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**The hysteria surrounding Hysteria:
Moral management and the treatment of
fe-male insanity in Bristol Lunatic Asylum**

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The hysteria surrounding Hysteria:
Moral management and the treatment of female insanity
in Bristol Lunatic Asylum



Bristol Lunatic Asylum- 1861¹

¹ Bristol Hospital Museum.

**Dedicated to Glenside Hospital Museum and its
volunteers, notably John Timm for his constant
support and everlasting interest.**

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Introduction

‘What confined women in the Victorian Asylum was precisely the ladies’ chain of feminine propriety and the straightjacket of a weird but mandatory feminine gentility.’²

On 5th March 1861, sixty three female patients entered the newly formed Bristol Lunatic Asylum of Glenside and joined the fifty male patients who were already being treated, a venture its Superintendent Dr Stephens described as ‘a boon to suffering humanity.’³ During the Victorian era, illnesses of the mind became formalised and vast numbers of madwomen were taken out of the domestic home and placed into the clinical setting of the asylum.⁴ However the notion that Bristol Lunatic Asylum provided liberal, humanitarian treatment opposes much discourse surrounding confinement. Erving Goffman’s *Asylums* discussed the lack of agency offered to patients within institutions, asserting how their asylum experience was regimented by routine and how authoritarian control dominated their existence.⁵ Moreover, Foucault’s pioneering text, *Madness and Civilization*, similarly dismissed the view that such establishments were solely reformatory, proposing instead they were manifestations of capitalist state control.⁶ Andrew Scull went even further in suggesting that the psychiatrists willed this expansion of state power in order to emphasise the need for their own profession and to uphold their own reputation, with such theories forming a history of repressive establishments and self-serving physicians.⁷

As a result of the 1845 Lunatic Act the provision of medical supervision became required of every asylum in England, thus granting the male psychiatric profession what psychologist and feminist Jane Ussher defined as a ‘monopoly over healing’.⁸ Feminist discourse describes how opportunistic men recognised the newfound necessity for psychiatry and took heed of

² E. Showalter, *The Female Malady: Women, Madness and English Culture 1830-1980* (New York, 1987) 98.

³ D.F. Early, *The Lunatic Pauper Palace: Glenside Hospital Bristol 1861-1994, Its birth, development and demise* (Bristol, 2003) 10.

⁴ For a comprehensive study of data and theory which demonstrates the overrepresentation of women in the asylum system in comparison to men, see E. Howell & M. Bayes, eds., *Women and Mental Health* (New York, 1981)

⁵ E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (London, 1961) 10-110.

⁶ M. Foucault, *Madness and Civilisation: a history of insanity in the Age of Reason*, trans by Richard Howard (New York, 1964)

⁷ A. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England* (London, 1979)

⁸ J. Ussher, *Women’s Madness: Misogyny or Mental Illness?* (Hemel Hemsted, 1991) 69.

the capitalist notion of supply and demand by venturing into the scientific field themselves.⁹ Such legislation therefore allowed the patriarchal figure to ‘define reality’ by granting the power over knowledge to psychiatric reformers such as Henry Maudsley and John Connolly as well as the individual superintendents and doctors of each asylum. Women were in turn relegated from their position as healers to secondary positions as matrons or ward attendants due to the limitations of female mobility within educated society, ensuring the male domination of the profession and consequential ‘masculine’ approach towards the causes and treatments of insanity.¹⁰

In the 20th and 21st centuries the culmination of this discourse has resulted in the formation of a ‘masculine scientist’ figure in psychiatric and feminist literature.¹¹ Germaine Greer’s prolific work, *The Female Eunuch*, stated, ‘The revolutionary woman must know her enemy’, before referring directly to doctors and psychiatrists as architects of public thought.¹² Feminists across the disciplines have discussed masculine dominance in terms of science and medicine, as de Beauvoir, Friedan, Figs and Millett have deliberated the use of their assumed knowledge of female anatomy and their own professional esteem to produce subordination.

In Elaine Showalter’s 1985 text, *The Female Malady*, the author explored how the management of asylums was used to enforce traditional sex roles and ladylike decorum in the Victorian period, providing a distinctly female experience of asylum life. This provocative assessment of female insanity contributed to the broader ‘women’s history’, painting the picture of institutions saturated with misogyny, places where doctors performed clitoridectomies and ovariectomies on unknowing female subjects and where their sexuality was inextricably linked to their madness.¹³

However, such sweeping damnation of the psychiatric profession has provoked a revision of misogyny within the asylum system. L.A. Hall’s article, ‘Does Madness have a gender?’ describes how Showalter’s ‘accusatory model’ is too simplistic in its branding of the Victorian psychiatry as exclusively patriarchal.¹⁴ Susan Lanzoni offers the theory of

⁹ Foucault described how these scientists were supported and promoted with the rise in formal state institutionalization, see Foucault, *Madness and Civilisation* (New York, 1964).

¹⁰ J. Ussher, *Women’s Madness*, 68.

¹¹ For stimulating debate surrounding the feminist approach to psychiatry, see N. Tomes, ‘Feminist Histories of Psychiatry’, in Micale & Porter, *Discovering the History of Psychiatry* (Oxford, 1994) 352-376.

¹² G. Greer, *The Female Eunuch*, (London, 1970) 19.

¹³ Showalter, *Female Malady*, 75-6.

¹⁴ L.A. Hall, ‘Does Madness have a gender?’, *History of Psychiatry*, 20, 4 (2009) 498.

‘negotiation’ to explain individual patient experience, implying that broad generalisations of male subordination are too far-reaching. Lanzoni’s revisionist theory proposes that there were of a series of outlets of power where individuals and bodies could determine the outcome of patient’s asylum experience, thus insinuating that doctors cannot be solely responsible for an inadequate treatment of women in psychiatry.¹⁵

Prior research surrounding Bristol Lunatic Asylum has been confined to only a few local histories, this dissertation therefore aims to expose sources that have been neglected and contribute to the memory of the asylum as well as debates surrounding gender within psychiatric history. *The Lunatic Pauper Palace: Glenside Hospital Bristol 1861-1994* was written by Dr Donal Early, a serving psychiatrist at Glenside for fifty years prior to its closure 1994.¹⁶ Although this is a local history which lacks reference to wider Victorian confinement, Early does provide a thorough history of past superintendents and medical staff, a particularly useful focus in this study due to the discussion of the power of the doctor over patient experience. Unlike Early’s broader history, this study will source material from the site’s opening in 1861 until the end of the century, as it will strictly be assessing Victorian confinement.

In this analysis, patient casebooks will be sampled to produce a microhistory of individuals whose stories would have otherwise been lost, providing insight into the psychiatric experience of the everymen, or in this case everywoman, of Victorian society.¹⁷ As Bristol Lunatic Asylum was an institution designed to treat ‘pauper’ lunatics, this history will encompass the ‘history from below’ approach, a method which has been discussed with specific reference to psychiatry with Roy Porter’s ‘The Patient’s View’.¹⁸ There has been an abundance of biographical literature surrounding private asylums, as upper class women wrote of the ‘fashionable’ nervous illnesses of which they were inflicted, their ability to eloquently detail their experience meaning that their accounts have been published readily and widely circulated. Elaine Showalter proposes how in ‘the annals of feminist literary history Virginia Woolf, Anne Sexton, and Sylvia Plath have become our sisters and our

¹⁵ S. Lanzoni ‘The Asylum in Context: An Essay Review’ *Journal of the History of Medicine and Allied Sciences*, 60 (2005) 499.

¹⁶ Early, *Pauper Palace: Glenside Hospital Bristol 1861-1994, Its birth, development and demise* (Bristol, 2003) N.B: ‘Glenside’ refers the site upon which the asylum is situated.

¹⁷ Carlo Ginzburg’s text *The Cheese and the Worms* popularised the method of microhistory to detail the musings of Italian miller Menocchio, an atypical chronicler of history with a unique insight regarding the world around him. C. Ginzburg, *The Cheese and the Worms*, trans. by John and Anne Tedeschi (London, 1980)

¹⁸ R. Porter, ‘The Patient’s View: Doing Medical History from Below’ *Theory and Society*, 12, 2(1985)175-198.

saints.’¹⁹ Despite signifying an entirely different time period, the lives of these madwomen from the upper echelons of society have come to be representative of the entire female experience of insanity and whilst their biographies do provide considerable insight, this dissertation will instead seek to examine the unexplored avenue of female *pauper* lunacy.

