significant producer of goods and profit.

Medical administrators also acknowledged the value of pauper work in other ways, which produced concrete benefits for pauper patients. In the late 1890s, the administration at Crichton dedicated significant funds and effort to the creation of new living quarters for the male pauper patients who worked at the farm, which demonstrated a commitment to the continued work of pauper patients. Pauper men who worked at the farm slept at a small farmstead, but due to the lack of arrangements near the farm, they were required to dine and spend their leisure time in the space of the Second House. This caused overcrowding, but it also

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<sup>167</sup> *Seventy-Third Annual Report of the Gartnavel Royal Asylum* (1886), 27.

<sup>168</sup> *Seventy-Third Annual Report of the Gartnavel Royal Asylum* (1886), 29.

<sup>169</sup> *Seventy-Third Annual Report of the Gartnavel Royal Asylum* (1886), 29.

<sup>170</sup> *Seventy-Third Annual Report of the Gartnavel Royal Asylum* (1886), 33-34.

<sup>171</sup> *Bethlem Royal Asylum Annual Report* (1900), 72.

hindered the ability of the paupers to work well on the farm, because their time was divided between two distant parts of the asylum. This prompted Commissioners to regularly recommend the expansion of the existing farm accommodations in the 1890s.<sup>172</sup> In the summer of 1899, a new farm annexe opened, which was a single-story building that provided dayrooms, dining-rooms, bathrooms, a kitchen, and servants' quarters. This space was used for the full accommodation of sixty working male pauper patients, which meant that these paupers were provided relative privacy compared to the overcrowded male wards of the Second House.<sup>173</sup> The Commissioners praised this new space by saying that the "fittings, furnishings, and general arrangements of this block are of the best description."<sup>174</sup> The decision to solve overcrowding by constructing a comfortable, modern space specifically for the paupers working on the farm meant that facilitating their work was a major priority for the asylum. Similarly, in 1899, the administration at Crichton Royal Hospital recognized the importance of the work that female pauper patients did, by building a new space for women working in the laundry to live in. It was a three-storey building with an "imposing exterior," situated near the laundry facilities, eliminating some separation between the work and living spaces of these pauper women and facilitating their labour.<sup>175</sup> Besides cottage houses and villas for the highest-paying private patients, the farm and laundry annexes were the only dedicated separate spaces built at Crichton Royal Asylum, suggesting that working paupers deserved some of the luxuries of the highest-paying patients. Asylum administrators poured extensive funds into spaces that facilitated patient labour and allowed them the exceptional advantage of living away from ward life, demonstrating that pauper work was valuable beyond its economic advantages. This is also one instance where pauper patients were able to use their labour to gain extra comforts. The

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<sup>172</sup> *Thirty-Eighth Annual Report of the Scottish Commissioners in Lunacy* (1896), 61.

<sup>173</sup> *Forty-Second Annual Report of the Scottish Commissioners in Lunacy* (1900), 65-66.

<sup>174</sup> *Forty-Second Annual Report of the Scottish Commissioners in Lunacy* (1900), 66.

<sup>175</sup> *Forty-Second Annual Report of the Scottish Commissioners in Lunacy* (1900), 66.

detached annexes were more private and more comfortable than the standard pauper wards, suggesting that labour allowed both male and female pauper patients to exercise their agency.

When the geographic nature of the asylum did not allow for pauper patients to work outdoors extensively, assigning male paupers work became more difficult. In 1890, Commissioners in Lunacy visiting Bethlem Royal Asylum criticised the small number of male patients being employed. Only twenty-six male patients were employed that year, as ward cleaners, which only represented about 25% of the total average male population in the asylum.<sup>176</sup> Compared to Crichton, where it was reported that all those who were “able and willing” to work found employment, the percentage at Bethlem was small.<sup>177</sup> Though a specific breakdown of gender was not given, in 1893, 542 patients were employed at Crichton, which represented 56% of the total population – a much greater total number of working patients, because Crichton had a farm where male pauper patients were employed. Bethlem did eventually improve on this front, with 120 patients working in 1900, representing roughly 66% of the total patient population.<sup>178</sup> However, Bethlem’s medical administrators had to be creative with their implementation of work, due to their position as an urban asylum with no farm. Bethlem’s male pauper patients worked largely in ward cleaning or on the grounds, as well as in various trade workshops that were established in the late 1890s.<sup>179</sup> These patients were also rewarded, though in different ways than those at Crichton. Patients working at Bethlem received an additional four ounces of bread per day, as well as one ounce of cheese or half an ounce of butter.<sup>180</sup> These rewards, like private space at Crichton and extra food at Bethlem, allowed the pauper patients to attain a level of comfort that they would otherwise not be able to afford.

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<sup>176</sup> *Bethlem Royal Asylum Annual Report* (1890), 67.

<sup>177</sup> *Thirty-Eighth Annual Report of the Scottish Commissioners in Lunacy* (1896), 60.

<sup>178</sup> *Bethlem Royal Asylum Annual Report* (1900), 44.

<sup>179</sup> *Bethlem Royal Asylum Annual Report* (1908), 98.

<sup>180</sup> *Bethlem Royal Asylum Annual Report* (1908), 98.

The work of pauper women benefitted them in different ways. Twenty-four female patients were reported to be working as cleaners in Bethlem's wards in 1890, representing only 18% of the total female population that year. However, an additional forty-six female patients were employed doing needlework for the asylum, bringing the total percentage of working female patients to 52% in 1890.<sup>181</sup> Needlework was one of the great methods of employing pauper women in the asylum. At Crichton, the women in the Second House were responsible for making clothes for roughly seven hundred patients, as well as the making and hemming of the hospital's linens. They were also responsible for most of the mending for the clothing of the First House patients.<sup>182</sup> Implementing needlework as employment for female pauper patients took very few resources in terms of space, equipment, and supervision, but was an essential task for the functioning of the asylum, making it an ideal employment for pauper patients. Beyond needlework, pauper women in the asylum almost exclusively worked on domestic service tasks in the asylum, like laundry, food preparation, and ward cleaning, which served to mimic the gender divisions of the Victorian home.<sup>183</sup> In fact, this very practically mimicked the work that these female patients did in their pre-asylum lives. 38% of the women admitted to Crichton in 1902 were either domestic servants, cooks, laundry women, or housewives.<sup>184</sup> That same year, 28 of the 61 women admitted to Gartnavel worked as domestic servants before their confinement.<sup>185</sup> These statistics reflect the fact that women often continued to do their pre-asylum work after their institutionalisation, which mimicked the structures and realities of the outside world. This minimised the institutional nature of the asylum and allowed it to more accurately mimic the domestic space, which likely also made the transition to asylum life less jarring. For the women who did work before their confinement, domestic labour could

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<sup>181</sup> *Bethlem Royal Asylum Annual Report* (1890), 67.

<sup>182</sup> "Round about the Crichton," *New Moon* 49, no. 629 (July-August 1896) : 31.

<sup>183</sup> Hide, *Gender and Class in English Asylums*, 105.

<sup>184</sup> *Sixty-Third Annual Report of Crichton Royal Hospital* (1902), 23.

<sup>185</sup> *Eighty-Ninth Annual Report of the Gartnavel Royal Asylum* (1902), 30.

also be advantageous. Unpaid domestic labour in the form of housewifery was deeply aspirational for working-class Victorian women, historian Joanna Bourke suggested.<sup>186</sup> She has suggested that working class women saw opting out of paid labour and into unpaid domestic duties as an ideal to be attained, as many working-class women had to complete domestic labour and work outside the home.<sup>187</sup> She also suggests that these working class women used domestic work to increase their individual power within the family unit, through increased control of their family environment.<sup>188</sup> For the working class women who made up the pauper and lower-private classes of the asylum, it was very possible that their time in the asylum was the first time in their lives when they had the freedom to focus on domestic labour without additional, public-realm employment. Thus, for many pauper women, their asylum work, even if it differed from their pre-asylum occupation, allowed them a sense of accomplishment, comfort and even prestige.

Ultimately, pauper patients were able to glean some benefits from their labour in the asylum, either through a sense of personal accomplishment or through a concrete increase in practical comforts. The work they did was clearly essential to the institution, which the administration recognized and appreciated. The relationship between working pauper patients and the asylum was thus a mutually beneficial system, which suggests that institutional domesticity (of which employment was a key part) was successful in this instance. Even for private patients, who posed a greater challenge, the implementation of employment as part of the therapeutic regime of the asylum was successful. Doctors and administrators were willing to compromise class expectations and take innovative approaches to assure that even private patients were able to receive the therapeutic benefits of employment. Employment, however,

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<sup>186</sup> Joanna Bourke, "Housewifery in Working-Class England 1860-1914," *Past & Present* no. 143 (1994): 196.

<sup>187</sup> Bourke, "Housewifery," 172-173.

<sup>188</sup> Bourke, "Housewifery," 182.

was far from the only well-executed form of institutional domesticity – what patients did after working hours mattered just as much.

### Cultural Recreation in the Asylum

In 1896, the Bethlem Dramatic Company received great praise for their Christmas performance of the burlesque *The Babes in the Wood*. The audience was cautioned that, should they find themselves exhausted by extreme laughter, a stretcher could be arranged to help them out of the room. The play was, despite its amateur cast comprised mostly of asylum staff, was extremely well-received by its audiences and brought joy to the halls of Bethlem Royal Hospital during the holiday season.<sup>189</sup> It may seem ridiculous to imagine an asylum medical officer, in an age of tenuous professionalism, donning a cross-dressing costume and performing a cartoonish caricature of an aristocrat for the amusement of his patients. However, it was not uncommon. Cultural recreation like concerts and theatre were central to the domestic environment of the asylum. After a long day of work, patients often participated in recreational activities in the evenings, centered largely on cultural pursuits, like music and theatre. Orchestras and theatre troupes from the local community would come and visit asylums for these evening entertainments, but staff and patients were just as likely to play music or perform for their compatriots.

The rise of rational recreation in wider society was easily transposed into the asylum. In the outside world, leisure had become a major definer of class, and therefore, domesticity. However, cultural pursuits had also become an avenue for middle-class philanthropists to moralize and enlighten the ‘fallen’ working class. Industrialization, urbanization, and increased wages for the working class proliferated the rise of unsavoury pastimes, like drinking,

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<sup>189</sup> “Local Notes,” *Under the Dome* 5, no. 17 (March 1896): 31-33.

gambling, and music halls, where immoral activities like prostitution loomed.<sup>190</sup> As a counter to these (perceived) rising vices, Victorian middle-class philanthropists began programmes of rational recreation, through the construction of libraries, temperance organisations, museums, public parks, and musical societies.<sup>191</sup> These morally-sanctioned activities served as a tool of middle-class social control of working class people, who were believed to be inherently morally weaker.<sup>192</sup> The idea that certain kinds of culture could moralize and rationalize the insane flourished with doctors who theorized on the moral and social causes of insanity. Culture became an essential therapeutic element in the asylum and was a successful implementation of institutional domesticity. Asylum administrators demonstrated their commitment to cultural pursuits as treatment through the construction of recreation-specific spaces at the end of the nineteenth century. Furthermore, I argue that culture allowed institutional hierarchies to be relaxed and couched in more familial terms, which gave the asylum a more domestic feeling. Culture was a setting where patients could exercise some level of agency as cultural producers. This agency contributed to an illusion of liberty, which was also an essential element of institutional domesticity. Cultural recreation was a successful implementation of institutional domesticity because it shrouded institutional hierarchies and allowed patients to exercise agency.

As both passive recipients and active producers, patients engaged in various cultural events within the asylum. To facilitate access to cultural pursuits, many asylums needed dedicated spaces for recreation and performances. Asylum administrators' dedication to culture as a form of treatment was emphasized by an increasing commitment to creating recreation-specific spaces at the end of the nineteenth century. At Bethlem Royal Hospital, 1895 was marked by the opening of a new, much-anticipated Recreation Hall. With a fixed stage, dressing

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<sup>190</sup> Bailey, *Leisure and Class*, 132-133.

<sup>191</sup> Bailey, *Leisure and Class*, 132.

<sup>192</sup> Bailey, *Leisure and Class*, 132-133.



rooms, and storage space, it was a significant addition to the recreation activities of the asylum. For years previously, Percy Smith, the Physician Superintendent, had been requesting a new entertainment space for the asylum.<sup>193</sup> The asylum had, in fact, come under fire by the Commissioners in Lunacy in 1893 for its lack of dedicated recreation space. Commissioners Charles Palmer Philips and Frederick Needham called the lack of theatre and recreation space “a patent defect” in the institution and argued that very few other English asylums lacked such a vital component to their asylum.<sup>194</sup> Before the erection of the Recreation Hall, Bethlem staff would put up a temporary stage in the female side of Gallery 3 at the beginning of every winter season.<sup>195</sup> While the summer was marked with outdoor activities like trips, picnics, and drives, the winter required indoor evening recreation, often requiring a stage for events like plays and concerts. The temporary nature of the pre-Recreation Hall solution posed significant issues for Percy Smith, Bethlem’s Physician Superintendent. First, it eliminated the possibility of any indoor entertainment during the summer months. Though medical staff preferred to entertain patients outdoors during the summer, for the benefits of fresh air and exercise, the lack of possibility for indoor amusements during the summer was still limiting.<sup>196</sup> Additionally, the temporary structure monopolized space for eight female patients while it was up, causing a potential overcrowding. However, the issue that Smith emphasized the most was the fact that the location of the temporary stage in the female wards meant that many male patients and attendants traipsed through the strictly female space, threatening the strict gender division of the asylum and as a by-product, the homosocial space of the Victorian home.<sup>197</sup> In constructing a dedicated space for mixed-gender recreation, away from the gendered living and sleeping quarters, the Recreation Hall assured moral propriety as well as facilitating access to recreation.

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<sup>193</sup> *Bethlem Royal Asylum Annual Report* (1891), 51.

<sup>194</sup> *Bethlem Royal Asylum Annual Report* (1893), 65.

<sup>195</sup> *Bethlem Royal Asylum Annual Report* (1891), 51.

<sup>196</sup> *Bethlem Royal Asylum Annual Report* (1891), 51.

<sup>197</sup> *Bethlem Royal Asylum Annual Report* (1891), 51.

The construction of a dedicated space for recreation at Bethlem had a significant impact on the ability of patients and staff to enjoy the entertainments that were so crucial to the peaceful functioning of the asylum. In a review of the annual visit of the Plowden Bijou Orchestra, in the months before the Recreation Hall was opened, they hoped that next year “might find us in the full enjoyment of sofa stalls, opera glasses, cloaks and shawls, and other concert going impedimenta in the spacious building now approaching completion.”<sup>198</sup> At Crichton, similar sentiments were expressed about their Recreation Hall, saying that it was “admirably suited for dancing.” Specifically, asylum staff pointed to the newly-installed electric light, the decorations (plants and evergreens, in the case of the New Year’s Ball), and the thoughtful organisation of the space.<sup>199</sup> The Recreation Hall space had to be flexible, as its patrons pointed out regularly, since it was used for a variety of cultural recreations. It had to be suitable for a lively dance, while at other times, it had to be fit for a relaxed piano concert. In the latter cases, the furniture within the space was moved to change the entire atmosphere of the room. The piano was placed in the centre of the hall, with audience near the fire on either side, an arrangement which “seemed to give universal satisfaction, and certainly added greatly to the comfort of the listeners.”<sup>200</sup> The physical space of the Recreation Hall facilitated access to a variety of cultural pursuits, due to its dynamic nature. Moreover, the agreement needed to build a dedicated cultural space involved convergence of opinions between the Governors of the hospital, the medical staff, and the Commissioners, who indeed praised the Bethlem’s long-overdue Recreation Hall as “a very fine room.”<sup>201</sup> The Recreation Hall, as a dynamic and versatile space, demonstrated the commitment of all asylum actors to the pursuit of culture as a form of healing in the asylum. This dedicated space would set the stage for further successful

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<sup>198</sup> “Local Notes,” *Under the Dome* 5, no. 17 (March 1896): 31.

<sup>199</sup> “Round about the Crichton,” *New Moon* 49, no. 619 (February 1896): 3.

<sup>200</sup> “Round about the Crichton,” *New Moon* 48, no. 617 (December 1895): 11

<sup>201</sup> *Bethlem Royal Asylum Annual Report* (1896), 42.

realisation of institutional domesticity, by facilitating patient-staff comradery and allowing patients to harness increased agency from cultural production.

