LANCASTER ASYLUM IN THE 1850s and 1860s: PATIENTS AND TREATMENT

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The mid-Victorian years in England are often seen as prosperous, placid and complacent: a period of burgeoning material prosperity and consensus politics, in which the English basked in the glories of world industrial leadership and the propertied classes could relax in the knowledge that the Chartist challenge to the established order in the late 1830s and 1840s had shrivelled and died. Beneath the comfortable surface, however, lay nagging doubts and fears. Challenges were emerging which called into question the eternal verities of Crown, Church and Constitution. The condition of the working classes, and especially the teeming multitudes of the urban slums, aroused recurrent fears of crime, disease and moral contagion, creeping out like a miasma to infect the rest of society. Within this universe of half-acknowledged unease, the fear of insanity and the insane had a prominent place.

The proportion of England's population officially adjudged to be insane rose sevenfold between 1807 and 1855, from 2.26 to 16.5 per 10,000. By 1844 more than 80 per cent of them were paupers, and this proportion continued to increase for the rest of the century. But lunacy was not seen as solely a problem of poverty and poor relief. Its spectre haunted the propertied classes as well, and their anxieties were fuelled by regular controversies over the 'wrongful confinement' of the sane in asylums, and by sensational depictions of this theme in popular literature, most famously in Charles Reade's novel *Hard Cash*. Insanity seemed threatening, to an extent which was out of all proportion to its recorded incidence in the population, partly because it was seen as arising in many cases from the stresses of an increasingly complex industrial civilisation, and therefore seemed capable of assuming epidemic proportions. But perhaps more important was the uncertainty of the criteria for determining whether someone was insane. One of the reasons for the increase in recorded insanity was the widening range of behaviour which could attract the diagnosis: the concept was elastic, and an emergent psychiatric profession was busily stretching it. In particular, the notion of 'moral insanity' was gathering credence by the 1840s; and its stigmatisation of all nonconformist, sinful or even mildly eccentric behaviour as potentially connoting lunacy was especially threatening. Medical opinion was divided about the causes, symptoms and nature of insanity, including the relative importance of the social and the physical; and doctors often differed publicly, with embarrassing results. But the spreading toll of lunacy, in an increasingly statistically-minded but still statistically naive age, still seemed inexorable.

It was in this uncertain climate of attitudes and opinions that the asylum system came into full flower. Its growth had been encouraged by the emergence of changing attitudes to the treatment of lunacy in England, especially at the beginning of the nineteenth century. Widespread publicity was given in 1813 to a book by Samuel Tuke, which detailed the regime of 'moral treatment' at a Quaker asylum, the York Retreat; and the Retreat's system, which built on earlier innovations elsewhere, steadily gained credence and converts over the next generation. It sought to restore patients to reason by reasonableness, rewarding acceptable behaviour and gently discouraging the unacceptable, in surroundings which were quiet, rural and calculated to encourage reflection and repose. This approach saw lunacy as curable, but emphasized moral virtues and the patient work of lay attendants rather that the role of medical intervention. Nevertheless, it was assimilated into the ideas and practices of the nascent psychiatric profession, the'mad-doctors' of the early nineteenth century; and efforts were made to apply it in large asylums dealing with pauper lunatics, as well as in small, expensive establishments for private patients. In either case, the purpose-built asylum was seen as an essential therapeutic environment, providing control, agreeable surroundings, and distraction from the external stresses which had helped to provoke the insanity.

The building of Lancaster Asylum predated the ascendency of the new orthodoxy of 'moral treatment'. It opened in 1816, after the Justices of the Peace who governed the county had responded positively to an Act of 1808 which empowered counties to set up lunatic asylums for paupers, to be paid for out of the county rates. This Act was a response to a campaign for the more humane treatment of lunatics, who were often kept under regimes which smacked more of imprisonment and torture than of therapy. This reflected older ideas of lunatics as being subhuman, evil and beyond the prospect of amelioration or cure; and the Act was intended to place lunatics under the disinterested care of medical practitioners, although its aims were also clearly custodial in the sense that the uncontrollable, the unreasonable and the helpless could now be sequestered from society and managed more effectively than had hitherto been the case in workhouses.