In Bristol there was an intense focus on ‘moral management’, a regime which involved placing both male and female patients under the continuous supervision of attendants and relying on observation to prevent unruly behaviour rather than intensive drug regimens or disciplinary restraint.²⁰ As sources provided by the asylum may have been favourable towards its staff to protect the status of the institution, reports provided by the Visitor’s Committee will also be sourced for information regarding instances regarding restraint, deaths and discharges. The Committee was an independent body formed of local dignitaries and aldermen who presided over the quality of care provided by the asylum, this is therefore an important inclusion as the records provide an impartial account of experience under incarceration due to their relative independence.²¹

In ‘Puerperal Insanity in the 19th and 20th Centuries’, Rehman, St Clair and Platz constructed a comprehensive statistical analysis of female psychosis by sampling the patient casebooks of the Royal Edinburgh Hospital.²² Such an examination is necessary and essential in the wider discussion of psychiatry, as it distinguishes the diverse range of female diagnoses and the frequency with which delusions and hallucinations were recorded. This analysis of Bristol Asylum will also use patient casebooks, but will instead employ a narrative method to produce a personal rendition of individual patient experience.²³ Historian Hilary Marland describes how casebooks are an invaluable form of evidence, as they allow women to be seen as ‘individuals with individual problems rather than a group of susceptible women with weak biological profiles’.²⁴ This study will therefore use qualitative assessment data in order to look beyond the statistics and discuss the meaning behind the discourse of doctors rather than asserting broad generalisations based solely on impersonal quantitative data.

¹⁹ Showalter, *Female Malady*, 4.

²⁰ Showalter, *Female Malady*, 78.

²¹ D. Large, *The Municipal Government of Bristol 1851-1902* (Bristol, 1999) 151-170.

²² Rehman, A-U, D. St. Clair & C. Platz, *Puerperal Insanity in the 19th and 20th Centuries*, *British Journal of Psychiatry* (1990) 156.

²³ The newfound popularity of the narrative method has been discussed in Stone, L, ‘The Revival of Narrative’ *Past and Present*, 85 (1979) 1-18.

²⁴ H. Marland, ‘Disappointment and desolation: women, doctors and interpretations of puerperal insanity in the nineteenth century’, *History of Psychiatry*, 14 (3) 306.

This analysis of Bristol Lunatic Asylum will be divided into three distinct sections, to deliberate the role of ‘The Asylum’, ‘The Doctor’ and ‘The Patient’ at Glenside and to discuss how these three separate components contributed to overall patient experience. The analysis of ‘The Asylum’ will evaluate the daily management of females by investigating how their living quarters were divided and how their daily routines were structured in terms of recreation and exercise to recreate an accurate portrayal of their psychiatric experience. The use of work therapy will be explored in terms of gender-specific work roles for men and women, a unique feature of studying a pauper asylum and pauper lunatics opposed to the upper class insane, who were more likely to partake in such therapeutic treatments as massages, rest cure and repeated water baths, demonstrating a stark difference in care.²⁵

Secondly, the role of the ‘Doctor’ will be explored alongside the concept of the ‘Masculine Scientist’, considering the degree of control placed on the patients, specifically whether the medical staff restricted the personal liberties of women through the implementation of drug treatment, physical restraint and solitary confinement.²⁶ The disclosed judgement of the medical staff will be assessed by analysing the female casebooks written by the physicians themselves as well as the photographs they provided in the admissions books, to consider the importance of female appearance as a mark of the individual patient’s progression and as a form of asylum promotion. This chapter will therefore discern whether at Bristol doctors were as misogynistic in their management as Showalter suggests, or whether they were sympathetic to the female patients’ plight.

The final chapter will focus on ‘the Patient’ by analysing female admission figures and by ascertaining how the female presence was felt within the asylum. This section will consider the feminist issue of agency, discussing how far female inanity can be considered as an act of rebellion against the constraints of Victorian femininity. Each segment will therefore provide insight into female asylum experience, firstly in terms of how it was managed, secondly how it was treated in practice and thirdly in the manner in which the patients reacted to total confinement in the microcosm of the asylum setting.

²⁵ For an comparison of a pauper and private asylums and their treatments during the late nineteenth century see A. Shepherd, ‘Mental health care and charity for the middling sort: Holloway Sanatorium 1885-1900’ in A. Borsay & P. Shapley, *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c. 1550-1950* (Burlington, 2007) & For information regarding Brislington House, Bristol’s own private asylum, see BRO 39801/F/29.

²⁶ Showalter, *Female Malady*, 79.

Chapter One: 'The Asylum'

The imposing buildings of the Bristol Lunatic Asylum asserted dominance in a classically Victorian fashion, providing an architectural symbol of authority and echoing Foucault's claim that the asylum was an emblem of capitalist dominance.²⁷ The size and grandeur of Bristol Asylum can be depicted from the building plans and photographs (see appendix 1 and 2), clearly intending to usher the patients into submission, whilst allowing the psychiatric staff to assume their own roles of power through their association to the intimidating setting.²⁸ The moral management employed by the psychiatrists involved enforcing a rigid routine in daily asylum life, standardising work, leisure and exercise in attempts to stabilise the minds of the patients.

Discourse surrounding Victorian asylums has discussed how female patients were subject to more 'careful watching' than men, whilst their physical separation ensured that they could be observed more closely in their own domain. Separate quarters were allotted with the construction of detached wards and 'visiting rooms', thus ensuring a gendered asylum experience as patients were often only surrounded by members of their own sex.²⁹ In Bristol however, the overseeing Visiting Committee greatly praised the staff and their efforts towards integration and social mobility with the provision of a mixed dining hall, describing how, 'the association of the sexes is undoubtedly conducive to their conduct and behaviour, it also provides a welcome break in the routine of asylum life'.³⁰ By allowing a minimal amount of contact between the sexes as a permanent fixture of each day, the staff made use of the physical setting to maintain a degree of incorporation, thus demonstrating how medical men weren't exclusively fixated on the segregation of the sexes.

Histories of insanity have described medical staff who employed 'ritualized forms of abuse' and of female victims who were impregnated by their own doctors.³¹ Although these examples are far from representative of standardised care, records from Colney Hatch Asylum disclose how female patients were five times more likely to spend in padded cells or sedated than their male counterparts, insinuating that women were treated with more severity

²⁷ Foucault, *Madness and Civilisation* (New York, 1964)

²⁸ C. Yanni, 'The Linear Plan for Insane Asylums in the United States before 1866', *Journal of the Society of Architectural Historians* (2003) 62, 1, 24-26.

²⁹ Showalter, *Female Malady*, 79 & BRO Bristolplans/arranged/41.

³⁰ BRO 30510, 'Visiting Committee report 1894', 14.

³¹ Marland, 'Disappointment', 317 & R. Gardiner Hill, *Lunacy: Its Past and Present* (London, 1870) 4.

than men within the asylum setting.³² In Bristol however, total isolation was rarely experienced or at least rarely documented, as the 1894 Visiting Committee maintained that there was no single instance of seclusion for males or females for the entirety of that year, signifying a looser interpretation of the concept of ‘confinement’.³³ At Glenside a programme of almost constant observation was introduced in place of punitive treatment in order to prevent harm to others and to oneself. Doctors introduced a suicide card which identified and drew attention to high risk patients whilst ensuring that attendants conducted routine suicide watches throughout the wards, resulting in only one case of suicide in Bristol between 1858 and 1883 out of 265 recorded in English asylums.³⁴ The focus on moral management was therefore remarkably effective in Bristol as a preventative for physical harm, whilst the attentive nature exhibited by the doctors and attendants suggests that they were not solely sadistic in their practice.

Superintendent Dr Stephens prohibited the use of straightjackets at the asylum’s opening in 1861, asserting that physical restraint was only administered if there was no other option.³⁵ A ‘Register of Mechanical Restraint’ was compiled and documented the nature of control administered to patients and the duration of their restriction. In 1892, Clara Loader was restrained twenty-four hours a day for six days in either a straightjacket or ‘wristlets and sheet’, a constrictive garment worn to prevent injury to both the staff and the patients.³⁶ This case demonstrates how mechanical restraint was implemented despite the asylum’s initial reprehension against it and the great severity with which it was administered, as twenty-four hour restraint considerably restricted the liberties of the patient. It is significant to note however that between 1890 and 1895 only two cases of such restraint were reported and whilst both of these instances involved female patients, it is an incredibly small proportion when considering the 652 patients in residence at this time.³⁷

In opposition, the 1872 Commissioners’ Report took note of several instances of restraint that had not been recorded, as well as the deaths of two patients in the month prior to the

³² R. Hunter & I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum Friern Hospital* (London, 1973) 91 & Granville, *Care and Cure*, 1, 184. & Showalter, *Female Malady*, 81.