Staff, both administrative and medical, spent significant time on the production of culture in the asylum, in very direct ways. Physician superintendents and upper-level medical staff did not just organise regular visits from external bands and orchestras. They were active participants in the act of theatre or music. Bethlem Royal Hospital had its own Orchestra, composed mostly of staff, which was central to many recreational evenings in the asylum. First mentioned in 1891 and conducted by Mr. Wilson, the band played at most musical evenings, theatre performances, and dances at the asylum, and was reported to have “added very largely to the pleasure and ‘go’ of the dances.”<sup>202</sup> The Glasgow Royal Asylum also had a staff band, which formed in 1906. They quickly became fixtures at the Thursday Evening dances for patients and staff.<sup>203</sup> Over their first year of existence, the staff band grew in number and were reported to have improved significantly, due to regular practise. These regular practises suggest a significant time commitment outside of working hours for some members of the asylum staff, demonstrating a dedication to the production of asylum culture for patients.

At times, asylum staff would also put on theatrical performances for patients, like the notable 1895 performance of *Aladdin; or, the Wonderful Scamp* at Bethlem Royal Hospital. The musical and theatrical performance was incredibly well received by the audience, with many of the main roles of the play being taken by medical officers or, in one particular case, the wife of Dr. Hyslop, Assistant Medical Officer and future Physician-Superintendent of Bethlem.<sup>204</sup> One of the clinical assistants, Dr. Pring, played the part of the donkey, which the reviewer in the hospital magazine commented on with a great sense of humour – “the able way in which he took the part shows how carefully he must have studied the donkey’s little ways,

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<sup>202</sup> *Bethlem Royal Asylum Annual Report* (1893), 51.

<sup>203</sup> “Notes,” *The Gartnavel Gazette* 20 (October 1907): 2.

<sup>204</sup> “Local Notes,” *Under the Dome* 4, no. 13 (March 1895): 35.

from the wink of an eye to the wag of the tail [...] He has evidently mistaken his present vocation.”<sup>205</sup> In the next year’s production, Dr. Pring “showed [himself] to be a veritable Zoological Garden; last year a perfect ass, and this a monkey.”<sup>206</sup> Another staff member, Mr. Martin, played the part of a widow, dressing in drag and an audience member commented that “his get-up, his voice and his *lady-like* ways were productive of continuous laughter.”<sup>207</sup> The Bethlem orchestra also provided the music for this performance, in addition to the play being largely acted by staff and their families or friends.<sup>208</sup> A patient commented that broadly, the audience was “especially pleased at the happy way in which everything progressed, as this is the first time in Bethlem in which such an elaborate development has occurred” since previous performances had not required such wide-ranging sets and costumes.<sup>209</sup> This performance showed a great moment of levity in the asylum, and shows the fertile ground that culture played in the treatment of patients. With doctors and attendants dressed in ridiculous costumes, eliciting intended laughter on the part of a patient-dominated audience, theatre and musical entertainment proved to be a way of obscuring the institutional nature of the asylum, allowing it to more easily mimic domesticity. While the traditional Victorian home was also deeply hierarchical, it was a fundamentally different – and to doctors, more desirable – style of hierarchy. As part of nineteenth century psychiatric treatment, physician superintendents sought “a parental kind of authority” over their patients, which was imagined to be kinder and more humane than a traditional doctor-patient relationship.<sup>210</sup> The ability of patients to socialise with their staff in recreational settings entrenched strictly institutional hierarchies in more relaxed,

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<sup>205</sup> “Local Notes,” *Under the Dome* 4, no. 13 (March 1895): 35.

<sup>206</sup> “Local Notes,” *Under the Dome* 5, no. 17 (March 1896): 33.

<sup>207</sup> “Local Notes,” *Under the Dome* 4, no. 13 (March 1895): 35.

<sup>208</sup> “Aladdin Up to Date,” *Under the Dome* 4, no. 13 (March 1895): 27.

<sup>209</sup> “Aladdin Up to Date,” *Under the Dome* 4, no. 13 (March 1895): 27.

<sup>210</sup> Iain Smith and Alan Swann, “Medical Officers and Therapeutics,” in *Let There Be Light Again: A History of Gartnavel Royal Hospital From its Beginnings to the Present Day*, ed. Jonathan Andrews and Iain Smith (Glasgow, 1993), 56.

familial terms. This couched the inherently institutional nature in more comfortable, domestic terms.

Patients were also central in the production of culture in the asylum, which even further allowed the illusion of domesticity to flourish, through the creation of a sense of patient liberty and agency. Allowing and encouraging patients to be active participants in cultural amusements – producers, hosts, and critics – gave patients agency within the institution. In 1895, patients at Crichton Royal Hospital began to organise Drawing Room evenings, where “Crichton talent [was] in full force.”<sup>211</sup> The article recounted two concerts, performed by patients, whose performances were lauded. Patients were not just performers but were sometimes responsible for all elements of some of these cultural evenings, from the publicity to the stage production. There was “an unusually large amount of talent among the Crichtonians, which is well utilized in the getting up of programmes, notices, and scenery.”<sup>212</sup> Some of artwork in the concert programmes were even deemed worthy of Raphael Tuck & Sons, a popular postcard and greeting card company.<sup>213</sup> In other cases, upper-class patients could host others in their rooms, like with “a very smart little social function” hosted by two female patients at Crichton. The spring “Daffodil tea” had snacks, thematic décor, and party favours, as reported in the institution’s newspaper.<sup>214</sup> Despite the fact that these patients were ultimately institutionalised and thus under the strict rules of the asylum, they were able to have some control over their social and cultural lives. The ability for these patients to become producers of social interaction assured these patients a sense of agency, which ultimately contributed to the larger, overarching illusion of domesticity in the asylum.

In the realm of recreation, patients also had the unique agency to complain if they were unhappy with the way recreation unfolded. In the Letter to the Editor column – affectionately

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<sup>211</sup> “Round about the Crichton,” *New Moon* 48, no. 617 (December 1895): 11.

<sup>212</sup> “Round about the Crichton,” *New Moon* 48, no. 617 (December 1895): 11.

<sup>213</sup> “Round about the Crichton,” *New Moon* 48, no. 617 (December 1895): 11.

<sup>214</sup> “Round about the Crichton,” *New Moon* 49, no. 621 (April 1896): 4.

known as the “the column for anonymous grumblers” – *The Gartnavel Gazette*, the institution’s quarterly publication, published a letter from a patient who had strong opinions about the way dances were currently managed.<sup>215</sup> The anonymous patient argued that there needed to be more dancing at the monthly concerts and complained that people did not dance during the encores, meaning that he would not get the chance to dance with all of the many ladies who sought his company.<sup>216</sup> Though this seems trivial in the wider scheme of complaints about the asylum, the patient states that many fellow patients have agreed with him on this subject, suggesting networks of communication between patients where they were able to freely express their displeasure. The patient’s ability to complain privately among patients, as well as anonymously in the widely-read institutional magazine, suggests an environment where patients were able to harness cultural production to generate some agency.

Beyond the realm of music and theatre, asylum administrators cared deeply about the literary culture in the asylum and it was a central focus of the broader attempts at making the asylum cultured. When it appeared that others believed Bethlem to be lacking literary culture, Bethlem’s medical and administrative staff responded passionately. In the “Notes Apropos” column for the September 1893 edition of Bethlem’s institutional magazine *Under the Dome*, the columnist quotes a newspaper passage which states that the Commissioners in Lunacy were not satisfied with the state of the “provision made in asylums for the literary cravings of their patients,” after their year of asylum inspections.<sup>217</sup> They encouraged the addition of “mental food” beyond a daily newspaper in the asylum, and recommended weekly and monthly periodicals, as well as “books of an entertaining kind,” which had become relatively cheap recently.<sup>218</sup> This accusation of literary dearth could have provoked a gulf between the asylum administration and the Commissioners in Lunacy, but Bethlem staff did not think this complaint

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<sup>215</sup> “Letter to the Editor,” *The Gartnavel Gazette* 2 (April 1903): 15.

<sup>216</sup> “Letter to the Editor,” *The Gartnavel Gazette* 2 (April 1903): 15.

<sup>217</sup> “Local Notes,” *Under the Dome* 2, no. 7 (September 1893): 68.

<sup>218</sup> “Local Notes,” *Under the Dome* 2, no. 7 (September 1893): 68.

applied to them. They paraded their catalogued lending library, the many bound volumes in the many reading rooms in the asylum, and the supply of daily, weekly, and monthly newspapers supplied to each gallery as proof that there was no shortage of intellectual sustenance for patients at Bethlem.<sup>219</sup> Months later, the editor of *Under the Dome* was still concerned with this misplaced accusation of literary scarcity and emphasised the addition of 190 volumes to the library at Bethlem since the start of the year, with a total number of volumes around 680.<sup>220</sup>

In fact, the library appeared as a point of pride in the records of the asylum, with nearly annual statistics recorded regarding the increasing in library books. From 1895 onwards, the Governors of Bethlem allocated funds to the library at Bethlem and at the Convalescent Home associated with the institution, and books were a common donation from friends of the institution. By 1900, Bethlem's library was still flourishing and growing consistently. The number of texts increased every year, from about four hundred books in circulation in 1895 to over two thousand books in 1900.<sup>221</sup> Each year, the Library at Bethlem was able to include more of the most popular books published that year, and the records of the books purchased each year are rife with familiar names in Victorian and Edwardian fiction – Trollope, Dickens, Walter Scott, and Warton, among others – and popular subjects for non-fiction, like biographies of Queen Victoria and histories of the modern world.<sup>222</sup> Not only had the number increased, which the doctors asserted “speaks in support of how much the Library is appreciated,” but there are record of many of the books needing repairs over the year due to wear and tear.<sup>223</sup> This indicates that the books were being read regularly by patients. One attendant worked nearly full-time as a hospital sub-librarian, under the supervision of Maurice Craig, Assistant Medical Officer, who had held the title of head librarian since 1895. Together, Craig and his assistant

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<sup>219</sup> “Local Notes,” *Under the Dome* 2, no. 7 (September 1893): 68.

<sup>220</sup> “Notes Apropos,” *Under the Dome* 3, no. 9 (March 1894): 18.

<sup>221</sup> “The Library,” *Under the Dome* 9, no. 36 (December 1900): 246.

<sup>222</sup> “The Library,” *Under the Dome* 16, no. 64 (December 1907): 152-155.

<sup>223</sup> “The Library,” *Under the Dome* 9, no. 36 (December 1900): 246.

established a variety of rules for library use, which were carefully followed by the patients.<sup>224</sup> In 1907, Craig resigned from the position of head librarian, he left the position saying that the Library had “greatly increased in popularity” and was “greatly appreciated by both patients and nurses.”<sup>225</sup> The asylum administrators were clearly concerned with the production of a healthy literary culture in the asylum, which was directly in line with the suggestions of the Commissioners in Lunacy, indicating that literary culture was a point of convergence for the two actors. Additionally, with the consistent funding from Governors of the hospital and indicators of apparent approval by patients, the implementation of literary culture was a successful example of recreation in the asylum. Though it did not provide physical benefits like sport nor the social benefits of concerts and dances, literary culture remained an important facet of patient liberty, and thus, domesticity in the asylum. The books in the asylum allowed patients to have an enduring connection to the outside world, gave them common knowledge to create inter-patient communities, and allowed them a sense of agency in their ability to make choices, while simultaneously acting as a form of treatment through rational recreation.

### Writing in the Asylum

This moment of literary panic coincides with the rise of institutional magazines in the asylum. Bethlem Royal Hospital, Gartnavel Royal Asylum, and Crichton Royal Hospital all produced an institutional magazine during the period under consideration and these magazines formalised a sense of legitimate community, both within the institution and across multiple asylums. Bethlem’s *Under the Dome*, Crichton’s *New Moon* and *The Gartnavel Gazette* all contained similar features. Each included notice for future events, recapitulations of previous events, and reviews of certain cultural experiences in the asylum, like plays or concerts. They also

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<sup>224</sup> “The Library,” *Under the Dome* 9, no. 36 (December 1900): 246.

<sup>225</sup> “The Library,” *Under the Dome* 16, no. 64 (December 1907): 152.



contained pieces of short fiction or poetry written by their community members, especially patients. There were also longer-form articles about history or politics, usually penned by members of the institution. Some equally contained serialised pieces of travel writing, like the war correspondences from a doctor at the front of the Second Boer War that were published in *Under the Dome*.

These institutional magazines were a particularly salient form of cultural community-building and contributed to the creation of the illusion of patient liberty. By reading about their fellow patients and the staff that cared for them, the institutional magazines formalized an institution-wide community, in an age when Royal asylums were too large to feasibly know everyone. The events they attended were reflected back at them, reinforcing the social aspect of the asylum and acting as a form of hyper-local news. The articles and stories in the magazines gave inmates a common literary ground upon which to discuss and debate. All of this served to create common knowledge and history, which can be read as a form of community-building for patients. Additionally, the fact that these magazines accepted and encouraged writing from patients meant that the patients were given a sense of liberty and control over the cultural narrative of their healing space. Essentially, these institutional magazines created a space for patients to be on equal footing with administrative and medical staff, essentially shrouding the hierarchies that made the institution institutional.

In non-institutional contexts, scholars have imagined talking about one's community and gossiping as a form of resistance from a marginalised community – “weapons of the weak”.<sup>226</sup> In tracing gossip, women's historians have been able to access the social and political opinions of working-class women and other communities which did not leave behind much written material. Historians have argued that women used gossip to create social norms and

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<sup>226</sup> James C. Scott, *Domination and the Arts of Resistance: Hidden Transcripts* (New Haven: Yale University Press, 1990), especially chapters one and two. “Weapons of the Weak” refers to an earlier Scott monograph, which he refers to in this text but which is less relevant to the question of gossip.

assert the limits of their individual communities in informal but powerful ways.<sup>227</sup> However, a major methodological hurdle for the study of gossip has been the lack of sources for the oral culture. One significant workaround for this issue has been to consult and critically read press accounts of gossip, which often preserved a record for the gossip of a particular community. In reading the news presented in the three asylum magazines under consideration here, I will suggest that they served as a form of gossip – a way to formalise the limits of an institutional community through collective knowledge. By replicating this norm of community knowledge through gossip, I will suggest that this was an essential facet of mimicking the outside world within the asylum. Additionally, I will then suggest that by allowing patients to be part of the writing process, they became architects of this knowledge and were granted an increased sense of liberty through this process.

Community knowledge through magazines and journals is particularly important in the late nineteenth century context, because of the changes happening to print culture more broadly. By the mid-nineteenth century, the landscape of print culture in Britain had changed dramatically. The levels of literacy in Britain had increased significantly and modern technologies meant that books, magazines, and newspapers were more readily available to a wider range of people.<sup>228</sup> Historians have pointed to technological improvements in ability to manufacture paper, the emergence of lithography as a printing method, improvement of the printing press technology, and the construction of a national railway for easier distribution of reading material as contributing to changing attitudes around reading over the course of the nineteenth century.<sup>229</sup> Newspaper and magazines, however, were undergoing their particular cultural evolutions with the rise of society journalism and New Journalism. Magazines,

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<sup>227</sup> Melanie Tebbutt, *Women's Talk?: A Social History of "Gossip" in Working-Class Neighbourhoods, 1880-1960* (Brookfield, VT.: Scolar Press, 1995) 4-5.

<sup>228</sup> Susie Steinbach, *Understanding the Victorians: Politics, Culture and Society in Nineteenth-Century Britain* (New York: Routledge, 2017), 3.

<sup>229</sup> Matthew Bradley and Juliet John, Introduction to *In Reading and the Victorians* (New York: Routledge, 2016), 4.

journals, and newspapers were emerging which printed the news and gossip around particular communities, usually elite ones, and this marked the transition between print culture as a form of education to print culture as a form of leisure.<sup>230</sup> These late nineteenth century imprints, historians have suggested, served to reproduce and disseminate gossip, but also served to lend authority to and legitimize gossip.<sup>231</sup>

The newspapers and magazines that emerged in the asylum at the end of the nineteenth century can similarly be understood as a place to discuss the hyper-local news of the institution. These, much like society magazines, served to create and legitimize a community among its readers, through the use of shared knowledge. Each edition, the newspapers would give recaps of the major recreational activities, including frequent reviews of any musical or theatrical performances. They recorded which dances happened, how many people attended, and if the crowd seemed to enjoy them. These newspapers also recorded any doctors, nurses, or attendants who left, which meant that there were often records of marriages, promotions, and moves for staff. The Editor of *Under the Dome* encouraged the continuation of the magazine because he saw the magazine as a record of local history that might be useful to future historians. He claimed that “perhaps in this way it may be valuable or interesting to the archeologist at some future date, long after your present Editor has ceased to be able to put pen to paper, and a bound copy may in some distant age evoke the same excitement that the discover of important papyri in Egyptian tombs does at the present time.”<sup>232</sup> The Editor viewed *Under the Dome* as providing a recorded, common history for future generations, which is a necessary element of community-building. Ultimately, this retrospective on the first year of publishing for the magazine *Under the Dome* reveals how influential the magazine was to the creation of an institutional memory and therefore, community. By replicating the structures of gossip and magazines which were

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<sup>230</sup> Gary Weber, “Henry Labouchere, ‘Truth’ and the New Journalism of Late Victorian Britain.” *Victorian Periodicals Review* 26, no. 1 (1993): 42.