Lancaster was the fourth rate-supported county asylum for paupers to be set up, as befitted a populous county with a rapidly-growing industrial population and a reputation for social dislocation and political unrest. In its early years it was run on firmly custodial lines, with much use of leg-irons, strait-waistcoats and heroic doses of purgatives. Its isolated, rural situation owed more to the availability of land and, perhaps, to a desire to make escape more difficult than to any espousal of 'moral treatment' notions of a desirable rustic environment. But in 1840 Lancaster's new asylum superintendent, Samuel Gaskell, overturned the existing orthodoxy and introduced not only 'moral

treatment', but also the more radical and controversial 'non-restraint' system.

The 'non-restraint' system involved the total abandonment, even in large pauper asylums, of all mechanical restraint on patients' movement, and an exclusive commitment to management by moral suasion. The system was pioneered, first at Lincoln, then by the great self-publicist John Conolly in the enormous Middlesex Asylum at Hanwell, in the late 1830s; and Gaskell's Lancaster followed suit soon afterwards. It was not an easy step to take. It involved changing the attitudes of existing staff, in an institution which with over 500 patients was already becoming difficult for the most conscientious of superintendents to supervise personally, and which was already showing symptoms of overcrowding. We must add to this the difficulty of squeezing money for improved amenities out of Justices whose main concern was to keep the rates to a minimum, and who wanted to see large numbers of patients cured and returned to productive work in order to justify their expenditure. Under the circumstances, the new system seems to have made remarkable headway in the short run. Mechanical restraints were removed, as were nineteen tons of iron bars and gates; the grounds were landscaped, and the patients were classified and set to work; regular amusements, sports and exercises were introduced, and reading was encouraged; and the medical officers enjoined that patients should be reasoned with and treated in a friendly, kind, indulgent way. These innovations were proudly set out in the annual reports. We may doubt whether things really ran as smoothly as this: whether, for example, the attendants behaved as kindly to difficult patients in private as when they were on display. And we know that the threat of physical punishments or restraints, such as seclusion and plunge-bath treatment, was never removed altogether. Moreover, the Gaskell regime failed to increase the proportion of patients discharged 'cured', although the proliferation of seemingly incurable 'idiots and imbeciles' sent to the asylum from the workhouses in the 1840s made life more difficult in this respect.

Gaskell left in 1849; and this brings us to the difficult years of the 1850s and 1860s, when patient numbers increased much faster than the resources the Justices were prepared to allocate to the asylum, and the ideals of moral treatment and non-restraint had to be progressively compromised, while it became increasingly difficult to recruit suitable attendants. Matters were brought to a head by an enquiry into the violent death of a patient in 1870, which revealed the existence of a regular pattern of casual brutality among unsupervised attendants who were effectively left to run the wards on their own. The pressures on Lancaster should have been eased by the successive opening of new asylums elsewhere in the county, at Prestwich and Rainhill in the early 1850s and Whittingham a few years later; but, as contemporaries noted with alarm, every expansion of asylum places seemed to produce sufficient increased demand to fill them almost immediately. And the shortage of cures made matters worse, as the asylums silted up with long-term patients who became institutionalised. Under these conditions, the high hopes for the asylum as therapeutic institution, on which much of the early expansion had been predicated (especially the major development of the 1840s), seemed to have been falsified, and the asylums appeared to be degenerating into mere warehouses for relatively expensive but fundamentally unsatisfactory custodial care – 'museums of madness', in the words of the sociologist Andrew Scull. This was the degenerative process over which Gaskell's successor John Broadhurst presided. Like many of his colleagues, he seems to have been increasingly preoccupied with paperwork rather than patients (indeed, the paperwork on many of the *patients* was actually neglected), and to have lost touch with what was happening on the wards.