³³ BRO 30510, ‘Visiting Committee report 1894’, 30.

³⁴ Early, *Pauper Palace*, 26 & For figures calculated by The Lunacy Commission see A. Shepherd & D. Wright, ‘Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint’ *Medical History*, 46 (2002)176.

³⁵ Early, *Pauper Palace*, 10

³⁶ BRO 40513/C/14/1.

³⁷ BRO 40513/C/14/1.

Committee's visit, tainting the asylum's reputation for upholding the utmost care.³⁸ In 1892 there continued to be dissatisfaction from the Visiting Committee, who described the inability of ward workers to accurately record incidents of restraint and their suspicion of mistreatment, resulting in the dismissal of three males and one female member of staff due to the 'charge of ill-treating a patient'.³⁹ Although few cases of restraint seem to have been administered it could merely be that few cases were recorded, as instances of excessive constraint would have tarnished the prestige of the asylum authority.⁴⁰ The omission of records therefore alludes to staff acknowledgement of the officious eyes on the institution and as a result the worst cases of abuse may have been lost in efforts to uphold the reputation of the institution.

Moral management controlled the routine of asylum life, including the regularisation of meal times, leisure and exercise. Inside the asylum the dietary requirements allotted to the female patients of Bristol Lunatic Asylum were fairly considerable (see appendix 3) and the health of the patient was prioritised and frequently conferred in the casebooks.⁴¹ Skin conditions, sores and ulcers were treated, teeth pulled and weight regularly documented by the medical staff as an indicator of progress, suggesting that the asylum doctors did attempt to treat the physical condition of female patients, regardless of whether mental health could be reclaimed. Regular entertainment provided in the form of plays and recitals often featured female patients who assumed the roles of reformed ladies, attending picnics and performing on the pianoforte to the overseeing Committee of Visitors and to demonstrate their transformation whilst replicating the upper class women of high society.⁴² The Committee was formed of members of society who held influence over the fate of the asylum, including Justices of the Peace and aldermen, thus the promotion of the healthy, reformed women was arguably an advertisement for the institution and its rehabilitative effects rather than purely a celebration of the patients' own personal transition.⁴³

In his promotion of the asylum, Superintendent Dr Stephens described Glenside as a 'light, airy and cheerful residence', provided with abundant grounds which were influential in a

³⁸ Early, *Pauper Palace*, 17.

³⁹ BRO 30510, 'Visiting Committee Report 1894', 7.

⁴⁰ See D. Large, *The Municipal Government of Bristol 1851-1902* (Bristol, 1999) 151-170 & D.F. Early, *Lunatic Pauper Palace*, 10.

⁴¹ Consisting of 4oz of cooked meat, 12oz vegetables and 3oz of bread most dinnertimes, alongside the provision of 'Rhubarb or Fruit pies' when in season, this being a far cry from the image of starved and secluded patients depicted by Showalter. Showalter, *Female Malady*, 79.

⁴² Early, *Pauper Palace*, 13-14.

⁴³ BRO: M/BCC/MEH/1/4, 'Lunatic Asylum Visiting Committee minute book', Oct 6th 1865-Jan 30th 1874.

patient's recovery.⁴⁴ The rural setting and acres of land available made regular outdoor activity possible, whilst exercise outside of the asylum setting could be seen as curative. At Colney Hatch Asylum, Hunter and Macalpine stressed how women were taken on fewer excursions than men and how male patients enjoyed engaging in matches on their private cricket-ground which females could only enjoy from their 'specially fenced –off enclosure'.⁴⁵ In Bristol, exercise was similarly segregated and the introduction of a cricket team in 1872 included male patients and medical men, possibly allowing a casual interaction and a breakdown of the formal doctor-patient power roles inside the asylum setting.⁴⁶ The records disclose no such equivalent for the female patients, who were encouraged to partake in calisthenics and leisurely walks around the grounds, prohibiting women from undertaking any strenuous action which was deemed inappropriate to their role as the 'fairer sex'. Although studies by Hunter and Macalpine and Showalter have underlined the segregation of physical activity as an example of sexist conduct, the asylum system was simply mirroring the 19th century perception that vigorous exercise for women was unbecoming, suggesting that this practice did encourage a feminization of the asylum experience but that this was not particularly discriminative or unique to care at Bristol.

Showalter described how 'in one large asylum in 1862, only 50 out of 866 female patients ever went from their ward to the day room', suggesting a severe lack of mobility even within the asylum setting.⁴⁷ However, in a sample taken by the Visiting Committee in Bristol on 30th December 1894 over 330 out of 342 female inmates partook in outdoor exercise (see appendix 4), thus demonstrating that although there was a distinct divide in the type of activity implemented, women were not entirely sheltered within the asylum walls.⁴⁸ This difference between Showalter's findings and those found in the Bristol records could either demonstrate a uniquely liberal regime implemented in Bristol or what has been referred to as 'the gradual de-institutionalization of the insane', as the 30 year gap between the two samples could represent a change in what was believed to be curative in psychiatry and a shift towards a more 'moral' approach to recovery.⁴⁹

⁴⁴ Early, *Pauper Palace* 10.

⁴⁵ Hunter & Macalpine, *Psychiatry*, 45, 76, 88.

⁴⁶ 'Bristol Lunatic Asylum v. Mr W.G. Grace Jnrs', *The Bristol Mercury and Daily Post*, September 18th 1888.

⁴⁷ Showalter, *Female Malady*, 82.

⁴⁸ In the Sunday sample, 330 out of 342 female patients took outdoor exercise, a significantly greater figure than males. See BRO 30510, 'Visiting Committee report 1894', 30.

⁴⁹ M. Finnane, 'Asylums, Families and the State', *History Workshop Journal*, 20 (1985)142.

An integral feature in the moral management of Bristol Lunatic Asylum was the implementation of work therapy to invigorate and occupy the minds and bodies of the patients, theoretically making them less hyperactive, manic and troublesome. There was a clear distinction in the distribution of work roles, as the majority of male patients worked in workshops as upholsters and tailors or by grafting outdoors on the asylum farms, whereas the indoor domestic duties attributed to the women included washing, sewing, cleaning and cooking for the entire asylum population.⁵⁰ In John Connolly's manual of asylum reform, *Treatment of the Insane*, he proposed that the women of the institution should be kept 'busy and cheerful in a scrupulously clean kitchen', assuming that domestic chores would satisfy or even delight female patients as they were more suited to their feminine nature.⁵¹ Connolly therefore exhibits a chauvinistic presumption of the female personality but one that was widely accepted in Victorian society and one which very few people would have been vaguely conscious of.

Laundry was particularly valued for its therapeutic effects in moral management, as Victorian Sociologist Harriet Martineau described how at Hanwell Asylum, women 'would be rearing their clothes to pieces if there was not the mangle to be turned', signifying its ability to act as an outlet for aggression due its physical involvement.⁵² One month before her discharge, Hester Withey, a patient diagnosed with 'puerperal mania', was described as having 'improved considerably both mentally and physically' with this being demonstrated by the manner in which she 'now works usefully in the laundry at asylum', associating the change in her work ethic to the change in her sanity.⁵³ In casebooks, the description of a patient as 'helpful on the ward' was often attributed to those women who were nearing their discharge and, in the eyes of the medical men, were close to recovery. When a patient became attentive and dutiful they were therefore demonstrating their ability to act in accordance with the rules of the asylum and thus comply with the conventions of civilised Victorian society.

Although gendered work roles were the norm in moral management, in an extract taken over three days in December 1894 (see appendix 4), it was shown that men were employed in the

⁵⁰For an extended list on the occupations for the men and women employed at the asylum see BRO 30510, 'Visiting Committee report 1894', 30 & For wider discussion regarding how work roles were attributed to 'reinforce conventional sex-role behaviour', see E. Showalter, *Female Malady*, 82.