<sup>231</sup> Weber, “New Journalism,” 40.

<sup>232</sup> “Editorial,” *Under the Dome* 1, no. 4 (December 1892): 36.

essential to the outside world, the institutional magazine became a core element of asylum domesticity.

The inclusion of the patient voice in these magazines, however, served to further the role of institutional magazines in community-building. The production of these magazines allowed patients a certain amount of control in the institution, both by allowing them to be cultural producers in their own right as well as breaking down the normal hierarchies of the asylum. In the fourth edition of the Bethlem institutional magazine *Under the Dome*, the Editor reflects on the first year of publication. In this reflection, the Editor emphasises that the first of the two main goals of the institutional magazine included “to help in giving amusement and occupation to those whose health necessitates residence here for longer and shorter periods.” The Editor pointed to the fact that more than twenty of the pieces in the first three editions were submitted by either past or present patients, which indicates, in his eyes, a great engagement of patients with this literary project.<sup>233</sup> He encouraged the continuation of the magazine project, citing the continued influx of contributions from patients and unpublished pieces prepared for future publication, as well as the increasing length of each edition over the course of its first year of publication, from twenty-four pages to forty-two pages.<sup>234</sup> The continued desire for patients to have their work published in the magazine can certainly be read as an indicator that – for some patients at least – the magazine was a positive and productive force.

In some cases, patients were more explicit about their affection for the legitimizing force of the institutional press. One patient-authored poem, entitled “To the Editor,” extols the virtues of the magazine:

“Subjects new and old do these pages unfold/  
We are glad that such is the case,/ For if  
only the new were accepted by you/  
Our writing might find no place.// For a topic we  
look, and by hook or by crook/  
Our scribbles appear to succeed./ We feel grateful to  
those who, not given to prose,/ Our attempts are inclined to read./ In riddle and pun we

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<sup>233</sup> “Editorial,” *Under the Dome* 1, no. 4 (December 1892): 36.

<sup>234</sup> “Editorial,” *Under the Dome* 1, no. 4 (December 1892): 36.

find excellent pun,/ And our leader to aid us is good,/ And though he may wonder at  
 many a blunder,/ Our frailties are understood.// Our poor scattered wits are prone to take  
 fits,/ And our help may be but small;/ But we, while in this home, wish success to the  
 Dome,/ and success to our doctors all.”<sup>235</sup>

This poem suggests a deep gratitude to the editor of the magazine for facilitating a place where patient writing could be shared. The line “we feel grateful to those who, not given to prose,/ Our attempts are inclined to read” suggests that the magazine’s wide audience differentiates the process of writing for patients. It also suggests that there was something important with the institutionally-sanctioned nature of the magazine, which separated it from, for example, the dissemination of ones’ poetry and prose through informal means around the asylum. Often, much like with the poem suggests, patients were equal architects of community knowledge and common institutional culture. When Mr. Henry Graves, a long-time Bethlem Hospital governor, died in 1891, it was a patient who wrote his multi-page obituary in *Under the Dome*. The patient combined information about Graves’ life with his impact on the physical space of the institution. Graves had donated many engravings to the hospital which hung in the wards and at Witley Convalescent Home, which the patient explained had a significant impact on making Bethlem the pleasant space it had become.<sup>236</sup> The publication of patient writing was inherently legitimizing, as was the wide-ranging audience. The contributors ranged from doctors, administrators, and patients, and there is certainly indication that the magazine was read by all levels of those involved. The editor at Bethlem counted twenty Governors of the hospital among the first year of subscribers, which suggests that those at the highest levels of the asylum administrative structure were reading the work produced by past and present patients.<sup>237</sup> This served to even out the proverbial playing field for all residents of the asylum, making the institutional newspapers a place where asylum hierarchies were least clear.

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<sup>235</sup> “To The Editor,” *Under the Dome* 1, no. 4 (December 1892): 37.

<sup>236</sup> “Mr. Henry Graves,” *Under the Dome* 1, no. 4 (December 1892): 12-15.

<sup>237</sup> “Editorial,” *Under the Dome* 1, no. 4 (December 1892): 36.

In many cases, patient writing would appear side-by-side with writing from staff and administrators. In nearly every edition of Bethlem's *Under the Dome*, there were two simultaneous columns recapping news from the last quarter, including events, major staff changes, and other general interest stories. One, called "Local Notes," was written by the Chaplain, who was part of the administrative staff at Bethlem and worked as the Editor-in-Chief of the magazine. The other regular column in *Under the Dome* was called "Notes Apropos" and was written by a patient at the asylum.<sup>238</sup> The fact that the patient voice was presented equally with the voice of a staff member is certainly significant in terms of breaking down the hierarchies within the standard asylum through the cultural pursuit of writing. This is especially true when considering the opinionated nature of some of the patient writing, including the Notes Apropos column. Similarly, before the version of *Under the Dome* that began in 1892, which has been examined at length here, there was another magazine, also called *Under the Dome* which began in 1889. A hand-written publication, it has not survived the historical record, but it was generally short-lived anyway, since the patient that began it was discharged a year after it first emerged. This was, however, enough time and controversial content to inspire a rival patient-produced magazine, named *Above the Dome*.<sup>239</sup> This ability for patients to produce and counter-produce cultural knowledge in the asylum gave them a tremendous amount of agency, which was generally unseen in other facets of asylum life. Ultimately, patients had a particular kind of freedom on the pages of the institutional periodicals, which they were not always granted in the asylum. Patients were essential to the publication and production of institutional periodicals. By placing staff and patients as equals in this one realm, it suggests that written culture was a space of great liberty in the asylum for patients, despite the fact that these newspapers were ultimately controlled by staff. The circulation of newspapers and the creation of community knowledge through them was a clear

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<sup>238</sup> "Notes Apropos," *Under the Dome* 2, no. 8 (December 1893): 116.

<sup>239</sup> *Bethlem Royal Asylum Annual Report* (1890), 57.

mimicking of local and society newspapers, which were immensely vital cultural artefacts in wider Victorian society. Through the destruction of hierarchies and increased liberty, institutional magazines were great harbingers of domesticity to the asylum.

Ultimately, culture was an essential element of psychiatric therapy at the end of the nineteenth century, but it was also a flexible environment for patients to practise their agency and, in small ways, challenge the asylum hierarchies. Through the levity brought about by staff involvement in culture and the agency given to patients through their role as cultural producers, the asylum was able to shed some of its institutional nature. Particularly in the case of institutional magazines, patients were able to be community builders and agents of cultural production. It is unsurprising, then, that patients embraced institutional domesticity when doctors attempted to implement it. Employment, too, was a facet of institutional domesticity in the asylum, despite the fact that it was part of the public sphere in the wider world. Doctors overcame class and gender expectations that lingered from the outside world and were able to successfully assure that all patients had meaningful work. In the case of pauper patients, especially, their labour was a tool of agency, which allowed them to bargain for more luxuries which were beyond their means, otherwise. Ultimately, doctors were very successful in assuring that there were no idle hands for Satan to find in the asylum. Patients found themselves constantly occupied by an exciting routine of employment and amusements. However, activities were not the only way in which doctors sought to de-institutionalise the asylum. As I suggested in this chapter, with discussions about the construction of Recreation Halls and labour annexes, the physical space of the asylum could be a determining factor in the successful implementation of therapeutic domesticity. In some cases, I will demonstrate, space was a much more challenging battleground for the realisation of institutional domesticity. Despite unwavering attempts by doctors, the physical space of the asylum was often more reluctant to relent to domesticity than its inhabitants.





## Chapter Two - Utopic Spaces: Regulating Movement and Space in the Asylum

“Home Sweet Home!” proclaimed one anonymous patient, on their first night at Crichton Royal Hospital in 1890.<sup>240</sup> This, they claimed in an article published in the *New Moon*, was their very first impression of Crichton. Upon settling into the asylum, the patient claimed that that they would always remember Crichton’s “beautiful situation of buildings and the quietude [...] of its surroundings” as the setting for some of their “purest, brightest, and happiest days.”<sup>241</sup> As the patient extolled the many comforts and pleasant activities they engaged in while at Crichton, they stated that only the poorest of spirits would not be able to make themselves “if not at home, at least comfortable and happy here.”<sup>242</sup> This reminiscence suggests that some patients viewed the asylum as a second home, which was furthered by the physical structure of the asylum. In many parts of the asylum, patients found comfortable, inviting interiors, which were reminiscent of the Victorian home. However, the interiors of the Victorian home were infused with cultural meaning and influenced the individuals that lived within the home. Increasingly, the nineteenth century middle-class home was segregated, with individual rooms being designated for a particular usage for the first time.<sup>243</sup> This organisation of space was deeply influential on the social relationships that unfolded within the home. Some historians have argued that the primary use of Victorian spatial organisation was to regulate the relationships between residents of a home into their proper roles.<sup>244</sup> For example, while upper-class and upper-middle-class homes had expansive (if unsightly) quarters for their many staff members, the average middle-class family found themselves in much closer proximity to their staff members due to limits on the physical space of the home. This resulted in intricate and strict

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<sup>240</sup> “My First Impressions of Crichton,” *New Moon* 47, no. 594 (November 1890): 1.

<sup>241</sup> “My First Impressions of Crichton,” *New Moon*, 1-2.

<sup>242</sup> “My First Impressions of Crichton,” *New Moon*, 1.

<sup>243</sup> Jane Hamlett, *Material Relations: Domestic Interiors and Middle-Class Families in England, 1850-1910* (Manchester: Manchester University Press, 2010) 40.

<sup>244</sup> Hamlett, *Material Relations*, 210.

scheduling of the common spaces to assure that family and staff rarely interacted, preserving the family's privacy.<sup>245</sup> Similarly, the decoration of the family home was an experience fraught with gendered power and marital hierarchies. For much of the nineteenth century, the decoration and organisation of the home was a joint husband-wife endeavour. With the husband typically as the controller of the family finances, decoration and consumption of home goods was a setting for husbands and wives to define the nature of their relationship.<sup>246</sup> Ultimately, the decoration of the space and the ability to move within space were foundational elements for shaping relationships between family members, as well as relationships with their live-in staff.

In mimicking the Victorian home, therefore, the asylum had to contend with some similar challenges. The organisation and decoration of the asylum also had an important impact on the ways in which the patients interacted with staff and other patients. The aesthetics of the asylum space were important, with significant time and effort placed into the class-appropriate decoration of the asylum space. However, the asylum space was intended to regulate movement in ways that the Victorian home did not. Individual movement in the asylum, for example, was carefully controlled by the medical staff, not just by the prescriptive expectations that regulated the Victorian home. Medical staff had the right to restrict patient access to certain parts of the institution and in some cases, restrain them physically from moving altogether. Similarly, patients in the asylum faced constant surveillance in ways that people did not at home. There was also the unpredictability of insane behaviour to be contended with, which required additional safety measures and certain practicalities that the traditional home did not require. These elements added an additional layer of complexity to the implementation of domesticity in the physical space of the asylum.

Mimicking the domestic environment had become essential to the landscape of enlightened, modern, and humane psychiatric treatment at the end of the nineteenth century.

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<sup>245</sup> Hamlett, *Material Relations*, 55.

<sup>246</sup> Hamlett, *Material Relations*, 86-87.

Domestic arrangements in the asylum were often posited as the enlightened alternative to cruel practises. In fact, the physical space of the asylum maintained negative connotations in the wider nineteenth century cultural imagination. In the early modern period, Bethlem (Bedlam) became synonymous with pandemonium and chaos. By the nineteenth century, the cultural landscape was rife with disturbing images of confinement in the asylum. Caricaturist George Cruickshank's infamous engraving of a Bethlem patient in a "grotesque custom-build harness made of chains and rods, preventing virtually all movement" was circulated widely during the early nineteenth century. In its day, Bethlem doctors protested that this was necessary and humane, but it was easy for the public to view it as barbaric, cementing mechanical restraint as part of the cultural imagination of mental institutions in Britain.<sup>247</sup> Combined with damning patient testimonies, like the 1818 publication of the pamphlet *The Interior of Bethlehem Hospital Displayed*, the asylum was imagined as a place of systematic cruelty, housing bothersome individuals with nowhere else to go.<sup>248</sup> These scandals of the early nineteenth century produced enduring images. For one, though Bethlem changed locations multiple times during its history, these early nineteenth century scandals took place in Bethlem's Southwark location where it would remain until the twentieth century. These images of cruelty and barbary, therefore, were closely associated with the space I discuss in this thesis. Additionally, historians have suggested that the fact that Bethlem was the most prominent psychiatric institution in Britain for most of its history meant that Bethlem's scandals defined the wider cultural perception of psychiatric institutions.<sup>249</sup>

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<sup>247</sup> Porter, *Madmen*, 131.

<sup>248</sup> Porter, *Madmen*, 130-131.

<sup>249</sup> Porter, *Madmen*, 129-130.



**Figure 5** Caricaturist George Cruikshank's depiction of asylum inmate James Norris <sup>250</sup>

These cultural images translated into a proliferation of advocacy groups across Great Britain, who promoted better treatment in asylums. Early reformers began the Alleged Lunatics' Friend Society (ALFS), established in 1845. The Society was primarily concerned with the possibility that sane people might be improperly confined in the asylum, due to cruel family and friends who sought to control the patient's property or finances while they were incarcerated in the asylum.<sup>251</sup> The founder of this organization, Richard Paternoster, had been forcefully incarcerated in an asylum by his father but was quickly released, forty-one days later. The ALFS spent a large portion of their time lobbying Parliament to overhaul the admission process for asylums, proposing a jury-style system with a build-in and easily accessible appeals process.<sup>252</sup> The Alleged Lunatics' Friend Society disbanded in the 1860s, but was quickly

<sup>250</sup> Wise, *Inconvenient People*, 68.

<sup>251</sup> Wise, *Inconvenient People*, 68.

<sup>252</sup> Wise, *Inconvenient People*, 72.

replaced by the Lunacy Law Reform Association (LLRA), in 1873. This group was led by a middle-class woman, Louisa Lowe, who campaigned against the existing Lunacy Laws and specifically, the influence of the Commissioners in Lunacy. She had also been wrongfully committed to an asylum and had found the appeals process unsatisfactory. The Association proposed and lobbied for a whole new national system of Lunacy Laws, including more difficult and judicially-influenced admission processes, though unlike the ALFS, Lowe's organisation considered gender to be one of the major factors leading to improper confinement. The lobbying of the LLRA eventually attracted the attention of Parliament, resulting in a report from a Select Committee on Lunacy Laws.<sup>253</sup> Despite the existence and successes of these organisations, by the end of the nineteenth century, asylums were still imagined as spaces to house inconvenient family members. These lobby groups promoted and legitimized the idea that nineteenth century asylums were isolating, cruel places, where patients were completely segregated from the civilized world. By the late nineteenth century, asylum administrators were aware of the stigma against asylums and they were deeply concerned. Because much of the stigma against asylums was centred on physical space, making its physical space seem comfortable, free, and domestic was essential for battling the stigma. Modern treatment and domesticity, especially the construction of an illusion of patient liberty, became closely intertwined by the end of the century. In this chapter, I will examine the ways in which doctors attempted to use the physical space of the asylum to rehabilitate its reputation.

Beyond their attempts to rehabilitate the asylum's public image, doctors were also generally in consensus about the fact that early admission to the asylum improved the chances that a patient would heal. For example, when Gartnavel stopped accepting pauper patients, physician superintendent David Yellowlees noticed that the recovery rates for the asylum dropped. He attributed the increase in chronic, long-term cases to the fact that middle- and

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<sup>253</sup> Wise, *Inconvenient People*, 311-316.

upper-class patients usually waited a lot longer before accessing asylum treatment. This was in part due to the financial burden placed on private patients, who were not subsidized by the state in the way paupers were. He also suggested that pauper patients did not have the space in their family homes to deal with acute bouts of insanity, so those patients were sent on short asylum sojourns. Middle- and upper-class patients tended to deal with these acute bouts of insanity at home, lowering the asylum's overall recovery rate and making their cases more difficult to deal with once the patient was finally admitted.<sup>254</sup> Treatment for mental illness in the nineteenth century was exclusively centered in the asylum space, with next to no options for out-patient treatment. Therefore, potential patients and their families had to trust the asylum space and the doctors within it, because once a family member was exhibiting signs of insanity, doctors felt it was essential that they reach the asylum as soon as possible. In this system, community care only inhibited the effectiveness of eventual asylum treatment.