Recent research on Lancaster Asylum has focused on the patients and their treatment during these difficult and perhaps transitional years. Abundant documentation survives in the Lancashire Record Office at Preston, in the form of admissions registers, case-notes and related materials, which provide tabulated evidence of a kind which is well suited (with appropriate caution) to quantitative analysis. Work of this kind forms one facet of the undergraduate dissertations currently being completed by Allan Hogg and Liz Hurley.

Lancaster Asylum took patients whose families could not afford private treatment; so its intake was predominantly working-class, although, as Gaskell was aware, many precariously-off clerks and small or middling business families were caught between the devil and the deep blue sea: they could not afford the fees of private establishments, especially if it was the breadwinner who was ill, but they sought to avoid the stigma of a pauper asylum, especially as the route to it often led through the workhouse. People of this stamp frequently found their way into Lancaster. But it was the lowest levels of the working class who were most prominently represented, though never overwhelmingly so. There were significantly higher proportions of unskilled labourers and female domestic servants than there were in the population at large. Inmates at mid-century (before the opening of Prestwich and Rainhill) were drawn disproportionately from the great cities of Liverpool and Manchester, while the lesser manufacturing towns sent less than their fair share. People who had migrated long distances (and not just the Irish) were also unduly likely to find their way into Lancaster Asylum. All this suggests, circumstantially, that the pattern of admissions reflected social pathology rather than the genuine geographical distribution of something we can straightforwardly label 'insanity'. People whose behaviour presented severe problems to family and neighbours were more likely to be consigned to custodial care if they lacked the backing of regular wages, savings, insurance provision through Friendly Societies, and the mutual support networks of kin, neighbours and workmates which were strong in the lesser industrial towns but weak in the great cities. This is all the more plausible because the decision to treat someone as insane and suitable for asylum admission was very seldom taken by anyone with any specialist expertise. The route began with family or neighbours, or sometimes in the magistrates' court (leaving aside the small minority of 'criminal lunatics'). It then ran through Poor Law officialdom, and only when a 'medical person' was required to agree with two magistrates that an individual was a proper case for confinement did the medical profession enter the picture. The likelihood of his having any 'psychiatric' training or experience was almost nil. So Lancaster, like other asylums, took the patients who were wished on it by inscrutable external circumstances, and did what it could with them.

This point is also relevant to the place of women in the asylum population. The American feminist Elaine Showalter has argued that insanity was above all 'the female malady' in Victorian times: that perceptions of women's physiology and cultural roles made them especially likely to be stigmatised and treated as insane. The concept of 'moral

insanity' was particularly dangerous to indiscreet, passionate or assertive women in the heyday of the 'double standard'. At first sight, the Lancaster experience would seem to contradict this viewpoint, for in the 1850s and 1860s the asylum consistently had a lower proportion of women among its inmates than did the outside world. But in this respect Lancaster was unique among the Lancashire asylums, for Prestwich, Rainhill and then Whittingham usually contained a slightly higher representation of women than demography would lead us to expect. Lunatics who were retained in workhouses included a much more prominent female presence.Women accounted for over 70 per cent of workhouse lunatics in 1854, when Lancashire's workhouses still held more lunatics than all its asylums put together; and in 1873 the figure was nearly two-thirds, although by this time the workhouses held only a quarter of Lancashire's swollen total of over 8000 pauper lunatics in institutions (not counting the Royal Albert at Lancaster). The proportion seldom fell below 55 or 56 per cent. This almost certainly reflects the tendency of workhouse management to keep their more tractable inmates, and send only the less manageable cases to the asylum. Workhouse support was, things being equal, significantly cheaper than asylum care. But it is instructive to be reminded that, in this respect and perhaps in others, Lancaster's experience was not representative of the rest of the county.