⁵¹ J. Connolly, *Treatment of the Insane Without Mechanical Restraints* (London, 1856) 58. For the difference between male and female occupations, see BRO 30510, 'Visiting Committee report 1894' 14.

⁵²H. Martineau, 'The Hanwell Lunatic Asylum', *Miscellanies*, 2 vols. (Boston, 1834), 1, 232, quoted in Showalter, *Female Malady*, 83.

⁵³ BRO 40513/C/3/12, 12.

kitchen, bakehouse and laundry room and between 117 and 123 of 200 employed male patients took their roles as ‘ward helpers’, whose tasks included the supervision of wards and their general cleanliness and maintenance.⁵⁴ The inclusion of men in domestic occupations does imply a less rigid enforcement of sex roles than previously imagined; however the fact that no females were involved in male-orientated labour or hard graft is enlightening, as although their determination to do so cannot be deduced, there was no such occupational mobility for women who seemed to be resolutely tied to their domestic duty.

Psychiatric reformer I.R. Granville spoke of the purposeless nature of female labour, specifically tasks which required, ‘sorting coloured beans into separate piles that were dumped together again at night’.⁵⁵ Work therapy could similarly be considered exploitative, as laundresses at Hanwell and Colney Hatch were worked from six-thirty in the morning until late afternoon six days a week, as Showalter described how such therapy was seen as the ideal answer to ‘two dirty problems’.⁵⁶ In Bristol however, female patients worked to supply the asylum with garments and food, as the need for pauper labour was established due to the lack of private donations and reliance on unions.⁵⁷ In private asylums middle and upper class patients did not have to partake in such labour, whilst work was familiar to many paupers at Bristol and regrettably foretold a future of domestic duties that would continue even if a patient’s condition recovered.

The moral management of the asylum was therefore gendered in terms of leisure, exercise and work therapy, providing an asylum experience which was heavily dependent on the sex of each patient. Such organization associated the reformed male patient with hard graft, outdoor labour and the masculine virtues of strength and virility, whilst the reformed female was tied with domestic duties which were akin to her supposed feminine and maternal predisposition. The assumption that such gender roles were forced or unequal however must be avoided, as although women did not play rigorous sport or labour in the fields of the institution, such evidence is unsurprising when considering Victorian standards of normality and is not necessarily indicative of misogyny or sexism within the asylum setting. The gendered work roles may be seen as regimented in the eyes of the 21st century observer, however such gendered occupations could have merely been allocated to ensure that each

⁵⁴Two men were employed in the kitchen, one in the bakehouse and three in the laundry room. BRO 30510, ‘Visiting Committee report 1894’, 30.

⁵⁵ J.M. Granville, *Care and Cure*, 2 (London, 1877) 177.

⁵⁶ Showalter, *Female Malady*, 83- 84.

⁵⁷ To view the ‘Statement of Income and Expenditure’ of the Asylum, which includes private donations and union funding, see BRO 30510, ‘Visiting Committee report 1894’, 33.

patient had a working role and to maintain the asylum's self-sufficiency. The division of experience was therefore characteristically Victorian in its focus on categorisation, management and efficiency rather than in its sexism, as the priority of the psychiatric staff and asylum attendees was fundamentally to ensure that every patient had a working role in order to maintain the future survival of the institution.

Chapter Two- 'The Doctor'



Medical Officers - circa. 1889⁵⁸

The scientific revolution shaped what feminist historians and psychologists have referred to as 'the masculine scientist', the figure of a male doctor with complete autonomy, who treated female patients as subordinate and whose diagnosis and management of psychosis was tainted with sexism and misogyny.⁵⁹ Through a close analysis of the casebooks at Bristol, one can therefore determine the causes attributed to condition of the female lunatic, the treatment administered to aid their recovery and the opinion of the doctor throughout their confinement in order to decipher how the patients' plight was interpreted in the eyes of medical men.

Victorian neurophysiologist Thomas Laycock demonstrated how female insanity was understood using biological reasoning, classifying that insanity, whenever experienced by a woman, was always closely allied to her 'menstrual, gravid (pregnant), and parturient

⁵⁸Source: Glenside Hospital Museum

⁵⁹For a comprehensive discussion of the debates surrounding the 'masculine scientist' or 'gentleman doctor' see Ussher, J., *Women's Madness: Misogyny or Mental Illness?* (Hemel Hemsted, 1991) 66-76.

periods'.⁶⁰ The female bodily condition was a constant theme in casebooks in Bristol, as causes for insanity were identified on admission and were often directly correlated with the female body. Edith Oxley was described to suffer 'greatly in former times at menstrual periods...' whilst for patient Sammy Goodman, her monthly periods were described as the time when she was 'most restless and irritable'.⁶¹ In the casebook of Emma Harris, her 'menstruation' and the consequential irregularity of her personality was defined as the very cause of her madness, thus providing a thoroughly female diagnosis as it was based entirely on her biology.⁶² In the cases of male patients, there seems to be no equivalent connection between their masculinity and their madness, this recognition of the female condition therefore differentiated and disconnected male and female psychosis, as doctors directly associated the female monthly cycles with their fluctuating temperament and defined a distinctly feminine category of insanity.

The female diagnosis which was most frequently recorded in the admission books of Bristol Asylum was 'puerperal insanity', a condition which was believed to appear up to six weeks after childbirth and was known for its rapid and spontaneous onset, often being identified in patients with no previous history of mental illness.⁶³ One in eight females were diagnosed with puerperal insanity on admission to Bristol asylum in 1894 and were known to exhibit symptoms of mania in the form an argumentative and troublesome temperament and by deviating from decent female behaviour or neglecting their maternal duty.⁶⁴ Throughout the admission books doctors therefore associated menstruation, pregnancy and the menopause to lunacy, thus ensuring that female insanity could be related at every interval of a woman's biological development.

In the table listing the 'apparent or assigned' causes of mental disorder on admission, the doctor's consideration of female emotionality can be verified. Three women in 1894 were said to suffer from the 'Moral cause' of 'Love Affairs (Including Seduction)' with such social conditions being repeated in the pages of doctors notes (see appendix 5), whereas men were more likely to suffer from 'intemperance in drink', 'privation and ill health' or 'unknown'

⁶⁰T. Laycock, 'On the Naming and Classification of Mental Diseases and Defects,' *JMS*, 9 (1863) 160.

⁶¹BRO 40513/c/3/12, 8.& BRO 40513/C/3/11, 5.

⁶²BRO 40513/c/3/11, 2.

⁶³For a comprehensive assessment of puerperal psychosis in the Royal Edinburgh Hospital see A-U-Rehman, D.St. Clair & C.Platz, 'Puerperal Insanity in the 19th and 20th Centuries,' *British Journal of Psychiatry* 156, (1990) 861.

⁶⁴BRO 35510, 'Visiting Committee Report' 1894, 23 & Marland, 'Disappointment', 308-9.

causes.⁶⁵ Doctors therefore accepted that female madness could be triggered by their sensitivity and emotionality more readily, whilst men were more likely to be governed by external or unknown factors which involved fewer personal afflictions or excitements.

In the second half of the nineteenth century obtrusive practices such as clitoridectomy, hysterectomy and the removal of the labia were introduced as it was asserted that female sexuality caused women to become restless and excitable, whilst masturbation and sexual enjoyment were seen as indicators of an unsound mind.⁶⁶ Scientists made the direct link between female sexuality and psychosis, theorising that by altering the female body, women could control their sexual assertions and behave in a more rational manner. In Bristol, doctors employed less gendered and less punishing treatments, however purgatives, opiates and sedates did feature in the majority of cases. Drug therapy was seen to be generally effective, as detailed in the casebook of Emily Partridge, a patient of a nervous disposition who suffered from mania and exhaustion and was often seen rocking before ‘rushing about to go and hide herself’. The Medical Officer recorded the marked difference in her condition after taking ‘Bromieda’, a sedative, describing how she ‘now sleeps well, eats well and is very much improved’, as the patient was discharged only one month later.⁶⁷ Drugs were therefore seen as reformatory but were used primarily to control behaviour and hyperactivity and not to drastically alter the female body in the form of obtrusive surgical procedures.