Therefore, it was not enough simply to domesticate the interiors – the public had to be made aware of the asylum's comforts. Thus, the process of combatting stigma often took the form of increasing transparency between the outside world and the asylum. In 1893, the Chairman of the Board of Directors of Gartnavel Royal Hospital felt that “the old fear that Asylums were Institutions for confinement only was gradually disappearing.”<sup>255</sup> He mentioned that there were many patients who did not even want to leave the asylum when their time was done, because the asylum space was filled with so many happy memories.<sup>256</sup> The asylum structure was central to his reasoning behind the change. When the asylum was first constructed, it was on the outskirts of Glasgow, distanced from the heart of the city. By the 1890s, however, “the city had grown round it, and it formed quite an agreeable feature in the landscape.”<sup>257</sup> In the Chairman's view, the physical institution transformed from an ostracised

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<sup>254</sup> *Seventy-Eighth Annual Report of the Gartnavel Royal Asylum* (1891), 12.

<sup>255</sup> *Eightieth Annual Report of the Gartnavel Royal Asylum* (1893), 3.

<sup>256</sup> *Eightieth Annual Report of the Gartnavel Royal Asylum* (1893), 3.

<sup>257</sup> *Eightieth Annual Report of the Gartnavel Royal Asylum* (1893), 3.

place of sequestration into a thriving part of the wider community, which in turn made it feel more trustworthy for the community it was a part of. Despite the Chairman's optimistic outlook a decade earlier, stigma still lingered as late as 1907. The institutional magazine at Gartnavel was praised for allowing its "beyond-the-walls readers" a true glimpse into the daily and ultimately pleasant pace of asylum life, which was thought to continue the fight against asylum stigma.<sup>258</sup> By exposing outsiders to the pleasant activities within the walls of the asylum, the magazine sought to combat ignorance, prejudice, and superstition which were all "present in the public mind regarding Asylum life."<sup>259</sup> It was not enough to modernize the asylum and its activities – the cultural perception had to change.

These efforts to improve the public's perceptions of the asylum space were not just hollow public relations campaigns, however. For an asylum to be modern, it had to be comfortable and had to allow patients the sense that they were not incarcerated. In other words, it had to produce an illusion of liberty. To achieve this, doctors and administrators made concrete changes to the asylum space, in both permanent and impermanent ways, which were believed to bring about a sense of comfort, freedom, and domesticity in the asylum's physical space. In this chapter, I will examine the implementation of domesticity in the asylum's physical space on two levels. First, I will explore the ways in which medical administrators and asylum inspectors sought to bring domesticity to the traditional institutional space, through redecoration and renovation. Redecorating the asylum's scenography was a constant battle, intended to draw on elements of the Victorian home, both material and immaterial, to obscure the institutional nature of the asylum. Other changes to the asylum scenography included the implementation of an open-door system and the elimination of physical restraints, both of which also served to obscure the institutional nature of the asylum through the production of an illusion of liberty for patients.

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<sup>258</sup> "Notes," *The Gartnavel Gazette* 17 (January 1907): 2.

<sup>259</sup> "Notes," *The Gartnavel Gazette* 17 (January 1907): 2.

Then, I will examine the emergence of a new style of asylum space, the villa, which more directly took the form of a Victorian home. These spaces of healing – associated with the asylum but often geographically distanced – were often implemented in old country houses and fundamentally resembled the domestic environment, on an architectural as well as decorative level. These spaces did not have an inherently physically institutional nature to obscure, since architecturally they already resembled the Victorian home. However, constructing the coveted illusion of liberty was still fraught with challenges, which ultimately threatened the successful implementation of domesticity, even in the most physically domestic spaces. Upon examining these both styles of implementing domesticity, I will suggest that the implementation of Victorian domesticity in the physical space of the asylum was burdened by challenges and limitations.

#### Domesticating the Existing Space: Décor, the Open-Door System, and Restraint

Wards were regularly redecorated and renovated to keep them looking clean, comfortable, and modern. It was a constant battle of domesticity against the inherently institutional nature of the asylum. In the early nineteenth century, these institutions were built with modernity in mind, but nearly a century later, the spaces often seemed dated. By the 1890s, the spaces seemed institutional and anti-modern to its inhabitants. Alongside this, many of these buildings were haunted by the stigma borne of asylum scandals in the early nineteenth century. Medical administrators sought to couch the unfriendly, institutional interiors in domestic aesthetics to bring about a sense of modernity and comfort in the asylum, to varying levels of success. For example, renovation and redecoration occasionally helped the physical structure of the asylum accommodate changing patient populations. In the early nineteenth century, Bethlem was imagined primarily as an institution for pauper patients. By the end of the century, the social composition of the patients began to transform and there was increasing need for



accommodation suitable for the middle- and upper-classes. Bethlem, with its central London location, was geographically constrained and had little room to expand outwards in the way that Crichton and Gartnavel could. Historians have suggested that Bethlem's administrators were deeply concerned with the decorating the interiors as a result of the institution's ability to develop outwards.<sup>260</sup> In Bethlem's case, changing the interiors of the asylum to suit differing class expectations helped reconcile changing patient populations with the unchangeable architecture of the hospital.

In other cases, decoration was a powerful tool intended to shroud the institutional demeanour of the asylum in domestic aesthetics. In 1907, the ladies' wing of Gartnavel's West House was "sumptuously refurnished and tastefully redecorated." Specifically, the "interiors have been effectively altered by breaking up the long open spaces by means of open arches."<sup>261</sup> The nineteenth century asylum was frequently organised in a series of galleries, with long corridors. These, historians have argued, were one of the greatest visual cues about the asylum's institutional nature.<sup>262</sup> One strategy for combatting the institutional effect of the long corridors was by installing arched doorways, which effectively transformed the corridor into multiple, smaller rooms to the viewer, which appears to be how the administrators at Gartnavel sought to fix the issue. In fact, they were explicit about this aim. Dr. Oswald, the physician superintendent, claimed that breaking up the gallery with archways meant that the space had "a much less institutional appearance."<sup>263</sup> When Commissioner in Lunacy John MacPherson came to visit later that year, he praised the archways for being "pleasing to the eye" and claimed that "the character of the accommodation has [...] been transformed so as to correspond more closely to the domestic type."<sup>264</sup> The goal of these renovations was clearly to diminish the visual

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<sup>260</sup> Hamlett, *At Home in the Institution*, 41.

<sup>261</sup> *Ninety-Fourth Annual Report of the Gartnavel Royal Asylum* (1907), 40.

<sup>262</sup> Hamlett, *At Home in the Institution*, 43.

<sup>263</sup> *Ninety-Fourth Annual Report of the Gartnavel Royal Asylum* (1907), 19.

<sup>264</sup> *Ninety-Fourth Annual Report of the Gartnavel Royal Asylum* (1907), 40.

impact of the institutional nature of the asylum, through the use of domestic aesthetics. The effect this was believed to have on the patients was enormous. According to the Commissioners, “[these] improvements cannot fail to exercise a beneficial influence upon those who are confined more or less constantly in these wards.”<sup>265</sup> Simple changes to the decoration of a space fundamentally transformed the institutional nature of the space, and in turn, promoted the healing nature of the asylum environment.



**Figure 6** Archway designed to break up the long corridor at Holloway Sanatorium, though similar ones were found at Bethlem and Gartnavel <sup>266</sup>

When asylums were unsuccessful in domesticating their space, or were too slow in their efforts, they were often scolded by the Commissioners in Lunacy. At Bethlem, in 1893, Commissioners Charles Palmer Philipps and Fredrick Needham acknowledged efforts to

<sup>265</sup> *Ninety-Fourth Annual Report of the Gartnavel Royal Asylum* (1907), 40.

<sup>266</sup> Hamlett, *At Home in the Institution*, 42.

repaint some of the wards on the male side of the hospital, but categorically decreed that it was not enough, saying “renovation of this sort is much needed in many wards on both sides.”<sup>267</sup> The Commissioners framed this critique in terms of concern about patient healing and concern about the modernity of “this truly royal charity.” Like with Gartnavel, the Commissioners pointed out the “inconvenient length of the wards,” referring to the institutional gallery-like layout, and suggested that these be redecorated to match modern ideas about asylum architecture. The Commissioners suggested that redecoration would produce warmer, more comfortable spaces and would trick the eye into overlooking the institutional corridors.<sup>268</sup> They added that Bethlem’s outdated spaces meant they were “lagging in the rear of the march of progress,” suggesting that comfortable, domestic interiors were fundamental to modern treatment.<sup>269</sup> As I have suggested, the preoccupation with modernity in the asylum was a conscious response to cultural stigma about the asylum as a dangerous, unfriendly space. Careful implementation of comfortable and visually pleasing aesthetics was essential to rehabilitating the reputation of the asylum. Additionally, comfortable space was once again imagined as a component of healthcare, when Commissioners warned – in the same report – that “[in] wards occupied by the least promising patients, our experience tells us that improvements such as we have suggested would have the most powerful influence for good.”<sup>270</sup> Domestic, comfortable space in the asylum had a dual purpose – bringing enlightenment to the asylum’s reputation and creating a space that directly promoted patient healing. However, Commissioners in Lunacy chastised asylum administrators when they failed to maintain a suitable pace of modernization and domestication of the space. Something as minor as the length and décor of corridors was understood as a major barrier to patient healing and asylum

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<sup>267</sup> *Bethlem Royal Asylum Annual Report* (1893), 64.

<sup>268</sup> *Bethlem Royal Asylum Annual Report* (1893), 65.

<sup>269</sup> *Bethlem Royal Asylum Annual Report* (1893), 65.

<sup>270</sup> *Bethlem Royal Asylum Annual Report* (1893), 65.

modernity, making the process of modernizing the asylum through domesticity an endless battle.

The late nineteenth century also saw significant advancements in technologies like artificial lighting, which made life in the asylum space more comfortable. Before the advent of electric lights and the gas mantle around the 1880s, lighting a space beyond daylight hours was inconvenient and costly. Artificial light for most of the nineteenth century was largely limited to tallow candles, which produced a rancid smell and thick, sooty smoke that dirtied all surfaces.<sup>271</sup> Additionally, the primitive wicks had to be trimmed regularly, in ten-minute intervals, to assure that the light remained bright, which historians have suggested interrupted the flow of life within the lit space.<sup>272</sup> The other major issues with artificial lighting in the early- and mid-nineteenth century was how dim it was, which created barriers for the use of the space. The low, uneven light of the candle or fireplace made activities that required sustained concentration, like reading and games, more difficult.<sup>273</sup> This was more than just inconvenient, since cultural pursuits and amusements were key elements of psychiatric treatment in the late nineteenth century, as I explored in Chapter One. However, electric light began to be commonplace in the Victorian home by the 1880s, and by the late 1890s, it had begun to be common in the Victorian asylum, as well.

Everyone in the asylum hierarchy, from patients to Commissioners in Lunacy, was concerned with the question of sufficient light in the asylum, as it was an essential part of comfort in the asylum. Electric light came to Bethlem in the early 1900s.<sup>274</sup> At Crichton Royal Hospital, electric light was installed in most of the institution by early 1896, when the Commissioners in Lunacy praised the addition as a great benefit to the patients and the staff of

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<sup>271</sup> Simon Eliot, "Reading by Artificial Light in the Victorian Age," in *Reading and the Victorians*, ed. Matthew Bradley and Juliet John (New York: Routledge, 2016), 18.

<sup>272</sup> Eliot, "Reading by Artificial Light," 20.

<sup>273</sup> Eliot, "Reading by Artificial Light," 23.

<sup>274</sup> Hamlett, *At Home in the Institution*, 48.

the asylum. According to them, it was “safer, cooler, cleaner, and healthier” than the previous lighting options, which made it excellent for an institution dealing with the oft-unpredictable insane.<sup>275</sup> Patients, too, were fascinated by the technological improvements. Two different articles ran in Crichton’s institutional magazine, explaining how the “interesting and ingenious” technology worked and how it was installed in the institution, though they said little about the comfort that this technological improvement afforded them.<sup>276</sup> Gartnavel Royal Hospital installed electric lights in 1890, and during one of their visits, the Commissioners commended the electric lights for adding “to the cheerful appearance of the rooms in the evenings.” However, the benefits were not only for the patients and their personal comfort. The electric light was also praised for “facilitating the supervision of patients requiring special attention during the night, owing to the ease with which it can be turned on at any moment.”<sup>277</sup> In many ways, the installation of electric light was about making the lives of nurses and attendants easier, especially in their role as constant patient supervisors. It did, however, make the asylum more comfortable for all those who inhabited it, including patients. Despite this, the process of implementing domesticity into the asylum on an aesthetic level was a constant battle against the inherently institutional nature of the asylum. In the face of architecture that was inherently un-domestic and unpleasant to the late nineteenth century eye, decoration and modern technological improvement could only do so much. Additionally, asylum administrators had to weigh the benefits of certain elements of therapeutic domesticity against the practicalities of running an institution for the oft-unpredictable insane.

Beyond aesthetic improvements, medical professionals were also reimagining the patient’s interactions with the asylum space at the end of the century. Occasionally, this required changes to the physical landscape, which made a significant difference to the ways

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<sup>275</sup> *Thirty-Ninth Annual Report of the Scottish Commissioners in Lunacy* (1897), 57.

<sup>276</sup> “Electric Lighting,” *New Moon* 48, no. 612 (May 1895): 2 and “Electric Lighting at the Crichton,” *New Moon* 49, no. 621 (April 1896): 2.

<sup>277</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), 60.

that people – Commissioners, staff, and most importantly, patients – moved within the institution. The emergence of the open-door system at the end of the century was a product of these changed ideals. The open-door system required that there were very few locked doors in the entire asylum, except between the male and female wards, allowing anyone, not just staff, to move freely through the institution without a key.<sup>278</sup> The open-door system also sometimes resulted in a change to the physical scenography of the asylum, where any symbols of confinement and lost liberty were eliminated. For example, the medical administrators at Crichton had done away with the high boundary walls in the early 1890s, which was then replaced by an open fence.<sup>279</sup> There was, according to Commissioners, a type of “quietude” produced by the lack of high walls, fences, locked doors, and “irksome discipline.”<sup>280</sup> The Commissioners felt without a doubt that these techniques “resulted in an increase of tranquillity and contentment, or in other words, in a diminution of excitement.”<sup>281</sup> The open door system – and the construction of an illusion of liberty more generally – was frequently lauded by many as an essential element of enlightened and modern mental health treatment.<sup>282</sup>

Nevertheless, the open-door system was not without its critics. In the 1880s, a series of debates on the implementation of this policy emerged in *The Journal of Mental Science*. In the July 1881 issue, Dr. Fredrick Needham, who later became a Commissioner in Lunacy, sought to assess the open-door system, which was popular and increasingly commonplace in Scottish asylums, for possible use in England. In his article, Needham defined the open-door system as the elimination of locked doors and keys in the asylum, similar to the way Commissioners described it.<sup>283</sup> Needham wrote that “however necessary it may be to deprive insane persons from their full liberty of action, in the interest either of their own safety, or of that of society,”

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<sup>278</sup> Carmont, *The Crichton Royal Institution*, 22.

<sup>279</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), 52.

<sup>280</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), 52.

<sup>281</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), 52.

<sup>282</sup> Carmont, *The Crichton Royal Institution*, 22.

<sup>283</sup> Frederick Needham, “The ‘Open-Door’ System,” *JMS* 27, no. 118 (1881): 221.

it was equally important to afford patients the highest amount of liberty possible without a major risk.<sup>284</sup> In his quest to assess the open-door policy for his own potential use, he posed a series of six questions to his fellow medical practitioners:

- i) Does the open-door policy only work for private patients, or has it been successful with mixed asylums, as well?
- ii) Has it been tested for long enough in any asylum to be applied throughout the whole asylum, not just in particular class sections?
- iii) Are there any additional costs with the system that would make it impossible to implement throughout?
- iv) Does the system have any impact on the ability and willingness of patients to do physical labour each day?
- v) What precautions need to be taken to separate the excitable from the quiet, etc.? And what precautions to assure that those who want to escape cannot?
- vi) Is it possible that there is something specific to the Scottish disposition or education that allows this system to work, which might make it impossible for “another, more excitable race”?<sup>285</sup>

For Needham, this system seemed like a “Utopia in asylum life” did not seem practical for real life usage.<sup>286</sup> In asking these questions, he was attempting to weigh the value of his old ways of asylum superintendence against the potential value of a fundamentally new asylum scenography.<sup>287</sup> These questions, however, also pointed to the fact that, in many cases, institutional domesticity was at odds with the practicalities of asylum life, because the ideals of institutional domesticity required extreme personal liberty for unpredictable patients.

