CHAPTER 5

‘The Evil Effects of Mental Strain and Overwork’: Employment, Gender and Insanity

In 1875, an article penned by eminent Irish asylum doctor, Dr. Frederick MacCabe, appeared in the *Journal of Mental Science*.[1] In this piece, MacCabe considered the rising levels of mental strain young men were suffering due to overwork. He claimed that in this period, more than any other, young men were compelled to study more rigorously for examinations, following which they met with greater competition and pressures in their chosen professions. Among those most at risk he counted the commercial, official, professional and literary classes. MacCabe was writing in a period of relative prosperity in Ireland. Had he conceived of his article just a few years later, he might have emphasised the mental strain produced by an economic depression that began in 1879 and endured until the mid-1890s. By then, esteemed medical commentators including Daniel Hack Tuke and Thomas Drapes both linked the extreme poverty of the Irish population to high levels of mental illness.[2] As this chapter argues, while fear of poverty afflicted the rural poor during this era, anxieties about employment and the state of the economy were seen to affect other social groups.

Drapes and Tuke were not alone in relating economic factors to insanity. Labouring men committed to the Hanwell asylum in Middlesex between 1845 and 1850 were considered anxious about their economic future, suffering intense fears of poverty.[3] These patients’ fears were not emphasised in social commentary or psychiatric literature but rather by their families who named them as major causes for their insanity.[4] Following the Great Famine, Irish psychiatric thought had clearly begun

A. Mauger, *The Cost of Insanity in Nineteenth-Century Ireland*, Mental Health in Historical Perspective,
https://doi.org/10.1007/978-3-319-65244-3_5

to embrace these lay associations. In the south-east of Ireland, certifying medical officers for district asylum patients often cited fear of poverty, anxiety caused by unemployment and changed circumstances as causes of mental illness, based on evidence that family members had supplied to them. Fears such as these were thought to have a detrimental impact on patients' minds.[5]

Yet, historians of psychiatry have been curiously reluctant to emphasise medically recognised links between employment and illness in fee-paying asylum patients. In her comparison of the causes doctors assigned to York Retreat patients between 1796 and 1823 and 1874 and 1892, Digby found a tenfold rise in 'overwork' or 'over study' and a concurrent rise in 'business and money anxiety'. Despite these stark indicators of a growing reliance on work-related aetiologies, Digby has cautioned against the temptation to interpret this rise as reflecting the shift from the romantic age to the 'competitive problems associated with living in a mature capitalist economy afflicted with economic depression'. Instead, she infers that her 'fragile data' indicate 'a greater readiness to specify immediately observable features' in everyday life.[6] In contrast, this chapter argues that asylum doctors' recognition of certain life events and circumstances as causal factors of mental illness reveals much about contemporary psychiatric associations between employment, economic shifts and mental illness. Digby's findings might therefore be reinterpreted to reflect an increasing movement towards more 'psychological' understandings of mental illness.

In a similar vein, MacKenzie, in her study of Ticehurst private asylum, has argued that, between 1845 and 1915, asylum doctors assigned the causes of anxiety and overwork as 'sympathetic alternatives' to alcohol, based on her observation that some patients attributed these causes were heavy drinkers. According to MacKenzie, the reasoning behind this rested in the Ticehurst proprietors' sensitivity to families' perceptions of what had caused the mental disorder, which they largely echoed.[7] The frequent identification of alcohol as a cause of mental illness in Ireland reveals that asylum doctors there did not mirror this approach. Moreover, neither Digby nor MacKenzie have apparently made room for the possibility that families, and even patients, cited work-related or financial anxieties because they believed they had directly precipitated illness. In fact, patients and their families often reported that the pressures of employment and other economic factors were to blame. Professional opinion could outweigh these lay considerations, however, and this

study has yielded no evidence that relatives dictated to the doctors who assigned causes and diagnoses.

Importantly, both medical and lay commentators tended to link employment and mental illness primarily for male patients, with medical officers characterising male anxieties as a failure to fulfil gendered economic roles.[8] However, working-class women were not immune to being assigned financial or work-related strain. In early Victorian England, employment was central to the identities of poor women and lack of work was sometimes attributed to their mental illness, by medical practitioners and patients alike.[9] In Ireland, women's anxieties about poverty were also aligned with 'maintaining appropriate standards of female respectability'.[10] As Chap. 4 discussed, a high proportion of the women in this study did not work outside the home—a trend which increased in proportion to social status or wealth. Yet, women who remained at home played an important role in contributing to the family economy.[11] Moreover, a smaller section of women in this study did engage in paid work, while others were property owners. In spite of this, medical aetiologies of wealthier women's illnesses did not tend to hinge on their economic functions in any obvious way. Instead, they focused on domestic circumstances. While the illness of wealthier women in British asylums was also unlikely to be attributed to work-related or financial concerns, several scholars have emphasised the links drawn between women's reproductive functions and mental breakdown in contemporary psychiatric literature.[12] As Suzuki has argued, 'Victorian middle-class women had hysteria as the disease that symbolised their place in the separate spheres'.[13] As will be shown, in Ireland, female non-pauper insanity was attributed to a myriad of factors, the majority of which did not hinge on their biological functions.