However, dosage varied from patient to patient and the sources disclose little evidence of standardised regulation. In the case of Mary Ellen Locke Brideaux, the consistent use of sedatives was warranted due to her ‘restless’ and disruptive temperament and over the course of twelve days the seventeen year old was administered six times with ‘Hyoseine’, a soluble form of morphine, demonstrating the use of intensive drug regimens on moderately young patients. One entry as early as 10.15 am was justified simply due to the patient’s ‘noisy’ condition, whilst Mary’s experience demonstrates how drugs were prescribed relatively unconcernedly to control disruptive behaviour and not solely as a preventative for inducing

⁶⁵It is interesting to note that a large proportion of male insanity was attributed to ‘Intemperance in Drink’ (18 men compared to 3 women in 1894) with the intemperance of working class males frequently appearing in the casebooks and demonstrating the difference in causes relating to each gender. See BRO 35510, ‘Visiting Committee Report’ 1894, 23.

⁶⁶Distinguished gynaecologist and obstetrical surgeon Dr Isaac Baker Brown pioneered the use of clitoridectomy in his own manual, I. Brown. Baker, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females* (London, 1866) & For a greater discussion of his practice, see Showalter, *Female Malady*, 75-6.

⁶⁷ BRO 40513/C/3/12, 6.

harm.⁶⁸ Dr Thompson described how dosage could fluctuate between 1/200th and 1/60th of a grain inserted by mouth or injection and that ‘the effect, especially on the latter class of cases is simply marvellous’.⁶⁹ It could therefore be concluded that although the use of such drugs as sedatives were relatively mild forms of treatment, they were endorsed by the doctors and frequently used on females in the daily asylum experience, questioning the concept of a wholly ‘moral’ form of management even when understood using the stricter standards of Victorian ethical treatment.

The doctor’s attitude towards the female patients and their psychoses can be gauged from the female casebooks, as their judgement can be disguised in their discourse.⁷⁰ The renowned doctor and reformer, Joseph Mortimer Granville, described how women of the institution were consistently involved in ‘an excess of vehement declaration and quarrelling’, warning superintendents of their raucous nature and recommending rigorous work therapy to keep the women industriously occupied.⁷¹ In Bristol Asylum Georgia Maffs, a 20 year old domestic servant suffering from acute mania, was labelled as being ‘very lost and stupid’, whilst the medical officer described how she spoke ‘unnecessarily’ about ‘a great deal of incoherent rubbish’, exposing his aggravation at the exhausting nature of her condition.⁷² Alice Jane Wells, a housewife who had suffered from the characteristically female condition of ‘puerperal insanity with refusal of food’, was recognized by her blatant refusal to answer questions or comply with rudimentary instructions, instead opting to ‘show her tongue’ to tease and provoke authority. The medical officer in turn seemed to doubt her insanity, believing that she was ‘aware fully of what was going on around her and deliberately resisted efforts to open her mouth’.⁷³ This case therefore demonstrates the disbelief of the Doctor, exasperated with the lack of progress of the female inmate and her flagrant refusal to comply with the asylum rules, doubting the very nature of her condition.

Showalter discussed how doctors placed female patients in solitary confinement in the basement at Bethlem, ‘on account of being violent, mischievous, dirty and using bad

⁶⁸ BRO 40513/C/3/12, 18, 20.

⁶⁹ Early, *Pauper Palace*, 20.

⁷⁰ Hilary Marland, in her assessment of the patients of Edinburgh Asylum noted how the practising doctor referred to his pauper Irish patient as being ‘of coarse and vulgar habits like the rest of her class’, demonstrating the preconceptions of those men who were meant to be unbridled by prejudice. See Marland, ‘Disappointment’, 314.

⁷¹ Granville, *Care and Cure*, 1, 180.

⁷² BRO 40513/C/3/12, 1.

⁷³ BRO 40513/C/3/12, 2.

language', thus exhibiting characteristics that were distinctly 'unfeminine'.⁷⁴ Although at Bristol, the 'Register of Mechanical Restraint' does not detail why said restraint was administered, the discourse within female casebooks does define the behaviour doctors classified as 'unfeminine'. Victorian psychiatrists placed great emphasis on the appearance of female patients, frequently remarking on the 'dirty habits' of women as being evident of their unsound mental state. In the casebook of patient Emma Harris, her lack of cleanliness is constantly referred to as a manifestation of her madness, evident with her description as 'very wet, dirty and does nothing', whilst another entry describes how she 'does nothing and is untidy in her dress'.⁷⁵ The repetition of 'dirty' and the reference to her outward appearance demonstrates how the doctor prioritized her failure to conform to the appropriate standards of feminine propriety. In the casebook of Emily Bennett it was described how she was similarly 'untidy' in her appearance, whilst attention was paid to the manner in which she could be seen 'unfastening her dress'.⁷⁶ In the eyes of the doctor, appropriate clothing could be construed as a basic symbol of sanity and compliance with Victorian society, with its consequential destruction or removal, patients therefore demonstrated a strong deviation from femininity and mental wellness.

Superintendents used clothing and the feminization of women in their moral management, believing that women would eventually succumb to their inert predisposition to vanity. Granville adhered to this gendered notion with the claim that dress 'is women's weakness, and in the treatment of lunacy it should be an instrument of control, and therefore recovery', the recognition and acceptance of appearance being seen as normal and positive within society.⁷⁷ Nearing the end of her recovery, Georgia Maffs was described as notably 'brighter' and 'so much uniformed', as the resident doctor associated her improved physical state with her improved mental state.⁷⁸ In theory, females could therefore exhibit their improvement by emphasising their own femininity as an expression of sanity and conformity to Victorian standards, persuading the medical staff that they could adhere to the rules of society outside the asylum, or at the very least *appear* as though they could.⁷⁹

⁷⁴ Showalter, *Female Malady*, 81.

⁷⁵ BRO 40513/C/3/11, 2.

⁷⁶ BRO 40513/C/3/11, 3.

⁷⁷ Granville, *Care and Cure*, 1, 53.

⁷⁸ BRO 40513/c/3/12, 1.

⁷⁹ E. Showalter, *Female Malady*, 84.

In 1848, Dr Hugh Welch Diamond, the medical superintendent of the female department of Surrey Asylum first advocated the use of photography in psychiatry and noted its use as a reminder of a 'natural female vanity'.⁸⁰ Susan Sontag has since described how the photography was introduced to institutions to capture how insanity was physically manifested and to catalogue the progression of a condition, allowing the authoritative control to categorise and manage patients more effectively.⁸¹ In contemporary analysis the photographic sources could be considered subjective due to the ability to manipulate the background, clothing and hair style of a patient to emphasise a woman's progress and the reformatory influence of the asylum.⁸² The casebook of Edith Oxley includes two photographs, figure 1 features Edith on admission, a patient whose hair is short and unkempt, whilst her standard issue gown only adds to an already androgynous appearance. Figure 2, the patient's discharge photograph, displays a reformed Edith, wearing a fashionable hat decorated in flowers and a shirt with feminine ruffles, her hair seeming longer and styled thus emphasising her femininity and newfound care and appreciation of her appearance. The patient manages a slight smile but wears the same tired and worn expression, demonstrating how although the props do well to mask the misery, the patient fails to convey a complete vision of recovery.⁸³ The difference between the two sources demonstrates the manipulation of improvement at the hands of its staff, with the latter photograph arguably being more demonstrative of the doctor's own ideal picture of a healed woman than the reality of the weary figure in the photograph.

At Bristol Lunatic Asylum, the doctor-patient relationship was therefore one of subtle persuasion to transform the manic or melancholic female into a sane, rational and feminine woman. Mild drug regimens were implemented in place of severe surgical procedures, possibly due to its focus on moral management or as a consequence of its pauper status, as such operations were confined to private practices and performed by professional gynaecologists and surgeons, with the doctors feasibly relying on moral management not only because of its liberal nature but because it was economical. The discourse of casebooks offers interesting insight into the doctor's view of the patient's femininity, as the repeated

⁸⁰ See Hugh Diamond, 'On the Application of Photography to the Physiognomy and Mental Phenomena of Insanity' in S.L. Gilman, *The Face of Madness: Hugh W. Diamond and the Origins of Psychiatric Photography* (New York, 1976) quoted in 9, 19-20, 24.

⁸¹ S. Sontag, *On Photography* (Harmondsworth, 1977) 5, 21.