Doctors in favour of the open-door policy responded to Needham’s questions in droves. Dr. James Dunlop, the Assistant Medical Officer of Woodilee Asylum in Lenzie, Scotland, made his support of the open-door policy in the asylum clear. His perspective is particularly

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<sup>284</sup> Needham, “The ‘Open-Door’ System,” 221.

<sup>285</sup> Needham, “The ‘Open-Door’ System,” 221-222.

<sup>286</sup> Needham, “The ‘Open-Door’ System,” 221-222.

<sup>287</sup> Needham, “The ‘Open-Door’ System,” 221-222.

interesting, because Woodilee's Physician Superintendent in 1881 was Dr. Rutherford, who would, by the 1890s, be the Physician Superintendent of Crichton Royal Asylum, where he would be lauded for implementing a great system of patient liberty. This, in part, reinforces why the debates of the early 1880s were continually relevant in the 1890s and early 1900s – the doctors that participated in these debates continued to influence medical thought and rose in the ranks of psychiatry. At Woodilee Asylum, Dunlop pointed out, no doors were locked during the daylight hours, despite the fact that the asylum catered exclusively to pauper patients, largely from the “commercial and manufacturing city of Glasgow.”<sup>288</sup> Dunlop emphasised the working-class background of his patients to demonstrate that the open-door policy was successful, even under challenging conditions.<sup>289</sup>

Even its most fervent supporters agreed that the open-door system could not be implemented in a vacuum, however. Many of its supporters agreed that it needed to be part of a system of environmental and behavioural treatments, like employment and recreation. Dunlop specified that the system's success had to do with a strict schedule of outdoor amusements and work for the majority of patients' waking hours. Dr. Rutherford, who had previously preferred shorter working hours for patients, suggested that the open-door system required a more rigorous schedule of work and rational recreation for patients. For Rutherford and Dunlop, “[the] full employment of the patients renders it possible to give greatly extended liberty, and to do away with all remaining forms of mechanical or chemical restraint, such as walled courts, locked doors, stimulants, narcotics, and sedatives.”<sup>290</sup> Even its most fervent supporters admitted that the open-door system and the increased liberty it produced had to be supplemented with other forms of occupation to assure that patients did not escape or get into mischief.

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<sup>288</sup> Dunlop, “The ‘Open Door’ System,” 478.

<sup>289</sup> Dunlop, “The ‘Open Door’ System,” 478.

<sup>290</sup> Dunlop, “The ‘Open Door’ System,” 479.



In terms of cost of the open-door system, another of Needham's concerns, renowned psychiatrist Dr. Batty Tuke claimed that it did not increase the cost of the asylum administration.<sup>291</sup> Dunlop even went so far as to suggest that it lowered the cost of asylum maintenance.<sup>292</sup> Dr. Robert Cameron at Midlothian and Peebles District Asylum claimed that there was no need to hire additional staff to assure that the open-door system worked, which meant that there was little additional expense as part of the implementation of the system.<sup>293</sup> In fact, for Cameron, the only difference was that staff had to be more attentive of their patients and more vigilant with their surveillance, but argued that the essential patient management continued much like it had before the implementation of the open-door system.<sup>294</sup> Thus, on the subject of many of Needham's concerns – cost, feasibility, and the role of labour in the system – many doctors praised the system for the increased illusion of liberty patients were afforded.

Nevertheless, Needham was not satisfied by the answers of his contemporaries. In a rebuttal, he argued that the open-door system could not be successfully used for asylums with private patients. In Needham's view, pauper patients, who were regularly put to work in the asylum with outdoor physical labour regardless of the open-door system, benefitted from this system in ways that private patients could not. For patients of the private class, however, "whose education has been such as to have developed a strong- individuality and a habit of non-obedience," occupying the patients for the whole day would be difficult or, indeed, impossible.<sup>295</sup> The only doctor who directly responded with a case study from a mixed private-pauper asylum (like most Royal asylums were) was Dr. Cameron, who admitted that the implementation of the open-door system for private patients might result in increased seclusion of private patients who did not or could not work, undermining the ultimate liberty that the

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<sup>291</sup> J. Batty Tuke, "The Open-Door System" *JMS* 27, no. 119 (1881): 409.

<sup>292</sup> Dunlop, "The 'Open Door' System," 479.

<sup>293</sup> Robert W. D. Cameron, "The 'Open-Door' System," *JMS* 27, no. 119 (1881): 480.

<sup>294</sup> Cameron, "The 'Open-Door' System," 480.

<sup>295</sup> Frederick Needham, "The 'Open-Door' System," *JMS* 27, no. 120 (1882): 557.

open-door system promised.<sup>296</sup> As demonstrated in the first chapter, doctors struggled to find useful work for private patients because of class expectations that prohibited them from working in physical labour. Needham's articles reveal that the limits of the open-door system, largely due to the practicalities of asylum administration. On a structural level, the open-door system could be implemented in any asylum, since it required minimal structural changes and was not costly, according to its advocates. However, the behaviours of insane people were unpredictable and class expectations forbade some patients from working sufficiently long hours to thrive in an open-door asylum. While liberty was idealised as an essential element of the implementation of therapeutic domesticity, the realities of asylum living made the implementation uneven and controversial.

The debate over open-door system indicated that doctors were thinking critically about the ways that the patients moved around their space during their time in the asylum. The rhetoric around the open-door system echoed a similar debate about the use of mechanical restraint and seclusion in the asylum. Mechanical restraint was the most visually obvious way of restricting patient liberty in the asylum and posed a challenge to the implementation of patient liberty in the asylum. In a context where freedom to move around the asylum – either real or imagined – was an essential part of domesticity and modern asylum treatment, mechanical restraint seemed counterintuitive and downright barbaric. Nevertheless, the practise persisted into the late nineteenth century, inciting debates about modernity and enlightened treatment. The Scottish Commissioners in Lunacy defined restraint as “[whenever] a patient is made to wear an article of dress or is placed in any apparatus which is fastened so as to prevent the patient from putting it off without assistance, and which restricts the movements of the patient or the use of hands or feet.”<sup>297</sup> Seclusion, often considered in the same context as restraint, was defined as “[whenever] a patient is placed by day in any room or locality alone, and with the door of exit

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<sup>296</sup> Needham, “The ‘Open-Door’ System,” 556.

<sup>297</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), xlvii.

either locked or fastened, or held in such a way as to prevent the egress of the patient.”<sup>298</sup> Both of these definitions emphasise the lack of liberty involved in restraint and seclusion, either the physical restriction of bodily movement or the restriction of free movement within the asylum space. The 1890 Lunacy Act gave the Commissioners in Lunacy the right to ban certain forms of restraints as they saw fit, suggesting that the use of restraint needed to be carefully supervised. Additionally, the Act specified that physicians should only use physical restraints under particular circumstances, like surgery or to stop a patient from harming themselves or others. As a result of the Act, doctors were required to fill out a form specifying the means of restraint, the length of time used, and the reasons it was used every time they used restraint, which were then sent to the Commissioners in three-month intervals.<sup>299</sup> This change in legislation inspired discussion surrounding the use of restraints and seclusion among doctors. These debates revealed challenges facing institutional domesticity and its relationship with freedom and modernity.

The history of restraints had been regularly fraught with debate and reformist impulses. Historically, restraint was actually a symbol of modernity and rationality. In the early modern period, budding psychiatric professionals were concerned with assuring patients were institutionalised in specialised asylums, rather than being housed in homes or jails. Once there, these pioneering doctors sought to assure that these spaces were humane and used rational treatment. This, some historians have suggested, was a result of late Enlightenment concern with rational medical treatment and humanitarianism.<sup>300</sup> Despite this dedication to humane treatment, restraint was commonplace in the late-eighteenth century asylum. The most popular forms of mechanical restraint in the early modern period involved restricting movement of patients’ limbs, by means of devices like chairs with leather straps for arms and legs, beds with

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<sup>298</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), xlvii.

<sup>299</sup> *Bethlem Royal Asylum Annual Report* (1890), 49.

<sup>300</sup> Akihito Suzuki, “Mechanical Restraint,” in *Cultural Sociology of Mental Illness: An A-Z Guide*, ed. Andrew Scull (Thousand Oaks: SAGE Reference, 2014).

leather straps, and straightjackets.<sup>301</sup> By the late 1830s, some doctors viewed these methods of restraint as particularly cruel and the non-restraint movement emerged. During the 1830s and 1840s, seclusion and the confinement of patients into single rooms increased and was posited as a humane alternative to these increasingly unpopular mechanical restraints.<sup>302</sup> When patient liberty became an important element of psychiatric treatment at the end of the nineteenth century, the popularity of the anti-restraint movement expanded and came to encompass anti-seclusion sentiments as well. This popularity, however, did not preclude debates about the nuances of restraint usage. Questions of who was able to prescribe restraint as a treatment, the circumstances under which it was appropriate, and the types of restraints used dominated in the psychiatric community into the late nineteenth century. Freedom from restraint and seclusion was essential for the construction of an illusion of liberty, which was in turn essential to implement institutional domesticity. Theoretically, anti-restraint sentiments should have been an easily accepted part of modern treatment at the end of the century. Nevertheless, it was a consistent point of debate.

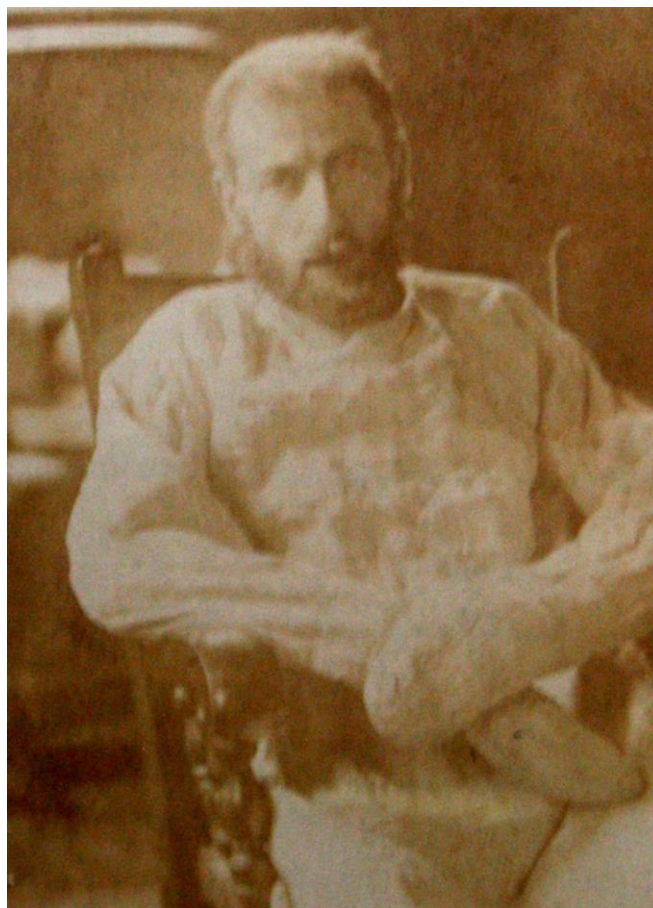
Doctors utilized the language of modernity and enlightenment on both sides of the pro- and anti-restraint debate. Though similar debates played at professional association meetings and in private correspondence, the mechanical restraint debate was encapsulated in a series of articles in 1889 and 1890 on the pages of the most prominent psychiatric journal of the period, *The Journal of Mental Science*. In a series of heated letters between Dr. Yellowlees of Gartnavel Royal Asylum and Dr. Alexander Robertson, a professor of medicine at the University of Glasgow, the two doctors presented many of the essential arguments for both sides of the mechanical restraint debate. Their dispute began with a seemingly uncontroversial statement made at an 1889 quarterly meeting of the Medico-Psychological Association. Dr. Yellowlees

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<sup>301</sup> Leslie Topp, "Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums, 1838-1844," *Social History of Medicine : The Journal of the Society for the Social History of Medicine* 31, no. 4 (2018): 757

<sup>302</sup> Topp, "Single Rooms," 754.

claimed at that meeting that “Restraint when dictated by harshness, irritation, or mere convenience is utterly wrong, but restraint when part of a well-considered plan of treatment, may, in special cases be perfectly wise or right.” Dr. Yellowlees went on to specify the particular cases when restraint was appropriate – he felt no hesitation in restraining a patient if they were suicidal or “in cases of extreme and exceptional violence.”<sup>303</sup> Both of these reasons for mechanical restraint were in line with the change made by the 1890 legislation, which specified that mechanical restraint could be used in the case of threat of harm to the patient or to others.<sup>304</sup>



**Figure 7** An anonymous Bethlem patient restrained by padded gloves<sup>305</sup>

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<sup>303</sup> Alex Robertson, “On the Use of Restraint in the Care of the Insane,” *JMS* 35, no. 151 (1889): 476.

<sup>304</sup> *Bethlem Royal Asylum Annual Report* (1890), 49.

<sup>305</sup> 09/HPC-02, “Album of photographs of hospital patients” at Bethlem Museum of the Mind Archives.

Yellowlees, however, also suggested that patients should be restrained if staff feared that they might destroy asylum property or if they were extremely fidgety.<sup>306</sup> The 1890 Act did not allow the use of mechanical restraint for these reasons, though that inspired criticism from doctors. Dr. Percy Smith from Bethlem saw restraint for the purpose of protecting asylum property as a necessary and justified use of mechanical restraint. He gave the example of one Bethlem patient who, before the 1890 legislation, would have been placed in a pair of padded gloves (considered by Smith to be a “harmless and mild” technique of restraint) after destroying twenty-four quilts and nine flannel dresses in a two-week period. This property damage cost the asylum an unnecessary and exorbitant £50, according to Smith.<sup>307</sup> Anti-restraint doctors saw this issue in a very different light. To Yellowlees’ statement, Dr. Robertson responded with a biting letter to *The Journal of Mental Science* that referred to Dr. Yellowlees as “the leader in Scotland of a retrograde movement.”<sup>308</sup> Robertson argued that the ambiguous results of using restraint did not justify returning to the “cruellest ... and darkest days” of the psychiatric profession. Robertson called for Yellowlees to demonstrate through concrete statistics that suicide, injury to others, and cost of maintenance from damage to property was lower at Gartnavel Royal Asylum than it was at places that followed the non-restraint principal. Dr. Yellowlees did comment on some of these points, explaining that Gartnavel Royal Asylum had only one suicide in the last fifteen years and very few serious accidents that he attributed in part to the use of mild restraints like padded gloves.<sup>309</sup> However, he refused to disclose the cost of maintenance due to damaged property, stating that there were too many variables and it constituted a false comparison to attribute any differences to the use of restraints.<sup>310</sup>

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<sup>306</sup> Robertson, “On the Use of Restraint in the Care of the Insane,” 476.

<sup>307</sup> *Bethlem Royal Asylum Annual Report* (1890), 49.

<sup>308</sup> David Yellowlees, “On the Use of Restraint in the Care of the Insane: To the Editors of ‘The Journal of Mental Science,’” *JMS* 35, no. 150 (1889): 287.

<sup>309</sup> David Yellowlees, “To the Editors of the ‘Journal Of Mental Science,’” *JMS* 35, no. 151 (1889): 478.

<sup>310</sup> Yellowlees, “To the Editors,” 478.

For both of these doctors, their position on the question of mechanical restraint was expressed in a language of modernity and enlightened treatment of patients. Robertson accused Yellowlees and the pro-restraint doctors of being “retrograde” and essentially anti-modern, harkening back to a time when asylums were inherently crueller. Robertson invoked the foundation-stone at Gartnavel Royal Asylum, which has a list of principles including “employing no mechanical personal restraint in the treatment of the patients.”<sup>311</sup> For Robertson, it was ironic that of Gartnavel’s administration understood the moral corruption of using restraints in the treatment of the insane many decades earlier, but his contemporaries did not. Yellowlees’ pro-restraint counter-argument also rested on the principle of modernity. He explained that “restraint prescribed by a humane and experienced physician is totally different from the restraint inflicted by cruel or unenlightened men in bygone days.”<sup>312</sup> For him, enlightened doctors could tell the difference between necessary and humane restraint, and cruel, unnecessary restraint. He also framed Robertson’s position in the language of religious fervor, suggesting that in not understanding the nuances of restraint, Robertson treated the non-restraint principle as “a rule revealed from heaven” rather than a scientific form of treatment.<sup>313</sup> For pro-restraint doctors, the use of restraint was a nuanced topic, and the ability to determine when and for whom restraint was appropriate required expert medical knowledge, experience, and training. Doctors like Yellowlees were able to view themselves as modern, despite supporting a system of treatment that was contrary to the vision of freedom and domesticity that characterised most modern asylum treatment. This suggests that daily practicalities – like the protection of asylum property and frustration with unruly patients – took priority over the grand ideal of implementing domesticity.