This chapter explores the causes assigned to paying patients in the selected asylums. 'Cause of insanity' was recorded in the admissions registers for all the asylums studied except Hampstead and Highfield. Analysis of these returns is supplemented by a survey of asylum doctors' casebooks, which cast further light on psychiatric definitions. Lay interpretations are also present in the case notes, where medical personnel recorded information supplied by families, friends and patients.[14] In addition, letters written by patients' friends and relatives provide indications of lay understandings.

Medical Aetiologies

It is often challenging to separate lay and medical definitions of mental illness. As we have seen, paying patients committed to asylums required two medical certificates. These forms allowed certifying doctors to record causes of illness and were later transcribed into admissions registers and casebooks, where asylum doctors could choose to confirm or alter the causes assigned.[15] Medical rather than lay authorities therefore usually had the final say over what was recorded.

Late nineteenth-century asylum doctors distinguished between moral and physical causes of insanity. Moral causes encompassed a range of 'psychological' factors such as grief, bereavement, business or money anxieties, religion and 'domestic trouble', and reveal much about perceptions of the life events or circumstances leading to mental illness. Physical causes, including accidents and injuries, physical illnesses, 'hereditary' and 'alcohol' are less instructive. Physical causes were accorded a pivotal space in the psychiatric discourse of this era, emulating widely held medical theories about the physical nature of mental illness. Asylum doctors in Ireland frequently cited alcohol and 'hereditary' as pathologies closely associated with theories of degeneration.[16] This bias towards commonly accepted causes obscures, to some extent, psychiatry's recognition of the 'psychological' causes of mental illness. It is therefore important to explore both explanations to gain a full understanding of the various frameworks embraced.[17]

As shown in Table 5.1, physical causes were more frequently reported for patients in this study. Among them 'hereditary' and 'alcohol' were

Table 5.1 Supposed cause of illness of first admissions to the case studies, 1868–1900

	Female						*Male*					
Asylum	Both	(%)	Moral	(%)	Physical	(%)	Both	(%)	Moral	(%)	Physical	(%)
District asylums	8	4.0	48	24.2	142	71.7	7	2.4	48	16.8	231	80.8
Bloomfield	0	0.0	4	30.8	9	69.2	0	0.0	4	50.0	4	50.0
Stewarts	5	3.9	11	8.6	112	87.5	0	0.0	9	9.6	85	90.4
St John of God's	N/A	N/A	N/A	N/A	N/A	N/A	5	1.9	72	26.7	193	71.5
Total	13	3.8	63	18.9	263	77.3	12	1.8	133	20.2	513	78.0

Compiled from Belfast, Ennis, Enniscorthy, Richmond, Stewarts, Bloomfield and St John of God's admissions registers

the most often named (Table 5.2). For those assigned physical causes, 'alcohol' accounted for 43% of men and 11.2% of women admitted. This high rate of alcohol-related admissions differs from Britain. While alcohol was recognised as a factor in the admission of private patients to Dundee Royal Hospital in Scotland, it was usually associated with the working classes.[18] Alcohol abuse was also less often identified as a symptom in English private asylum patients.[19] In contrast, of the paying patients assigned physical causes in this study, those committed to private asylums were actually more likely (54.8%) than those sent to voluntary (17.7%) or district (19%) asylums to be assigned alcohol. This suggests that alcohol had especially 'Irish' associations. Certainly, during the nineteenth century, the Irish reputation for drunkenness was publicised by English caricaturists to the extent that, according to Malcolm, 'in the English eyes, the Irish became violent, cruel and drunken'.[20] While Irish spirit consumption rose in the late 1860s and early 1870s, from 1850 temperance activities resulted in more censorious attitudes towards drunkenness, restricted opportunities for heavy drinking, and more facilities for sober recreation and entertainment.[21]

The influx of alcohol-related admissions to Irish asylums provoked comment from medical superintendents who observed and contemplated the nature of their patients' inebriety. In England, the decline in alcohol consumption between the 1820s and 1870s has been attributed to several factors including the medical community's increased hostility towards drink and their reluctance to prescribe it as a medicine.[22] It is

Table 5.2 Physical and moral causes by gender most commonly assigned to first admissions to the case studies, 1868–1900[a]