⁸² M. Hill & V. Pollock, 'Images of the Past: Photographs as Historical Evidence' *History Ireland*, 1 (Spring 1994) 9-14 & For a detailed analysis of both the male and female photographs of Bristol Lunatic Asylum, see Tobia, P., 'Faces of the Asylum: The Patients of the Bristol Lunatic Asylum in the Nineteenth Century', *The Regional Historian*, 25 (Winter/Spring 2013)

⁸³ BRO 40513/C /3/12, 8.

reference to the female biological composition demonstrates how gender was a predominant feature in the mind of the psychiatrist. It is interesting to note how said discourse familiarised a dichotomy that linked insanity with dirtiness and sanity with cleanliness, affirming that cleanliness, propriety and femininity were the achievable ideals to which female patients must thrive towards. The use of photographs demonstrates how the casebooks could have been forms of asylum propaganda, as the vision of the madwoman was the antithesis of the rationality and conservatism of the Victorian age and in her effective taming the psychiatric profession was therefore displaying its own capabilities and the overall effectiveness of moral management.



Figure 1



Figure 2

Chapter Three: ‘The Patient’

Feminist historian Carol Smith–Rosenberg’s in her stimulating work, ‘The Hysterical Woman’, described how hysterical madness allowed women to express ‘dissatisfaction with one or several aspects of their lives’.⁸⁴ Inside the asylum, female insanity was experienced by delusions, raucous and restless behaviour, refusal of food and suicidal tendencies, with such manifestations of madness being interpreted in feminist theory as a protest against their subordinate role in society.⁸⁵ In order to understand the true experience of female pauper lunacy, the significance of the numbers of women admitted to institutions and the female reaction to confinement must be determined, whilst also discussing the wider feminist arguments surrounding female agency within the asylum setting.

The over representative admission figures for female lunatics in institutions has been documented extensively by historians and psychologists since the 1970s, with the emphasis on ‘women’s history’ and desire to determine whether more women were admitted to asylums than men due to a female predisposition towards madness or as part of an unconscious misogyny that dominated the psychiatric profession.⁸⁶ In *Women and Madness*, Phyllis Chesler’s feminist analysis described how the insanity of the archetypal madwoman was diagnosed due to her irrepressible character being seen as the opposite of the ideal decorous and demure Victorian woman. However the accepted female characteristics of ‘dependency’ and ‘submissiveness’ were also symbolic of insanity for both males and females, with Chesler asserting that the Victorian woman could therefore be diagnosed with inanity and institutionalized, ‘whether she accepts or rejects crucial aspects of the female role’.⁸⁷

Dr W.A.F. Browne asserted that ‘in the case of a public asylum, a larger portion of the building should be allotted to females, as their numbers almost always predominate’.⁸⁸ Browne’s assumption that in any given district or county the asylum setting would need to adapt due to the greater number of female lunatics could have created a self-fulfilling

⁸⁴C. Smith–Rosenberg, ‘The Hysterical Woman’, *Social Research*, 39 (1972) 652-678.

⁸⁵ For a detailed historiography of feminist histories of psychiatry, see, N.Tomes, ‘Feminist Histories’, 352-376.

⁸⁶ Howell and Bayes use data and theory to demonstrate the stark difference in male/female admission in the Victorian age. E.Howell & M.Bayes, *Women and Mental Health* (New York, 1981) & Showalter’s described how in Hanwell Asylum in the 1870s women ‘exceeded men by 36 per cent’. Showalter, *Female Malady*, 263.

⁸⁷ P. Chesler, *Women and Madness* (New York, 1972) 52.

⁸⁸ Browne, W.A.F., *What Asylums Were, Are, and Ought to Be* (London, 1837) 184.

prophecy, of commissioners constructing larger quarters for females and doctors admitting more women to fill those quarters. The architects of Luke's Hospital remodelled its dormitories on the established contention that there would always be more female patients admitted, thus affecting the physical design of the institutions themselves.⁸⁹ At Bristol Lunatic Asylum overcrowding was certainly a severe problem, as demonstrated by the temporary beds fitted in the corridors of wards and the transferral of patients to neighbouring asylums.⁹⁰ Between 1861 and 1894 however, a difference of only 71 female patients can be averaged, 2065 women to 1994 men, this figure is significant as it suggests that female entry figures did not considerably predominate and that in Bristol, the epidemic of female hysteria was not as drastic as other institutions. In 1892, 106 men entered the asylum in comparison to 77 women, thus demonstrating how in male admission could even *exceed* female admission.⁹¹ Such statistics contribute to the wider history of asylum admittance and verify Andrew Scull's claim that within asylums, 'female predominance is far from monolithic'.⁹² At Glenside greater female admission cannot therefore be seen as demonstrative of the ingrained sexism of the medical profession, as there appeared to be no vast difference in said admission.

Within the asylum, patients relentlessly complained of harsh and punishing abuse at the hands of the medical officers. The accusations of the patients were seldom considered however due to their 'hysterical' state, with many suffering from religious delusions involving God and the Devil or malevolent figures inside the institution. Patient Alice Jane Wells was described as having a 'suspicious way of looking around her' and had 'accused the nurse of being "the devil" and then accused herself of being so'.⁹³ In accusing the *female* nurse of being the devil her protests seem to signify a general suspicion of authority rather than of the patriarchal control, whilst in accusing herself her delusions are demonstrative of her own inner conflict. Such cases therefore illustrate how patients did protest against the literal state of their confinement, however the feminist claim that it was part of a co-ordinated effort against patriarchal society seems to be too farfetched, as their protests were more likely to be against the confinement of their own illness prohibiting them in normal life.

⁸⁹ C.N. French, *The Story of St. Luke's Hospital* (London, 1951) 43.

⁹⁰ Early, *Pauper Palace*, 28.

⁹¹ See BRO 30510, 'Visiting Committee report 1894', 19.

⁹² Andrew Scull has similarly doubted the overrepresentation of women in asylums, proposing that gender imbalance did not 'amount to more than a few per cent', attributing this small difference to the greater life span of the female sex. A. Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Berkeley, 1989) 270.

⁹³ BRO 40513/C/3/12, 2.

Patients were generally mistrustful of the authority, a classic symptom of a condition that we would now categorize as schizophrenia and a feature of casebook discourse which can be misleading in analysis of patient experience.⁹⁴ Catherine O' Connor described how Nurse Harvey performed brutal punishments and how she whipped the patients on occasion, raising questions over maltreatment. However Catherine also discussed how she had lived with Jesus and how he 'took her life in Jersey', thus encapsulating how experiences of the patients' were often the products of their own mind.⁹⁵ Although it would be unscholarly and inaccurate to dismiss patients' testimonies entirely, the falsity of their claims and their delusional state must therefore be considered when used as evidence of cruelty.

Psychiatric reformer John Connolly noted how it was in the female quarters of the asylum 'where the greatest daily amount of excitement and refractoriness was to be met and managed'.⁹⁶ At Glasgow Royal Asylum, a male patient asserted that 'female lunatics were less susceptible to control than males. They are more troublesome, noisier and more abusive in their language', thus coinciding with the general opinion of the doctors and validating their assertions of female disobedience.⁹⁷ Bristol casebooks referred to women as disorderly and even erratic, particularly those patients suffering from mania, in which hyperactive tendencies were symptomatic of their condition.⁹⁸ The case study of the Georgia Anne Louisa Maffs detailed how she was seen 'screaming, flinging crockery about (and) refusing her food' as well as undressing herself and 'passing water' openly in the corridors, eventually refusing her narcotics and becoming 'quite unmanageable'.⁹⁹ Female psychosis was often interpreted by the loss of control of bodily functions, it being nigh on impossible to gauge whether their insanity had manifested itself physically in the complete lack of control over their own body or, as proposed by feminist theorists, whether females were deviating from feminine norms to demonstrate their dissatisfaction with their subordinate position in society.

The most threatening female protests were manifested in the suicidal tendencies of the patients. On October 28th Alice Wells was seen 'trying to get out of the window' and in the weeks that followed attempted 'to gouge her eye out' and suffocate herself by covering her

⁹⁴A. Beveridge, 'Voices of the mad: patients' letters from the Royal Edinburgh Asylum, 1873–1908' *Psychological Medicine*, 20, 4 (1997) 899-908.

⁹⁵BRO 40513/C/3/12, 5.

⁹⁶J. Connolly, *Treatment of the Insane Without Mechanical Restraints* (London, 1856) 107.

⁹⁷ Unknown Glasgow patient, *The Philosophy of Insanity*, (eds.) Frieda Fromm-Reichmann (London, 1860, 1947) 84 cited in Showalter, *Female Malady*, 81.