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<sup>311</sup> Robertson, “On the Use of Restraint in the Care of the Insane,” 477.

<sup>312</sup> Yellowlees, “To the Editors,” 478.

<sup>313</sup> Yellowlees, “To the Editors,” 478.

The use of restraint remained relatively commonplace in the asylum for most of the 1890s, despite the rhetoric around liberty and domesticity in the asylum. The Scottish Commissioners in Lunacy carefully monitored the use of restraint throughout the 1890s. In 1895, they began collecting data on the use of restraint from every asylum in the country, and in the 1901 report, the Commissioners presented all of this data in a table, along with their remarks. Across the five-year period and all twenty-nine asylums in Scotland, an average of 59 patients were restrained and 114 were secluded annually.<sup>314</sup> This represented an average of 0.55% of patients restrained and 1.05% of patients secluded annually.<sup>315</sup> Neither Crichton Royal Hospital nor Gartnavel Royal Hospital represented significant outliers. Crichton had 0.31% of its patient population being subjected to restraint per year and 0.23% of patients being secluded. Gartnavel Royal Hospital had 0.96% of its patients restrained and 0.86% of its patients secluded. This small number of restrained patients, according to the Commissioners, was worthy of congratulations.

Commissioners made it clear that there was nuance in the prescription of restraint, which the data could not properly show case. Many of these cases of restraint referred only to the gentle practise of locked gloves or other forms of restraint intended to stop the removal of surgical dressing, and that many of the cases of seclusion referred to “relegation, for a short time it may be, to a lighted and comfortable bedroom.”<sup>316</sup> Restraint and seclusion did not always mean physical discomfort and sequestration. However, they also warned that the same statistics disguised abuses of which the Commissioners have confirmed the existence, like the use of strait-jackets or confinement in a dark room, which were deemed unethical by the end of the century.<sup>317</sup> The Commissioners condemned this in the strongest terms, saying that they “do not regard such methods of treatment as consonant with the humane and enlightened views of the

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<sup>314</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), xlix.

<sup>315</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), xlix.

<sup>316</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), xlix.

<sup>317</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), xlix.



present day.”<sup>318</sup> The use of mechanical restraint and seclusion was counterintuitive to the persistent rhetoric about domesticity as healing, especially the concept of patient liberty, but both remained a regular part of treatment in the asylum. The inability for doctors and state officials to decide what the role of restraint should be in the asylum suggests that the implementation of domesticity in the asylum was not without its challenges. Often, doctors prioritised the practicalities of restraint over the grand ideals of domesticity. Furthermore, modernity, while closely intertwined with domesticity, could also be used to justify a position which fundamentally restricted the patient liberty which was so central to institutional domesticity. As a visual symbol of a lack of patient liberty, the continued use of restraint was contradictory to the implementation of therapeutic domesticity.

#### Truly Domestic Spaces: Villas and Convalescent Homes

At the end of the century, spaces for psychiatric care began to look fundamentally different on a scale well beyond simple aesthetics or control over movement in space. Asylums began to be disseminated into smaller buildings in more rural environments, called the villa or colony system.<sup>319</sup> These villas were large, mansion-like or hotel-like structures, detached and distanced from the main asylum space, housing smaller numbers of patients in less institutional environments. Crichton Royal Asylum successfully implemented an extensive villa system by the 1910s, and Gartnavel Royal Hospital had implemented some elements of the villa system, in a more limited fashion. Bethlem’s equivalent to this system was the Witley Convalescent Home, which shared the home-like environment of the villas but was strictly for patients who were convalescing. The villas functioned as semi-independent hubs away from the main structure of the asylum, with a head of household who manages each villa separately, but all of

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<sup>318</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), xlix.

<sup>319</sup> Allmond, “Liberty and the Individual,” 30-31.

whom reported back to the physician-superintendent. Every day, each villa's housekeeper requested their needs from the main asylum storerooms, including the daily food supply, the clothing that patients needed, and any replacements of minor furnishings in the villas.<sup>320</sup> At the villas, patients were "allowed absolute freedom of egress and ingress," which gave patients the sense that they were not institutionalised. These spaces had "all the comforts of private life" combined with the necessary supervision for patients' mental condition.<sup>321</sup>

The Commissioners were effusive with their praise for this system, because it allowed patients to be "free from arrangements suggestive of asylum detention, while remaining under skilled medical supervision and the care of trained attendants."<sup>322</sup> Crichton had six of these villas and they drew much of the Commissioner's attention, despite housing a relatively small part of the Crichton patient population. In October of 1891, Commissioners reported that there were 866 patients residing on the grounds of the asylum, dispersed among 6 villas.

Villa	Patient Population
Kinmount	43
Maryfield	15
Midpark	17
Rosehall	36
Spitafield	16
Hannahfield	11

**Table 4** Crichton Royal Asylum, Villa Patient Populations, 1891 <sup>323</sup>

As shown in the above table, the villas housed a total of 138 patients, or roughly 16% of the patient population that year. The rest of the patient population was split unevenly between the

<sup>320</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 66.

<sup>321</sup> *Fiftieth Annual Report of the Scottish Commissioners in Lunacy* (1908), 67.

<sup>322</sup> *Thirty-Eighth Annual Report of the Scottish Commissioners in Lunacy* (1896), 60.

<sup>323</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), 52.

First House, which housed 193 patients, and the Second House, which housed 535 patients.<sup>324</sup> The First House was largely occupied by the “higher class of private patients,” which is to say, the patients paying the highest rates of board. It was also the administrative hub of the institution. The Second House, on the other hand, was largely made up of pauper patients, though also had some private patients who had been admitted at lower rates of board.<sup>325</sup>

By 1900, there were 744 patients at Crichton, 590 of whom lived under “normal asylum conditions,” which is to say, they lived in the ward-style buildings of First and Second House.<sup>326</sup> An additional 145 patients lived in detached houses, including the seven villas and one farm annexe. This represented only 19% of the population in detached houses, but by 1904, there was an estimated 40% of the total asylum population (roughly 291 patients at the time).<sup>327</sup> This exponential growth indicates a significant commitment to the villa system as a modern treatment option. Rosehall House, the farm annexe discussed in Chapter One, was the exception among the detached houses, because it almost exclusively housed male pauper patients.<sup>328</sup> The villas housed high-paying upper-class patients, some in single gender houses and some in mixed gender environments.<sup>329</sup> Hannahfield, for example, was largely used for elderly male patients who were considered chronically ill and wanted to lead “quiet life amid surroundings suitable to their peaceful condition” for their final days.<sup>330</sup> Another of the villas, Friar’s Carse, was particularly revered because beloved Scottish poet Robert Burns lived in the adjoining farm for many years, which inspired some of his work. It had further importance to the institution because Dr. James Crichton, the man who left the endowment that allowed the hospital to be constructed, lived at Friar’s Carse for many years.<sup>331</sup> At Crichton, some of the villas were for

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<sup>324</sup> *Thirty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1892), 52.

<sup>325</sup> *Thirty-Second Annual Report of the Scottish Commissioners in Lunacy* (1890), 50-51.

<sup>326</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 65-66.

<sup>327</sup> *Sixty-Fifth Annual Report of Crichton Royal Hospital* (1904), 6.

<sup>328</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 66.

<sup>329</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 66.

<sup>330</sup> Carmont, *The Crichton Royal Institution*, 33.

<sup>331</sup> Carmont, *The Crichton Royal Institution*, 35-36.

patients to live in full-time, while other served as a summer cottage, for a temporary getaway from asylum life.<sup>332</sup> Gartnavel Royal Asylum did not own any dedicated villas like Crichton did, but did rent country homes for the spring and summers in the early 1900s, which served the same purpose.<sup>333</sup>

At Bethlem, there was no formal villa system, likely due to its urban location, but there was a convalescent home, which fulfilled many of the same purposes. Like the villas, a convalescent home provided a significant amount of individual patient liberty, beyond what the standard institutional space could provide. The convalescent home was intended to transition patients who appeared nearly recovered into the patterns of life outside the asylum. Like the villas, Bethlem's Witley Convalescent Home was mostly used the spring and summer months, and while it was largely for patients on the path to discharge, some well-behaved but chronic patients who were well enough to appreciate the change of scenery also frequented it.<sup>334</sup> Patients were sent between Witley and Bethlem on a rolling schedule to maximise the number of patients who could reside there temporarily, since the space at Witley was relatively limited.<sup>335</sup> Though an average of 130 patients stayed there per year, there was only ever approximately twenty patients there at any given time. The Witley Convalescent Home was located in Surrey, over sixty kilometres away from Bethlem's central London location, making it a stark contrast for the dwellers of the urban hospital. Witley Convalescent Home, like the villas at Crichton and Gartnavel, was a deeply domestic and rural space, with healing focused on physical exercise, outdoor amusements, and relaxation.

The villa system was the pinnacle of patient care in the eyes of the Commissioners, who said that "no arrangement for the care of the insane could be more ideal in its aspect, for it combines the largest possible degree of domesticity with the necessary amount of

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<sup>332</sup> *Sixty-Eighth Annual Report of Crichton Royal Hospital* (1907), 11-12.

<sup>333</sup> *Forty-Fourth Annual Report of the Scottish Commissioners in Lunacy* (1902), 83.

<sup>334</sup> *Bethlem Royal Asylum Annual Report* (1891), 47.

<sup>335</sup> *Bethlem Royal Asylum Annual Report* (1894), 56.

supervision.”<sup>336</sup> Commissioners championed Dr. Rutherford’s system at Crichton as the new ideal of care, rather than simply an excellent outlier. By the time Dr. Rutherford retired from his position as physician superintendent at Crichton Royal Hospital in 1907, the Commissioners in Lunacy truly believed him to be “a bold and original administrator, who never hesitated from motives of timidity or self-interest to introduce new and original methods of care and treatment.”<sup>337</sup> The Commissioners lauded Rutherford for inspiring many other institutions in Scotland to follow suit with their own villa systems.<sup>338</sup> By the 1910s, the system had become the expectation for modern treatment of the insane in the eyes of the state.

Even in the system’s infancy, the physician superintendent’s annual reports and institutional magazines framed these non-institutional spaces as idyllic spaces of healing. At Crichton’s villas, the patients were “as happy and as contented as their mental condition will permit.”<sup>339</sup> The women who vacationed at Gartnavel’s villas came back “bronzed and invigorated,” as a result of the change of scenery.<sup>340</sup> Bethlem’s Physician Superintendent Percy Smith regularly referred to the Convalescent Home as a “most important source of health and enjoyment” and suggests that “it materially adds to the value and use of this hospital.”<sup>341</sup> Even in light of the luxury they offered, these villas appeared to be cost effective as well. Dr. Rutherford, Crichton’s physician superintendent, reported to Commissioners in Lunacy that the cost per patient in the villas was slightly cheaper than the cost per head in the traditional asylum. The Commissioners responded that “were the method found to be slightly more expensive instead of more economical, the preponderating advantages enjoyed by the patients in these villas would be a sufficient justification for their existence.”<sup>342</sup> In fact, the villa system did not

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<sup>336</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 67.

<sup>337</sup> *Fiftieth Annual Report of the Scottish Commissioners in Lunacy* (1908), 68.

<sup>338</sup> *Forty-Ninth Annual Report of the Scottish Commissioners in Lunacy* (1907), 68.

<sup>339</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 64.

<sup>340</sup> “Notes,” *The Gartnavel Gazette* 16 (October 1906): 1.

<sup>341</sup> *Bethlem Royal Asylum Annual Report* (1899), 32.

<sup>342</sup> *Forty-Third Annual Report of the Scottish Commissioners in Lunacy* (1901), 66-67.

just benefit patients. The physician superintendents saw a trip to Witley or the villas as equally beneficial for the nurses and attendants, due to the “change to country air.”<sup>343</sup> The nurses and attendants benefitted from the peaceful space and physical activity in much the same ways that the patients did. However, there was an additional element of peace for the staff, because the patients in the convalescent homes and villas were largely self-sufficient and sane. Therefore, the nurses and attendants were afforded “a welcome relief to the arduous duties and responsibilities of the Hospital.”<sup>344</sup>

Both the rural environment and the private, comfortable quarters promoted a sense of healing for patients. The impact of the rural environment was perhaps most obvious at Witley. When compared to hyper-urban Bethlem, the natural environment at Witley was a stark difference for patients. The large grounds at Witley, like at the villas, provided opportunities for a variety of healthy, physical outdoor activities, in a semi-monitored environment. Sports and outdoor physical exercise were essential for patient treatment, which the expansive rural space of the villas and convalescent homes facilitated. Sports encouraged discipline and rule-following for both male and female patients, which doctors believed helped patients return to sanity more quickly.<sup>345</sup> The rural space of the villas and convalescent home allowed the room patients needed for these sports. Additionally, exercise required a certain amount of patient liberty, which villas and convalescent homes provided. At the July 1895 meeting of the Medico-Psychological Association, Dr. Clouston pointed out that historically, doctors were reluctant to prescribe exercise to patients in the asylum. Instead, doctors in earlier eras believed that exercise of all kinds and movement in general should be restricted as much as possible. This coincided with the height of the era of physical restraints, like chains, and the dawn of the era

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<sup>343</sup> *Bethlem Royal Asylum Annual Report* (1897), 34.

<sup>344</sup> *Bethlem Royal Asylum Annual Report* (1897), 34.

<sup>345</sup> Hide, *Gender and Class in English Asylums*, 117.

of chemical restraints, like opium.<sup>346</sup> By the end of the nineteenth century, however, those views were antiquated. Doctors sought to frame themselves as modern and enlightened by promoting the curative abilities of regular exercise of both body and mind, which were intrinsically linked. Mental exercise included things like “new scenes, pleasant surroundings, new work, [and] new amusements,” which showed promising results for insanity due to its effect on improving sleep, calming “maniacal and melancholia excitement,” and increasing appetite for good nutrition, among other things. Ultimately, exercise in proper doses served to make patients “more contented, more quiet, more manageable, and more human.”<sup>347</sup> Like most therapeutic techniques, Clouston emphasised that they were “capable of being used to do both much harm and much good.”<sup>348</sup> Exercise had to be prescribed by someone with expert medical knowledge, so as not to be misused, but was ultimately thought to be therapeutic for most patients in the asylum.

While residing at an asylum villa or convalescent home, patients could expect regular physical exercise, in the form of cricket matches, tennis, and long walks in the countryside. Bethlem’s administration regularly updated the outdoor infrastructure at Witley to facilitate outdoor sports. In 1894, Bethlem administrators proposed an asphalt tennis court for the months where it was impossible to play tennis on the grounds, “as some patients find the time hang heavily without some recreation in addition walking exercise.”<sup>349</sup> Some of these outdoor sporting activities were, of course, gender segregated. At the villas, male patients could participate in sports like hunting of pheasants and rabbits in the autumn, which overran the gardens at Crichton’s Kinmount villa.<sup>350</sup> Female patients in the villa system also participated in sports. For a long time, croquet had been unpopular in the asylum, replaced by badminton,

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<sup>346</sup> T. S. Clouston and J. Batty Tuke, “Rest and Exercise in the Treatment of Nervous and Mental Diseases,” *JMS* 41, no. 175 (1895): 601.

<sup>347</sup> Clouston and Tuke, “Rest and Exercise,” 602.

<sup>348</sup> Clouston and Tuke, “Rest and Exercise,” 600.

<sup>349</sup> *Bethlem Royal Asylum Annual Report* (1894), 45.

<sup>350</sup> “Kinmount,” *New Moon* 49, no. 629 (July-August 1896): 15.

lawn-tennis, and golf, but in the 1890s, Crichton had a revival in popularity for the sport.<sup>351</sup> Crichton's vast croquet lawn was a point of pride. Patients clamoured to play it every evening during the spring and summer, seeking to beat their previous scores and enjoying the comradery. Croquet was competitive but did not cause patients to lose their tempers, making it an exceptionally good sport for those convalescing from bouts of insanity.<sup>352</sup> Croquet was especially popular for female patients at Crichton, since it provided gentle exercise and allowed female patients to gain and show off their skill in sport and conversation. Doctors also thought that female patients enjoyed it since it allowed them to show off their shoes, though it is unclear if that was believed to have any influence on healing.<sup>353</sup> The villa system gave patients the liberty and space they needed to play sports and exercise, which doctors believed was essential to psychiatric therapy.