This evidence still does not provide strong support for Showalter; but her claims are given some credence by evidence that women were perceived as displaying different symptoms from men, and that they received different forms of treatment. Moreover, evidence collected by the national regulatory and inspecting body, the Commissioners in Lunacy, in 1874 suggests that cases of lunatics being cared for by relatives or others and deemed suitable for inspection by the Commissioners were almost all women in Lancashire.

Evidence on symptoms, and on perceptions of 'predisposing causes' and 'exciting causes' of insanity, can be found in the case-notes. The labelling of 'disease entities' at Lancaster was rudimentary and generally followed Pinel's classification of four forms of mental illness: mania, melancholia, dementia, and idiocy. Little can be done with these crude categories; but the case-notes and admissions registers offer a much wider range of observations. Work on the admissions registers of the 1850s indicates that women were much more likely to have 'emotional' causes of insanity ascribed to them: religious enthusiasm, grief at the death of friends and family, domestic (usually involving marital relations) and disappointment in love. 'Physical' causes involving illness, injury and drink were identified much more strongly with men. The very fact that these discrepancies could arise is indicative of the eclectic and decidedly 'unscientific' nature of contemporary psychiatry: it reflects a desperate hunting for possible 'causes' in whatever guise they might appear. Significantly, Lancaster was much less active in doing physical research on the brain than were the other Lancashire asylums: in 1873 post-mortems were performed on one-fifth of dead patients at Lancaster, compared with nine-tenths at Rainhill and two-thirds at Prestwich.

Women also received different treatment from men, quite apart from being allocated jobs deemed suitable to their sex within the asylum. During 23 sample weeks in 1857 two-thirds of the incidence of patients being held in solitary confinement involved women; and a similar proportion applied to patients being given 'medical treatment', which generally still involved a heroic interventionist regime of sedatives and purgatives. Expectations about female behaviour were clearly more demanding than for men, inside the asylum as well as out; and the Commissioners in Lunacy always saw fit to make especial comment on the appearance and dress of female inmates.

This interesting evidence does not provide full support for Showalter's case, for she argues that women were systematically oppressed by an asylum system which sought to remake them in acceptable guises of compliant domesticity. But it does bring out some key themes in the social history of asylums and insanity. It is also interesting to note that women were much more likely to be released quickly from the asylum, and discharged 'cured' or 'relieved', than were men. The incidence of 'successful' discharge looks very low if it is calculated as a percentage of the asylum population at any given time, falling as low as 4.6 per cent at one point during this period. But if the calculation is based on the percentage of *admissions* in a given year, the figure rises to one-third or better, with women comfortably outnumbering men. This partly reflects the finding that people admitted with 'moral' or 'emotional' symptoms were much more likely to be discharged with a positive prognosis, while ascribed 'physical' causes were much more likely to lead to long stays and institutionalization. In many cases, however, the 'moral'/'physical' dichotomy is misleading. The alcoholics, exhausted and mistreated half-starved women, and childbirth-related cases who bulked large among the rapid discharges often straddled these notional categories. But there is room for further work in this vein.

We hope that this short paper illustrates some of the possible avenues for research in the social history of Victorian insanity. As with other branches of medical history, this cannot be done satisfactorily without reference to attitudes, values and conditions in the wider society. Nor is it a straightforward, unproblematic record of 'progress' towards some higher state. All historians now agree that history is not like that! And it is all the more interesting and enjoyable as a result.

Further reading

Bynum W. et al. The anatomy of madness. 3 volumes: Tavistock Press, 1985-88. Volume 2 contains a paper on the Lancaster Asylum.

Scull A. Madhouses, mad-doctors and madmen. Athlone Press, 1981. Contains a statement of Showalter's argument, and a study of the treatment of pauper lunatics in Lancaster Asylum.

Scull A. Museums of madness. Penguin, 1979.

Walton, J.K. Lunacy in the industrial revolution: a study of asylum admissions in Lancashire, 1848-50. Journal of Social History 1979-80; 13:1-22.