⁹⁸Marland in her analysis of puerperal insanity discusses the differences between manic and melancholic symptoms. Marland, 'Disappointment', 308.

⁹⁹BRO 40513/C/3/12, 1.

head in blankets, mirroring the defiant nature of fellow inmates who swallowed dominos, pebbles and screws and used whatever means necessary to inflict personal harm.¹⁰⁰ Between suicidal episodes Alice had exhibited signs of recovery by eating well and working before harming again, such suicidal behaviour therefore exemplifies the frailty and unpredictability of the patient condition and high possibility of relapse, with her persistence thus signifying the determination of patients to end their inner torment.¹⁰¹

Within the asylum, the refusal of food was a common feature of female insanity and was demonstrative of a self-destructive disposition. However feminists have gone further in their analysis, discussing how starvation, emaciation and the destruction of femininity were forms of protest against the perception of women as mere objects of beauty.¹⁰² Feminists have formed parallels between the Victorian madwoman's refusal of food and the organised starvation of the suffragettes, claiming that both protests were protests against patriarchy.¹⁰³ In Bristol, a patient's refusal of food was often associated with their own diagnosis or depression. Hester Withey's starvation had led to a drastically low weight of 5st 13lbs as she claimed that her food was made of 'after-birth', associating her diagnosis of puerperal mania and postnatal depression to her delusional symptoms and insinuating that for Hester, her anorexia was less a protest against patriarchy and more literal manifestation of her own depressive disorder. Due to her dangerously low weight and frail condition, the asylum attendees ordered that her stomach be pumped with sustenance, thus demonstrating how the management of the asylum was firmly focused on the physical welfare of its patients.¹⁰⁴ Patient morality was prioritised for reasons two-fold, firstly due to the significance the soul within the wider religious connotations of Victorian society and secondly in terms of the reputation of asylum, as patients dying in such circumstances could be indicative of inadequate institutional care.¹⁰⁵ As a result of the patient's dissent, the asylum responded by removing the personal right of protest and 'reducing women to the dependence of an infant',

¹⁰⁰BRO 40513/C/3/12,2 & for the case of suicidal patient 'E.W', see Early, *Pauper*, 19. For a greater discussion of the typical methods patients used to commit suicide in the Victorian asylum see A. Shepherd & D. Wright 'Madness, Suicide and the Victorian Asylum', 176.

¹⁰¹ Even when patients were discharged and appeared recovered, a considerable number were re-admitted to the asylum, sometimes multiple times. Females were also more likely to be re-admitted to the asylum than males, 267 men and 321 women in 588 average total out of 4059 total admissions from 1861-1894. See BRO 35510, 'Visiting Committee Report' 1894, 18.

¹⁰²BRO 40513/C/3/12, 2.

¹⁰³This comparison is discussed in greater depth in, S. Orbach, *Hunger Strike: The Anorectic's Struggle as a Metaphor for our Age* (New York, 1986) 63, 33-35.

¹⁰⁴BRO 40513/C/3/12, 12.

¹⁰⁵ B. Gates, *Victorian Suicide: Mad Crimes and Sad Histories* (Princeton, 1988)

with such handling being seen as the only foreseeable means to ensure the survival of those suffering.¹⁰⁶

The institutionalization of women could be regarded as an influential factor in their unruly temperament, as medical men appeared to be cautious of the harsh effect of the asylum setting on the already delicate female psyche. John Connolly had warned against the admission of patients suffering from puerperal mania into the asylum, whilst Physician James Reid had recommended ‘a quiet country village’ or ‘sea-side’ as a more appropriate setting for the recovering madwoman.¹⁰⁷ On admission, Margaret Welsh had been diagnosed with acute melancholia and was described as ‘very silent and depressed’ after being found on the Clifton Suspension Bridge ‘with the intention of destroying herself’. Six months into her admission however she was noted for her ‘quarrelsome’ nature and the manner in which she enjoyed to ‘initiate some of the other patients’.¹⁰⁸ The notable transformation in the patient’s temperament implies that it could have been the variant of the asylum setting which had altered the symptoms of her condition, confinement therefore seemed to act as a catalyst to trigger the rebellious nature of the female patient and alter the very nature of her madness.

Although the admission figures prove that the numbers of insane females did not drastically predominate in Bristol, the recurrent references to their behaviour indicate that once they entered the asylum, their presence was undoubtedly felt. The notion that their psychotic symptoms were a form of remonstrance against masculine dominance could be favoured by feminists as it offers women a degree of agency over their condition and denotes that the plight of the madwoman was part of the greater history of feminist protest.¹⁰⁹ However the implication that the disease itself was a protest proposes that their illness could in some way be controlled or managed, with this explanation greatly underestimating the severity of the female condition.¹¹⁰ Moreover, much of the feminist discourse surrounding protest is arguably more applicable in the realms of high society, where women were seen as ornamental and decorative due to the emphasis on femininity and propriety. For pauper lunatics their refusal to eat or work could leave them destitute and starving, thus diminishing

¹⁰⁶ J. Oppenheim, *“Shattered Nerves”*: *Doctors, Patients, and Depression in Victorian England* (Oxford, 1991) 215.

¹⁰⁷ Marland, ‘*Disappointment*’, 309 & Reid, J. ‘On the causes, symptoms, and treatment of puerperal insanity’, *Journal of Psychological Medicine* (1858) 290.

¹⁰⁸ BRO 40513/C/3/12, 7.

¹⁰⁹ Tomes, ‘*Feminist Histories*’, 358.

¹¹⁰ Oppenheim discusses how feminist theory implies that women ‘manipulated sickness’ and that they were contented with their lives as either ‘dupes or dullards’. Oppenheim, *“Shattered Nerves”*, 229.

the likelihood of a self-inflicted protest as their protests would have gone unheard.¹¹¹ In Bristol Lunatic Asylum, female patients were in conflict with the unknown authoritative control and the physical restraints of their surroundings which, despite being physically protective, only seemed to aggravate their illness. In their refusal to comply with the rules of the asylum patients were force-fed and held under constant observation, ironically being consigned to the very subordination feminist theorists believed they were protesting against.

¹¹¹Ussher discussed how pauper lunatics didn't have the time or money to be 'mad', as the working classes had 'eat to work' and work, to eat. Ussher, *Women's Madness*, 78, 89-90.

Conclusion

This dissertation has endeavoured to use the analysis of a single asylum to explore whether the hysterical scholarly approach towards female hysteria and the misogyny within the male psychiatric profession can be justified. In Bristol Lunatic Asylum separate sex roles were encouraged for sake of ease within the grander scheme of moral management rather than as a result of the all-encompassing misogyny of a patriarchal institution. On admission, the relative similarity between male and female entry figures dismisses the contention that more women were placed into asylums solely because of their sex, implying that Victorian madness was not entirely feminized.¹¹² Moreover, despite the fact that the few documented cases of physical restraint were likely to involve women, these examples are in no way conspicuous enough to make broad conclusions of abuse at the hands of medical men. Over-representative female admission and inadequate care most likely stemmed from a failure to understand the nature the illnesses from which some of patients were suffering. Women were therefore misdiagnosed due to a lack of scientific knowledge, this being a fault of history rather than a conspiracy of the medical practitioners.

Subsequent investigation into asylum experience would benefit from a more ‘relational’ approach towards gender and psychiatric treatment.¹¹³ In his analysis of neurologist Jean-Martin Charcot and French medical theory, Marc Micale established that male hysteria was a prominent disease with its own symptoms and conditions, thus suggesting that recent histories have become female-centric and in doing so have ignored male psychosis almost entirely.¹¹⁴ By conducting a larger analysis of the experience of male *and* female patients at Bristol Lunatic Asylum, a comparison could be made with regards to their similarities and differences in incarceration, including a closer analysis of work roles and exercise to determine whether the promotion of masculinity was enforced with the same determination as femininity.

¹¹² Ussher discusses the contemporary notion that ‘in the nineteenth century madness itself became synonymous with femininity, and was firmly institutionalized as such’, Ussher, *Madness*, 71.

¹¹³ Nancy Tomes notes how Showalter includes only one chapter on male psychosis in *The Female Malady &* discusses the move towards histories which encompass the experience of both genders. Tomes, ‘Feminist Histories’, 365-366.