	Male	*Male (%)*	*Female*	*Female (%)*
(%) Physical				
Alcohol	226	43.0	31	11.2
Hereditary	148	28.2	145	52.5
Biological	0	0	35	12.7
(%) Moral				
Work/Finance	64	44.1	5	6.6
Domestic	11	7.6	17	22.4
Religion	8	5.5	6	7.9
Bereavement/Grief	7	4.8	13	17.1

Compiled from Belfast, Ennis, Enniscorthy, Richmond, Stewarts, Bloomfield and St John of God's admissions registers ([a]In cases where patients were assigned multiple causes, both are included in this analysis in order to illustrate their statistical significance)

plausible that the Irish psychiatric profession shared their English colleagues' hostility.[23] Certainly, in 1904 Drapes expressed his frustration at the repeated readmission of habitual drunkards to Enniscorthy district asylum, going so far as to blame excessive drunkenness in Wexford for an increase in insanity there.[24] While Drapes was probably commenting on his pauper patients, he evidently did not regard paying patients as being above reproach. This is seen in the case studies. Contrary to Drapes' statement concerning repeat admissions, only thirty-eight patients readmitted to the asylums studied were assigned the cause of alcohol. As Finnane has contended, 'since the insanity of a drunkard was questionable, his or her state when not drunk rarely justified long detention'.[25] For those assigned 'alcohol' whose length of stay is known, almost three-quarters remained in the asylum for less than one year. Notably, among those assigned physical causes, alcohol was most commonly attributed to Enniscorthy paying patients (24.5%) compared with those in Ennis (12.1%) and Belfast (6.8%). This implies that Drapes was particularly inclined towards this framework, which is unsurprising given his keen interest in temperance activities.[26] Nevertheless, there is little doubt that accommodating the 'drunken' was very much a role for all types of Irish asylums by the late nineteenth century.

Cox and Finnane have identified alcohol's prominence in the aetiologies of district asylum patients in Ireland. For example, between 1832 and 1922 drink accounted for the illness of 12.7% of patients admitted to the Carlow asylum.[27] Both historians have highlighted the absence of inebriate reformatories or retreats in the nineteenth century, suggesting that, in their stead, district asylums became the principal receptacle for this group.[28] This argument would go some way towards explaining the high proportion of drink-related admissions among paying patients in district asylums. It does not, however, account for the even greater percentage admitted to voluntary and private asylums. One explanation lies in class-specific, medical conceptions of 'drunkenness'. In 1875, the lunacy inspectors, discussing the feasibility of establishing 'receptacles for dipsomaniacs', argued that drunkenness among the 'lower orders without social position or means' was treated as an offence or misdemeanour, while among the 'better and richer classes' it tended to be perceived as an 'incipient malady'.[29] For the rich, then, a tendency to overindulge in drink may have been treated more as an illness than an offence.

As historians of British psychiatry have observed, certifying physicians were more reluctant to assign 'hereditary' as a cause of illness to

'upper-class and aristocratic patients'.[30] This hesitancy is also visible in this study. 'Hereditary' accounted for only 7.2% of assigned physical causes for St John of God's patients and 0.3% for Bloomfield patients, compared with 53.9% for paying patients sent to district asylums and 38.6% to Stewarts. This hints at the influence of patients' social status. Degeneracy was largely characterised as a working-class problem, bound up in the belief that the labour value of future workers would be jeopardised by the reproduction and amplification of the degenerative effects of the urban, industrial life over the generations.[31] By the late nineteenth century, commentators were emphasising the impending social uselessness of the poor and destitute.[32] An institution's religious ethos also had implications for the cause of illness attributed. The exceptionally low proportion of Bloomfield patients assigned 'hereditary' is in keeping with Digby's contention that the managers of the York Retreat were particularly sensitive to this label because of high rates of inter-marriage between members of the Society of Friends.[33] Patients' gender, too, was a determinant. 'Hereditary' was cited in 52.5% of women assigned a physical cause compared with only 28.2% of men.

Naturally, causes related to the reproductive cycle, here termed 'biological', were assigned exclusively to women in this study. These causes included 'menstrual', 'child birth', 'puerperal' and 'menopause'. In the British context, Digby has argued that both lay and medical interpretations of Victorian middle-class women's mental illness centred on biological models.[34] However, Levine-Clark has suggested that biological symptoms and diagnoses were more often applied to middle-class women, while working-class and pauper women were assigned alternative causative factors.[35] Yet, in this study, biological causes were not necessarily assigned to women considered higher in social ranking. For instance, while 11.4% of physical symptoms assigned to women admitted to Stewarts were biological, one-fifth of female paying patients in the Belfast district asylum were similarly described. Furthermore, none of the physical causes attributed to Bloomfield's middle- and upper-class female patients concerned their reproductive system, suggesting that some certifying physicians accepted biological aetiologies more than others did.