The interiors of the villas and detached houses also promoted healing and calm among patients. The villas, which were often repurposed country homes, allowed for an increased segregation of patients by class, which was also thought to inspire increased healing and calm. This, according to some physician-superintendents, was one of the greatest features of the villa system, because it meant that patients were neither noisy nor over-excited.<sup>354</sup> Because the "faculty of imitation is particularly strong in unhealthy minds," the environment that a patient found themselves in upon admission could mould their behaviour for the rest of their stay.<sup>355</sup> Rutherford suggested that "noisy and turbulent" patients would find themselves quiet and calm if they were placed under the care of attentive female nurses and in an environment where the other patients were calm, like the villa system.<sup>356</sup> With more individual privacy, these spaces did not run the risk of one noisy patient disrupting and distressing the rest, which was a hazard

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<sup>351</sup> "Croquet, Bowls, Lawn-Tennis, Cycling," *New Moon* 49, no. 629 (July-August 1896): 19.

<sup>352</sup> "Croquet, Bowls, Lawn-Tennis, Cycling," *New Moon* 49, no. 629 (July-August 1896): 20.

<sup>353</sup> "Croquet, Bowls, Lawn-Tennis, Cycling," *New Moon* 49, no. 629 (July-August 1896): 20.

<sup>354</sup> *Sixty-Seventh Annual Report of Crichton Royal Hospital* (1906), 15.

<sup>355</sup> *Sixty-Seventh Annual Report of Crichton Royal Hospital* (1906), 15.

<sup>356</sup> *Sixty-Seventh Annual Report of Crichton Royal Hospital* (1906), 15.



of the communal living typical of ward life. The very nature of the villa system allowed for more privacy, and as a result, more overall calm in the asylum.

Unlike in the traditional asylum space, inspections by the Commissioners in Lunacy did not produce a slew of recommendations for renovations and redecoration. In 1909, the Commissioner in Lunacy's biggest complaint about Witley was that some of the windows needed cleaning and that a few of the windows on the male side were closed on a day when the weather was beautiful.<sup>357</sup> Unlike the strict asylum space, where lighting was a constant battle, Witley was well-lit and described in idyllic terms in these Commissioners' reports.<sup>358</sup> These minor complaints were typical of the inspections of villas and convalescent homes. Because the villas were physically and architecturally home-like, their interiors did not require a constant battle against inherently institutional elements. Similarly, in 1913, the Commissioner in Lunacy inspecting Witley commented that some of the bedrooms were very stuffy and would be improved by installing windows that could be opened, even just partially.<sup>359</sup> Unlike the movement to abolish locks and closed doors in the asylum, which provided an illusion of liberty, the option for open windows represents a great amount of actual power in the hands of the patients. This demonstrated great faith in the healing nature of the villa-style space. The freedom afforded to patients in the villa system was unprecedented, and by all accounts of modern treatment at the end of the nineteenth century, the system seemed ideal.

However, this liberty afforded by the villas was not always without consequences. Patients in the villa system theoretically posed a comparatively low risk of accidents and suicides, because they were expected to be either near sanity or from the richest classes of patients, who were believed to be less likely to misbehave in general.<sup>360</sup> In deciding that a patient was fit for their time in a villa or convalescent home, the physician superintendent

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<sup>357</sup> *Bethlem Royal Asylum Annual Report* (1909), 161.

<sup>358</sup> *Bethlem Royal Asylum Annual Report* (1909), 161.

<sup>359</sup> *Bethlem Royal Asylum Annual Report* (1913), 27.

<sup>360</sup> *Sixty-Eighth Annual Report of Crichton Royal Hospital* (1907), 11-12.

usually had to be convinced that the patient was, as Percy Smith put it, “practically sane.”<sup>361</sup> However, the persistence of incidents of suicide or escape reveals the limits of the institution’s ability to implement institutional domesticity, even spaces that were physically identical to the Victorian home.

The villas and convalescent homes were supposed to be the pinnacle of institutional domesticity and were imagined as significantly better for treatment than even the best parts of the traditional asylum. In 1911, Bethlem’s superintendent W. H. B. Stoddart stated that Witley “continues to be of the greatest advantage to convalescing patients in fitting them for life in the outside world after their long illnesses and sequestration.”<sup>362</sup> This suggests that the traditional asylum space, despite the best efforts to implement institutional domesticity, continued to have traces of social isolation and discomfort. However, the rosy image that Stoddart presented of the villa system did not fully encapsulate the full range of patient experiences there. For example, attempts at escape were not uncommon in the villas or convalescent homes. In 1894, for example, there was one patient escape from Witley. Though the patient was recaptured after only one night, their escape indicates limits to the healing nature of the convalescent home and the physician’s role in medical knowledge.<sup>363</sup> Two years later, in 1896, another male patient was allowed to escape. In this second case, an attendant was fired for their misconduct and carelessness in allowing the patient out of their sight.<sup>364</sup> Theoretically, if the villas mimicked all the elements of a comfortable domestic life in the outside world, patients would have little reason to seek escape. The persistence of escapes suggests that even the most domestic part of the asylum could not fulfill all patient needs. Surveillance and forms of restricting liberty were still necessary to keep patients in the asylum. Though these were only a few isolated incidents,

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<sup>361</sup> *Bethlem Royal Asylum Annual Report* (1897), 35.

<sup>362</sup> *Bethlem Royal Asylum Annual Report* (1911), 16.

<sup>363</sup> *Bethlem Royal Asylum Annual Report* (1894), 45.

<sup>364</sup> *Bethlem Royal Asylum Annual Report* (1896), 38.

they do indicate a limit to the implementation of institutional domesticity, despite the glowing praise that Commissioners conferred on the system.

Similarly, suicides were also not unheard of in the villa system. In 1898, a patient who had been at Witley for three weeks after recovering from a bout of melancholia, committed suicide with a knife that he had snuck into the institution from a trip to the nearby village.<sup>365</sup> The asylum's coroner performed an investigation and ultimately decided that the asylum and its staff could be blamed. The physician superintendent emphasised that after the death of the patient, the patients' friends admitted that the patient had previously been suicidal and even made previous attempts. The asylum, however, had not been made aware of this fact.<sup>366</sup> The persistence of suicides in the villa system indicates that patients still needed surveillance and restrictions, despite the healing nature of the space. Both escapes and suicides demonstrate one of the greatest failings of the liberty associated with institutional domesticity – the fallible nature of medical knowledge. For a patient to access the extreme liberty of the villa-style space, a physician-superintendent had to deem them sane, but the reoccurrence of escapes and suicides suggests that the judgment of the physicians could be faulty. In cases where patients were granted additional liberty, beyond what was standard in the traditional asylum space, Commissioners often blamed physician superintendents' faulty judgement for any ensuing accidents.<sup>367</sup> Some physician superintendents felt these attacks were baseless and argued that the methods for assuring that patients were fit for additional liberty were rigorous. The physician superintendent would only decide to allow a patient to go to a villa or convalescent home after many one-on-one conversations with the patient and a full review of their medical history.<sup>368</sup> However, the physician-superintendent was expected to be intimately familiar with

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<sup>365</sup> *Bethlem Royal Asylum Annual Report* (1898), 29.

<sup>366</sup> *Bethlem Royal Asylum Annual Report* (1898), 29.

<sup>367</sup> *Bethlem Royal Asylum Annual Report* (1893), 47.

<sup>368</sup> *Bethlem Royal Asylum Annual Report* (1893), 47.

every patient in the asylum as part of their daily duties.<sup>369</sup> When considered alongside the physician superintendent's other daily duties, which included management of the staff, investigation into allegations of patient abuse, and occasionally private consulting work on the side, among other things, it is nearly impossible to imagine that one person could keep track of every patient in an asylum. The ability of psychiatrists to identify near-sanity was fallible, and this was one of the great limits of institutional domesticity. Unregulated patient liberty posed a threat for dire consequences.

Of course, the tragedies that happened at these villas did not completely undermine the enjoyment, healing, and liberty that patients experienced there. For many, it was a safe and comfortable place to convalesce. Certainly, for the doctors of the late nineteenth and early twentieth centuries, the good outweighed the bad, because the villa system proliferated across Scotland and England, becoming the modern standard of asylum architecture. Nevertheless, the failure of physician-superintendents to identify the qualities needed for a patient to thrive in the villa system suggested that institutional domesticity had its limits. The villa system was the most inherently domestic setting in the asylum environment, with many of the buildings being literal repurposed homes. However, the unpredictability of patients and the fallible nature of physician knowledge meant that institutional domesticity faced challenges, even in the most hospitable contexts.

Ultimately, villas and convalescent homes demonstrated a new era of asylum architecture. Their home-like architecture allowed for more privacy and a strong illusion of liberty for patients, which demonstrated a commitment to domesticity as a form of modern psychiatric treatment. Additionally, villas often were in comfortable, rural environments, which allowed for more physical exercise and calm surroundings in which patients were expected to heal more easily. Despite the praise the system received by Commissioners and physicians

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<sup>369</sup> HB13/2/211, "Regulations of Glasgow Royal Asylum," NHS Greater Glasgow and Clyde Archives (1899): 13-14.

alike, the persistence of suicides, accidents, and escapes in the villas and convalescent homes suggests a great failing of the villa system – human error. The limitations of nineteenth century psychiatric knowledge meant that physicians occasionally deemed a patient healthy enough for a sojourn at a villa or convalescent home without careful observation of their current state or mental health history. While this certainly does not fully undermine the comfortable and pleasurable nature of the villa system, it does indicate that, as a form of treatment, institutional domesticity faced challenges in implementation and limits in its function, especially since, on an architectural level, villas were fundamentally home-like.

Compared to the standard asylum space, however, the villa system seems even more idyllically domestic. While the villa system had all of the architectural benefits of the home, the traditional asylum space was, at its core, institutional. As a result, asylum administrators at the end of the nineteenth century found themselves in a vicious cycle of modernization and redecoration of the asylum space, battling against its dated and institutional nature. Medical administrators were also concerned with the way patients moved in the asylum space, in hopes of promoting an illusion of liberty within the asylum, which was a key element of implementing a sense of comfort and domesticity in the asylum. Doctors were interested in the open-door system, which theoretically allowed patients to access all parts of the institution without encountering locked doors. However, the practicalities of implementing this domestic therapy were difficult. Physician-superintendents feared the unpredictability of insane patients and worried about their access to unlimited freedom. The open-door system had to be supplemented by longer supervised working hours, to assure patients remained under control and constant surveillance. Asylum administrators struggled to find enough work for the middle- and upper-class patients to occupy their whole day, putting into question the feasibility of implementing the open-door system in mixed-class asylums. In a similar vein, doctors considered the use of mechanical restraint in their debates about the movement of patients within the asylum. On the

topic of mechanical restraint, doctors were divided. While some medical professionals felt that anti-restraint was the only possibly option for modern asylums, others felt that restraint had a place within their enlightened asylums. Restraint was convenient and practical, which superseded the idealised pursuit of institutional domesticity. The ability for mechanical restraint to co-exist in asylums where liberty was supposed to be a priority of modern treatment indicates the limits and challenges of the implementation of therapeutic domesticity.

Despite these challenges and contradictions, there is indication that the reputation of the asylum was being rehabilitated in the public's imagination at the end of the nineteenth century and the first decades of the twentieth. As early as 1897, the Scottish Commissioners in Lunacy suggested that an increasing number of private patients (from the middle- or upper-classes) were choosing to reside at Crichton Royal Hospital for the duration of their mental illnesses. To them, this suggested that "the reputation of the institution stands high [...] in the estimation of the public."<sup>370</sup> They attributed this increasing public trust to the modern and enlightened treatment methods championed by physician superintendent Rutherford, like the ones discussed in this chapter. The institutionalisation of private patients was especially important to consider, since the patients (or their families) had some agency in choosing in which institution a patient would be confined, unlike pauper patients. An increasing number of patients' families had faith that the asylum was modern and humane, suggesting that, despite the challenges of implementing institutional domesticity in the physical space of the asylum, physician-superintendents were successful in their rehabilitation of the public's perception of the asylum space.

This increasing trust was not always beneficial to asylums. In 1904, Rutherford reported that an increasing amount of elderly people and people suffering from somatic diseases that produced insanity-like symptoms were being sent to asylums. He attributed this to the fact that

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<sup>370</sup> *Thirty-Ninth Annual Report of the Scottish Commissioners in Lunacy* (1897), 57.

“the excellence of the care and nursing [in asylums] is becoming more widely known.”<sup>371</sup> Rutherford, like many of his contemporaries felt that these types of cases did not belong in the asylum, and he lamented the fact that incurable cases like those were lowering the overall statistics of recovery for the asylum.<sup>372</sup> Despite the fact that doctors desperately sought the rehabilitation of the asylum’s reputation through a campaign of modernization and domestication, the increased popularity of the asylum had its detriments. Ultimately, over the course of the 1890s and 1900s, the asylum’s reputation was on the road to rehabilitation. Despite difficulties in implementing institutional domesticity in the asylum space – the pinnacle of humane, modern treatment – families and community members were increasingly trusting of asylums. The families and community members increasingly believed that the physical space of the asylum and the treatment received within would encourage a quick return to sanity for their loved ones.

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<sup>371</sup> *Sixty-Fifth Annual Report of Crichton Royal Hospital* (1904), 10.

<sup>372</sup> *Sixty-Fifth Annual Report of Crichton Royal Hospital* (1904), 10.

## Conclusion: Beyond the Walls of the Institution

At the end of the nineteenth century, asylum physicians embraced domesticity, and the aesthetics and behaviours it encompassed, as a useful part of a therapeutic regime for mentally ill patients. Its implementation, however, was not simple. Almost certainly, institutional domesticity made life at the asylum more comfortable. This is especially clear in the attempts to domesticate the activities that took place in the asylum, as presented in an earlier chapter. Staff and patients were able to socialise and participate in cultural recreation together, which brought a sense of levity to their otherwise hierarchical relationships. These experiences couched the institutional hierarchies in desirable, familial terms. Recreation, especially cultural recreation, was also a context for patients to establish agency, which in turn produced a sense of liberty that concealed the institutional nature of the asylum. Patients could be producers of culture and exercise agency over their social calendars. This was particularly true in the patient experience of writing and producing institutional magazines alongside staff. On the pages of institutional magazines, patients became powerful producers of community knowledge and cultural history. In their writing, patients were placed on equal footing with staff, once again contributing to the m of institutional hierarchies. In the realm of employment, perhaps the most fraught kind of recreational asylum activity, doctors were able to circumvent complicated gender and class expectations to assure that all classifications of patients were able to work as part of their treatment. For private patients, medical staff in the asylum sought creative avenues through which they could allow patients to use their pre-existing skillset. Pauper patients, on the other hand, were able to use employment in the asylum as a means to gain additional comforts and a sense of purpose. Recreation and employment constitute successful examples of institutional domesticity.

Regarding the physical space of asylum living, domesticity likely made patient's lives more comfortable or, at the very least, more aesthetically pleasing. Unlike recreational



activities, domesticating the physical space presented extraordinary challenges, as examined in a previous chapter. At the start of the nineteenth century, the physical space of the asylum became infused with stigma as a place of improper confinement and cruelty. By the end of the century, doctors introduced domestic aspects, such as decoration and recreation, to rehabilitate the public's perception of the asylum. The traditional asylum space was inherently institutional in its nature and attempts to domesticate it were an endless battle. Doctors also struggled to agree on the best way to control patient movement within the asylum and these debates revealed the struggle to produce a sense of liberty, which was a key component of institutional domesticity. Even in the most physically and architecturally domestic space, the villa, asylum administrators struggled to implement a true sense of liberty among patients. Though these spaces were certainly more pleasant and comfortable than the standard institutional space, doctors were constantly concerned about the balance between liberty and necessary surveillance. The proliferation of suicides and escapes in the villa-style home can be understood as a failure to successfully implement that delicate balance between surveillance and domesticity.