¹¹⁴ Both Micale and Oppenheim try to uncover how mental illness has been experienced by both men and women throughout history. Mark S. Micale, ‘Hysteria Male/Hysteria Female: Reflections on Comparative Gender Construction in Nineteenth-Century France and Britain’, in Marina Benjamin (ed.), *Science and Sensibility: Gender and Scientific Enquiry, 1780-1945* (Oxford, 1991) 200-39 & Oppenheim, ‘Shattered Nerves’(Oxford, 1991).

In her retelling of *The Female Malady*, Showalter claimed that ‘English psychiatric treatment of nervous women was ruthless, a microcosm of the sex war intended to establish the male doctor’s total authority’.¹¹⁵ Such broad generalisations must be handled carefully with regards to psychiatric practice, as they omit the physical presence of the asylum and the agency of the female patient by emphasising only the doctor’s dominance.¹¹⁶ The concept of the ‘Masculine Scientist’ fails to consider the importance of the individual or of individual relationships which were specific to each institution, opting to choose the simplistic explanation of female subordination over the more complex theory of multiple relationships of diverse power.¹¹⁷ In this analysis the hysterical histories of hysteria have been discarded in favour of a revised woman’s history, producing an honest depiction of asylum experience, from the female perceptive. In debates surrounding gender and psychiatry scholars must therefore end their determined pursuit to find misogyny in sources before their scholarship becomes less of a ‘woman’s history’, and more of an aggressive anti-male analysis.

¹¹⁵ Showalter, *Female Malady*, 137.

¹¹⁶ This view concurs with Regina Morantz’s suggestion that the regurgitated description of masculine domination over the weak female patient ‘has become a sterile and tedious line of inquiry.’ R. Morantz, ‘The Lady and Her Physician’ in M.Hartman and L.Banner (eds.) *Clio’s Consciousness Raised: New Perspectives on the History of Women* (New York, 1974) 50-51.

¹¹⁷ Joan Scott instead described the doctor-patient interaction as ‘dispersed constellations of unequal relationships’, J. Scott, ‘Gender: A Useful Category of Historical Analysis,’ *American Historical Review*, 91 (1986) 1067.

Appendices

Appendix 1



Bristol Lunatic Asylum- circa 1861

Bristol Hospital Museum.

Appendix 3

PATIENTS' ORDINARY DIET TABLE.

BREAKFAST.

MALES—1 pint Coffee (*a*), 7 oz. Bread, $\frac{1}{2}$ oz. Butter.

FEMALES—1 pint do. 5 oz. do. $\frac{1}{2}$ oz. do.

DINNER.

SUNDAY, MONDAY, WEDNESDAY, AND FRIDAY.	{	MALES—5 oz. Cooked Meat, free from bone, 16 oz. Vegetables, 4 oz. Bread.
	{	FEMALES—4 oz. Cooked Meat, free from bone, 12 oz. Vegetables, 3 oz. Bread.
	{	1 lb. Fish substituted occasionally in lieu of the Meat.
TUESDAY AND THURSDAY.	{	MALES—Meat Pie (containing 4 oz. Uncooked Meat free from bone), 16 oz. Vegetables.
	{	FEMALES—Meat Pie (containing 3 oz. Uncooked Meat, free from bone), 12 oz. Vegetables.
SATURDAY.	{	MALES—1 $\frac{1}{2}$ pint Pea Soup (containing 3 oz. Uncooked Meat and 8 oz. Vegetables), 5 oz. Bread and 1 oz. Cheese.
	{	FEMALES—1 pint Pea Soup (containing 2 oz. Uncooked Meat and 6 oz. Vegetables), 4 oz. Bread, and 1 oz. Cheese.

TEA.

MALES—1 pint Tea (*b*), 7 oz. Bread, $\frac{1}{2}$ oz. Butter, or 7 oz. Seed Cake.

FEMALES—1 pint do., 5 oz. do., $\frac{1}{2}$ oz. do., 5 oz. do.

SCALE FOR (*a*) COFFEE PER 100 PINTS.—1 $\frac{1}{4}$ lb. Coffee, $\frac{1}{2}$ lb. Chicory, 3 lbs. Sugar, 1 gallon Milk.

SCALE FOR (*b*) TEA PER 100 PINTS.—13 oz. Tea, 3 lbs. Sugar, 1 gallon Milk.

EXTRA DIET.

Rhubarb or Fruit Pies in the season frequently, in addition to Sunday dinner, also salad of lettuce, &c., pickled cabbage or onions. Cabbages, leeks, parsnips, artichokes, turnips or carrots are frequently served with

Appendix 4

TABLE XVIII.—*Extracts from the Head Attendants' Journals, shewing the State and Occupation of the Patients on the 29th, 30th, and 31st December, 1894.*

MALES.				FEMALES.			
EMPLOYED IN	Saturday.	Sunday.	Monday.	EMPLOYED IN	Saturday.	Sunday.	Monday.
Garden, Farm, &c....	41	0	40	Laundry	24	0	24
Stores and Cellar ...	8	1	8	Kitchen	24	20	23
Kitchen	2	2	2	Dwelling Houses ...	1	0	1
Bakehouse	1	0	1	Dressmaking	10	0	10
Laundry	3	0	3	General Needlework	71	0	85
Tailors	3	0	3	Stocking Mending ...	14	0	0
Shoemakers	4	0	4	Ward Helpers... ..	102	124	103
Painters	0	0	0				
Upholsterers	17	0	17				
Ward Helpers... ..	117	117	123				
Total Employed ...	196	120	201	Total Employed ...	246	144	246
Admitted	0	0	0	Admitted... ..	0	0	0
Discharged	0	0	0	Discharged	0	0	0
Died	0	0	0	Died	0	1	0
Sick (in bed)	2	0	2	Sick (in bed)	2	2	2
Fits by Day	5	7	11	Fits by Day	6	4	6
Fits by Night	20	13	19	Fits by Night	4	4	1
At Chapel { Morning.	0	169	0	At Chapel { Morning.	0	194	0
{ Evening.	0	170	0	{ Evening.	0	184	0
At Prayers	235	245	244	At Prayers	0	193	195
Out-door Exercise ...	207	124	213	Out-door Exercise ...	0	330	252
Evening Amusements	171	0	0	Evening Amusements	143	0	0
In Seclusion	0	0	0	In Seclusion	0	0	0
Accidents	2	0	0	Accidents	0	0	1
Escaped	0	0	0	Escaped	0	0	0
No. of Patients in } the men's division }	310	310	310	No. of Patients in } the women's division }	343	342	342

BRO 35510, 'Visiting Committee Report' 1894, 30.

Appendix 5

TABLE VII.—*Shewing the probable Causes, Apparent or Assigned, of the Mental Disorder, in the Admissions, Discharges, and Deaths during the Year 1894.*

CAUSES.	The Admissions.			The Discharges.						The Deaths.		
				Recovered.			Removed, Relieved, or Otherwise.					
	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.
MORAL.												
Domestic Trouble (including Loss of Relatives)	2	2	4	1	1	2	0	1	1	0	2	2
Adverse Circumstances (including Business Anxieties and Pecuniary Difficulties)	4	9	13	1	6	7	0	0	0	2	0	2
Mental Anxiety and Worry (not included under the above two heads) and Overwork	1	4	5	2	1	3	0	0	0	0	2	2
Religious Excitement	5	2	7	2	2	4	0	0	0	0	0	0
Love Affairs (including Seduction)	0	3	3	0	4	4	0	0	0	0	1	1
Fright and Nervous Shock	0	1	1	0	1	1	0	0	0	0	0	0
PHYSICAL.												
Hereditary Influence	9	18	27	2	8	10	2	1	3	1	6	7
General Paralysis	8	0	8	0	0	0	1	0	1	9	1	10
Epilepsy	4	5	9	2	0	2	1	1	2	7	4	11
Other Forms of Brain Disorganization	0	1	1	0	0	0	0	0	0	0	0	0
Intemperance in Drink	18	3	21	8	2	10	0	0	0	0	0	0
Puerperal Condition	0	9	9	0	4	4	0	0	0	5	2	7
Other Causes and Old Age	9	11	20	0	0	0	1	1	2	4	9	13
Privation and Ill Health	17	8	25	7	8	15	5	0	5	2	4	6
Unknown	21	1	22	0	1	1	0	0	0	31	31	62
Total	98	77	175	25	38	63	10	4	14	31	31	62

the Admissions,

BRO 35510, 'Visiting Committee Report' 1894, 23.

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