In explaining the limitations of institutional domesticity, I argue that the asylum was not a passive environment onto which the physician superintendents were able to easily enact domesticity. In my case study of three asylums in Britain and Scotland, I propose that the asylum was composed of myriad actors, including patients, staff, patients' families and friends, and state inspectors, and they demonstrated agency to interact with, enforce, and challenge institutional domesticity. Even when doctors were able to successfully implement domesticity, as was the case with activities related to recreation and labour, patients were able to use these activities to express their thoughts, form institutional knowledge, and gain material benefits for themselves. In the physical environment of the asylum, the agency of other actors became even clearer. Doctors struggled to control the ways in which asylum inhabitants, especially patients,

moved through and interacted with their space, whether the space was architecturally institutional or domestic. The asylum was a complicated ecosystem of individuals, all with different experiences and priorities, and this provided an environment in which individuals interacted with and shaped domesticity in diverse ways.

Did patients ever leave the asylum and if so, what happened to them? Some patients were discharged, medically diagnosed as “recovered,” and they never entered the asylum system again. This was the case for Gartnavel Asylum patient, 44-year-old Eliza M., a merchant’s daughter, living in her family home near Glasgow. In late 1875, Eliza M. began experiencing delusions. After her two brothers died, she began experiencing paranoia and extreme nervousness, believing that her food was being poisoned and that Roman Catholics were plotting against her. She protested her innocence to anyone who would listen and begged her family to protect her against the people she believed wanted to persecute her. According to her admission paperwork, she was restless, incoherent, and in constant fear of a “dreadful calamity.” On January 17<sup>th</sup>, 1876, she was admitted to Gartnavel Royal Asylum with the diagnosis of melancholia.<sup>373</sup> She immediately struggled to eat while in the asylum, and often allowed food to go down her airway rather than swallow it. By September, her delusions worsened and she refused all food, believing in the involvement of the asylum staff in a plot to kill her. The staff at the asylum sustained her through a feeding tube, since they were unable to convince her to eat otherwise. This continued for nearly a decade.

Eight years into this patient’s asylum commitment, Dr. Yellowlees attempted to spoon-feed beef broth into Eliza but she fought against him. In the struggle, Eliza’s chair tipped backwards. In the moment of terror, Eliza forgot to fight back against the food and swallowed the broth. That was a turning point in her recovery and soon Eliza willingly consumed a full cup of broth every day. Eventually, she even used the spoon herself, rather than being spoon-

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<sup>373</sup> HB13/7/83, Admission Documents Male and Female 1876, NHS Greater Glasgow and Clyde Archives.

fed by the nurses. In February 1891, after fifteen years of residence at Gartnavel, Eliza was discharged with “recovered” status. Dr. Yellowlees reported that the miraculous recovery seemed permanent.<sup>374</sup> Eliza’s story is only one possible outcome for a patient committed to the asylum at the end of the century, and in many ways, Eliza defied the odds by staying out of the asylum thereafter. In many cases, patients were only able to cope with life outside the asylum for short periods before their symptoms became unmanageable. The prospects for full, permanent recovery from insanity were not generally optimistic. There was a fifty percent chance that a patient would be discharged as recovered at the end of their stay in the asylum. The other fifty percent would be unrecovered, usually discharged for financial or familial reasons. Of the half that did reportedly recover, fifty percent of those people were likely to relapse into insanity. There was therefore, generally speaking, only a twenty-five percent chance of recovery without return to the asylum.<sup>375</sup>

Other patients followed a cycle of returning to their homes then re-entering the asylum for treatment, throughout the course of their lives. One such patient found himself in the centre of a strange scene on the streets of London. He hailed a cab and urgently requested that the cabdriver take him to an asylum, because he sensed the impending return of his mental illness. This was not his first time in an asylum. Years earlier, he had been discharged from an asylum abroad but now he feared a mental illness relapse. According to asylum admission records, the patient presented symptoms of a “dangerous homicidal tendency” and praised by physician superintendent Percy Smith for being “a good example of the class of patient who is wiser than his relatives and who will seek for protection and care when [the family] will perhaps endeavour to postpone what is obviously the right course.”<sup>376</sup> In this instance, the patient was praised for knowing that he might become potentially dangerous and committing himself to an institution

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<sup>374</sup> *Seventy-Eighth Annual Report of the Gartnavel Royal Asylum* (1891), 13.

<sup>375</sup> *Eighty-Third Annual Report of the Gartnavel Royal Asylum* (1896), 13.

<sup>376</sup> *Bethlem Royal Asylum Annual Report* (1894), 42-43.

where he could be properly cared for. The asylum was a place of refuge for patients and, especially in cases where the patient could pose a threat to themselves or others, doctors were relieved to intervene early in their bout of illness, even if their recovery was not permanent.

In other cases, however, doctors realised that overcrowding and resource limitation was a distinct possibility if patients lingered in the asylum or returned too frequently. Some doctors feared that asylums had become too comfortable for patients, as a result of the structural and recreational changes of institutional domesticity, which would prompt patients to keep returning ceaselessly, leaving less space and fewer resources for those who were newly suffering from disease. At a March 1893 meeting of the Medico-Psychological Association, one doctor suggested that “Nowadays, when our institutions have so many of the comforts of home (and indeed, injudiciously, in some instances are furnished with comparative luxury), there is a danger of depriving the patient of a salutary dread of loss of liberty and domestic life, and of diminishing his sense of personal responsibility to the community.”<sup>377</sup> Another doctor reported hearing patients joke about their imminent return to the asylum upon their discharge, suggesting that they were looking forward to their next, inevitable sojourn to the asylum.<sup>378</sup> Ideally, patients would stay out of the asylum permanently, like Eliza Miller, but this certainly did not reflect the realities of many of the discharged patients.

In some cases, patients who relapsed into insanity did not re-enter into the asylum. Some struggled with the transition into a life outside the asylum and many patients fell into economic or social destitution upon discharge. This issue disproportionately affected poor women who did not have the financial and social support to successfully transition out of asylum life, a fact which prompted the emergence of a charitable institution. In 1879, the first iteration of the Mental After Care Association (MACA) was established at a meeting of prominent medical practitioners under the name of “The After-care Association for Poor and Friendless Female

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<sup>377</sup> P. St. John Bullen, “The Out-Patient System in Asylums,” *JMS* 39, no. 167 (1893): 492.

<sup>378</sup> Bullen, “The Out-Patient System in Asylums,” 492.

Convalescents on Leaving Asylums for the Insane.”<sup>379</sup> The goal of this association was to help transition recovering female patients from asylum life back “into social and domestic life.”<sup>380</sup> In the meeting where the Association was established, the founder Henry Hawkins (who was also the chaplain at the Colney Hatch Asylum) pointed to an epidemic of abandoned women who struggled to regain their independence after their recovery and discharge from the asylum. He claimed that these women often had “no relatives or friends to receive them, no home to return to, no situation or employment awaiting them in which they can earn their bread.”<sup>381</sup> At this same meeting, Hawkins referred to a common phenomenon of female patients who were fully recovered but were required to stay in the asylum for longer because they lacked family and friends in the outside world to receive them, sometimes because “relatives would be better pleased that the convalescent should find in the asylum a *permanent* abode, than that she should leave it and so possible become more or less burthensome to themselves.”<sup>382</sup>

Hawkins felt there had to be a link “between the hospital and the outside world” to ease the transition back to non-institutional life.<sup>383</sup> The Mental After Care Association was intended to find work for “poor and friendless” pauper lunatics, usually in the realm of domestic service, and give some small amounts of financial support to help patients back on their feet. They also boarded former patients in the homes of local volunteers.<sup>384</sup> Hawkins was keenly aware of the isolation that the asylum caused patients and pointed to factors such as age, distance from their home county or country, and stigma as reasons why someone might be “friendless” in the institution.<sup>385</sup> The establishment of MACA suggested that support from their “outside world” community could be useful to assure that they neither relapsed into insanity nor became

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<sup>379</sup> Jennifer Smith, “Forging the ‘Missing Link’: The Significance of the Mental After Care Association Archive.” *History of Psychiatry* 8, no. 31 (1997): 408.

<sup>380</sup> Smith, “Forging the ‘Missing Link,’” 409.

<sup>381</sup> Henry Hawkins, “After Care,” *JMS* 25, no. 111 (1879): 359.

<sup>382</sup> Hawkins, “After Care,” 359.

<sup>383</sup> Henry Hawkins, “Asylums and Their Neighbours: Can Neighbours Help?” *JMS* 23, no. 101 (1877): 12.

<sup>384</sup> “After-Care of the Insane,” *JMS* 36, no. 155 (1890): 596.

<sup>385</sup> Hawkins, “Asylums and Their Neighbours,” 11.

destitute. Its sustained role indicates that there was a significant problem with social and economic destitution at the end of a patient's asylum tenure. In 1887, the MACA helped forty-one people and by 1907, this number increased to roughly 370 individuals, where it stayed consistent until 1914.<sup>386</sup> This represented only a small percentage of the total poor lunatic population and only English paupers, since Scotland had no equivalent association. Though MACA had noble, lofty goals, there was still a significant portion of the vulnerable lunatic population that encountered social and economic difficulties after their discharge.

Other patients who were unable to return to institutional care faced even worse situations upon their discharge. Early in 1891, a young unnamed male patient was discharged from Bethlem Royal Hospital, showing no sign of suicidal tendencies. A few months later, he shot himself while in the United States. After this tragedy, the friends of the patient tried to launch a campaign against Dr. Percy Smith, charging him with mistakenly assessing the patient as recovered and fit for discharge.<sup>387</sup> In this case, Bethlem's Board of Governors ruled against this charge and did not hold the Physician Superintendent responsible for the death of this patient. Smith's defense boiled down to the fact that the patient's mother had written to him and expressed her opinion that her son had fully recovered, requesting his discharge. The mother was able to make this claim because her son had been let out on a temporary probation from the asylum and had seemed sane while residing with her.<sup>388</sup> Because of this familial testimony, Smith was absolved of any blame. He emphasized in his recounting of this story that it was impossible to know exactly how a patient might react upon their discharge, even if they appeared recovered within the confines of the asylum. Nevertheless, he argued, "it is only fair or even legally imperative to give a trial of liberty."<sup>389</sup>

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<sup>386</sup> Vicky Long, "Changing Public Representations of Mental Illness in Britain 1870 – 1970" (unpublished dissertation, University of Warwick, 2004), 181.

<sup>387</sup> *Bethlem Royal Asylum Annual Report* (1891), 44.

<sup>388</sup> *Bethlem Royal Asylum Annual Report* (1891), 44.

<sup>389</sup> *Bethlem Royal Asylum Annual Report* (1891), 44.

In an attempt to mitigate the likelihood of accidents happening upon release, patients were often released on temporary probations before their actual discharge, as alluded to in the previous case. It was generally accepted by the medical community that when “the restraints of the asylum are removed,” patients who seemed to be recovering could quickly return to their insane state, which probations were intended to test.<sup>390</sup> This inevitably led to errors in judgment on the part of the physician-superintendent who approved the probation. For example, Smith described the story of an unnamed female patient who had been released on probation. She had been diagnosed with melancholia with suicidal tendencies, but during her commitment, she “had apparently lost all such desire.”<sup>391</sup> After “careful consideration,” Smith discharged her into the care of her husband. Yet after a few days at home, the patient drowned herself in a river near their house. In this case, the Commissioners in Lunacy ruled that allowing the patient on probation was an error in judgement on Smith’s part. Smith defended his decision, arguing that the decision was made after many one-on-one conversations with this patient and that he regularly allowed probation for other patients, with higher risk of relapse than this patient, with successful results.<sup>392</sup> Because probations were intended to test the fitness of a patient for life outside the asylum, they held a relatively high risk for accidents, especially considering the tenuous state of psychiatric knowledge at the end of the century. Nevertheless, they were implemented in hopes that discharged patients would stay discharged. These individual stories present various patient outcomes after their discharge and highlights the permeable nature of the asylum.

In this thesis, I revealed various ways in which doctors brought the outside world into the asylum through the means of domesticity. Doctors consciously sought to mimic the outside world and the Victorian home within the asylum setting, in hopes of facilitating institutional

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<sup>390</sup> *Thirty-Ninth Annual Report of the Scottish Commissioners in Lunacy* (1897), xviii.

<sup>391</sup> *Bethlem Royal Asylum Annual Report* (1893), 44.

<sup>392</sup> *Bethlem Royal Asylum Annual Report* (1893), 47.

order and positively affecting patient treatment. However, these attempts took place in a moment where *real* domesticity – that is to say, domesticity that was not consciously constructed by medical professionals – was in a state of flux. Changing gender norms and an evolving socio-economic hierarchy contributed to the fading of traditional domesticity by the end of the century. Thus, the domesticity reconstructed by the physician superintendents in the asylum was idealized and did not reflect the realities of life outside of the asylum. Moreover, people and ideas moved between the asylum and the outside world in both directions. Patients returned to their families, friends, and wider communities, impacted by their time in the asylum. In some tragic cases, the patients were woefully unprepared for re-entry into the unpredictable wider world, either psychologically or socio-economically. The challenges faced by the vast majority of purportedly recovered patients who exited the asylum suggests that the attempts to domesticate the asylum space had limited success in reconstructing the outside world. In some ways, this gulf between recovery in the controlled environment of the asylum and the unpredictable real world demonstrates how truly impervious the institution was to domestication. Its regimented schedule and constant surveillance, even in the most domestic areas of the asylum, simply could not replicate the realities of the outside world. In practice, the asylum's institutional nature was impossible to fully obscure. Further research on the re-entry of patients into their communities might reveal that this gulf between the idealized, prescriptive domesticity in the asylum and the struggling domesticity in the real world made the transition more complicated.

Despite the fact that time in the asylum alienated patients from their communities, with no guarantee of long-term reprieve from their illnesses, doctors were able to implement a form of domesticity into the asylum. Domesticity infused the activities patients participated in and the spaces they navigated. Though at times, the implementation of this domesticity was uneven, controversial, and limited, the asylum did echo the Victorian home in many ways, which I have



discussed here. The emphasis on comfort and individual liberty that characterized institutional domesticity certainly made asylum living more pleasant for patients, to the point that some doctors believed that patients might prefer to be in the asylum than outside its walls. While domesticity was not a cure to mental illness, it did provide a comfortable, culturally rich alternative to mental healthcare in bygone eras. In the decades that came after the era of asylums, with the rise of outpatient treatment and psychiatric drugs, mental healthcare would become even more closely tied with the home. While these were certainly advancements in treatment, the fall of the asylum signaled a loss in some ways. In the asylum, patients were safe. Patients were able to form communities with others who, in some respects, understood their experiences better than their own pre-asylum communities. Some, at least, felt sentimental towards their time there. The end of the era of asylums in the twentieth century was, for some former patients, a moment worth mourning.

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## Curriculum Vitae

**Vesna Curlic****Education**

**Master of Arts**, University of Western Ontario (Sept. 2017 – Aug. 2019)

History (Thesis Option)

Thesis: *Domesticity in English and Scottish Lunatic Asylums, 1890-1914*

Supervisor: Dr. Shelley McKellar

**Bachelor of Arts**, University of Ottawa (Sept. 2013 – Apr. 2017)

Honours Specialization in History (French Immersion)

Graduated *magna cum laude*

**Honours & Scholarships**

- SSHRC Doctoral Fellowship (2019-2023) – Value: \$80,000
- Joseph-Armand Bombardier Canada Graduate Scholarships Doctoral (2019-2022) – Value: \$108,000 (Declined)
- Ontario Graduate Scholarship (2018-2019) – Value: \$15,000
- SSHRC Canadian Graduate Scholarship Masters (2017- 2018) – Value: \$17,500
- Western Graduate Research Scholarship (2017-2019) – Value: \$7,287
- Hilborn Travel and Conference Scholarship and William Edgar Travel Fund (2018)

**Publications, Conferences & Public Lectures**

“Protection and Care: Anxiety, Law, And Medical Legitimacy in the Lunatic Asylum, 1890-1914,” McCaffrey Seminar Series in History, Feb. 28, 2019

“Conflicts of Law and Medicine in the Victorian and Edwardian Lunatic Asylum,” Pathways to the Past Graduate Conference at Western University, Apr. 26, 2019

Curlic, Vesna. "Plummeting Stocks, Plummeting Health? An Examination of Depression-Era Healthcare Reforms and the Problem of Access." *The Mirror: Western University Undergraduate History Journal*, 37 (2017).

**Relevant Professional Experience**

**Teaching Assistant at Western University** (Sept. 2017 to Present)

- History 1810 Wars that Changed the World (Full Year, 2018-19)
- History 2181 Sexual History: Expression, Regulation, and Rights in the West since 1800 (Half-year – Fall 2017)
- History 2186 The Zombie Apocalypse: Panic and Paranoia in Human History (Half-year – Winter 2018)

**Archival Assistant at Western University Archives and Research Collections Centre** (Jan. 2018-Present)

- Organization and care of delicate archival material
- Interpretation of historical sources for listing