The high proportion of paying patients assigned physical causes reveals that Irish asylum doctors framed much of the illness they observed in these terms. However, subtle differences between aetiological trends for Irish and British non-pauper patients suggest that these causes were not routinely class- or gender-specific. Although the Irish

psychiatric profession had strong professional ties with its British counterpart, including several Irish members of the Medico-Psychological Association[36] and Irish participation in the *Journal of Mental Science*, Irish asylum doctors did deviate from the frameworks of their British colleagues. While, as Cox has demonstrated, Irish asylum doctors' explanations for the alleged increase of insanity in Ireland were mostly in line with the British and European intellectual climate, they clearly also drew upon their own personal and cultural understandings of their patient populations.[37] These cultural influences are evident in a heavier reliance on alcohol-related aetiologies in the Irish context. They are also particularly visible in the moral causes assigned, revealing that asylum doctors recognised not only the commonly held physical explanations of insanity, but also the complex socio-economic and personal circumstances which could affect mental health.

Table 5.2 details the most common moral causes assigned to patients in this study. For men, 44.1% of moral causes were work/finance-related. This category covered wide-ranging factors including overwork and over-study, business worry, anxiety, disappointment and trouble, business and money losses and want of employment, and were more often assigned in urban case studies. While, to some extent, the high proportion of work/finance-related causes might reflect a bias in the case studies in that the majority were Dublin-based asylums, as Chap. 4 discussed, half of the patients admitted to the voluntary and private asylums were not from Dublin. Nonetheless, among male patients in this study, all of the assigned moral causes at Bloomfield were work/finance-related ones, compared with only 12.5% in Enniscorthy and 30% in Ennis. Belfast was also particularly high at 64.3%, followed by Stewarts at 55.6%, revealing that business and finance-related aetiologies were seen to affect a wide socio-economic spectrum, particularly for those in urban contexts.

Women were far more frequently assigned 'domestic' causes, rather than work/finance related ones. These included domestic trouble, domestic trials, family affairs, family trouble and private trouble and situated woman snugly within the confines of the domestic sphere. Related causes were grief or bereavement of a family member which had reportedly affected women (17.1% of moral causes) more than men (4.8% of moral causes). The higher proportion of women assigned 'domestic' aetiologies (22.4% of moral causes) compared with men (7.6% of moral causes) reveals that these causes were gendered. Notably, almost one-third of these women were either farmers or had a designated occupation

recorded. As will be shown, even when women exhibited anxieties about their businesses or financial concerns, these were rarely attributed as causes of their illness.

To what extent, then, did patients' socio-economic background shape the identification of their illness? Robert A. Houston has argued that social position was an important determinant and this argument holds equally true for Ireland.[38] Patients' former occupation also influenced the causes attributed to their mental illness, particularly for male patients. Of those assigned moral causes, students were most often assigned 'over study' (80%), while more than three-fifths of those in trade, law or medicine were assigned work/finance-related causes. Among physical causes, alcohol was most commonly assigned to policemen (59.1%), clergymen (56.7%) and those in trade (55.4%). Alcohol was also believed to have caused the illness of six out of the seven publicans in this study, in keeping with Finnane's contention that a publican's occupation was perceived as a constant source of temptation.[39]

While we have seen that a myriad of medical and socio-cultural factors, including attitudes towards alcohol consumption, degeneration, gender and social class, influenced asylum doctors attributing causes, the opinions of patients and their relatives are obscured. The following sections explore medical case notes and the correspondence of patients' relatives and friends to gain a more nuanced appreciation of the lay and medical explanations of mental illness. These sections also examine the interactions between patients and their relatives and friends in accounting for the onset of their illness.

Urban Economies

During the 1840s, the proprietor of Hampstead House, Dr. John Eustace II, kept a casebook on patients admitted to his private asylum. Although his notetaking coincided with the Great Famine, Eustace did not refer to this cataclysmic event nor to any financial hardship afflicting the patients he described.[40] The most plausible reason for this omission is that Hampstead patients tended to be comfortable or wealthy Dubliners, for whom the consequences of the Famine were less devastating than for other social groups. Eustace's case notes do, however, set the stage for several other themes which emerge strongly in later casebooks for Enniscorthy, Richmond, Stewarts, Bloomfield, St John of

God's, Hampstead and Highfield. These themes include overwork for men and domestic trouble for women.

Eustace's notes on his male patients are comparable, in some respects, to those compiled by asylum doctors writing in the 1890s. For instance, he wrote of one patient, a John H., that he had 'held a situation in a Brewery where his business required him to remain up all night' resulting in insanity.[41] By the 1890s, medical and lay associations between work and mental illness were more pronounced. Suzuki has found that clerks sent to Hanwell in the mid-nineteenth century suffered from fears of losing their positions.[42] In this study, between 1868 and 1900 the illness of eight out of the nineteen clerks assigned moral causes was ascribed in the admissions registers to similar anxieties. However, case notes compiled about clerks in the 1890s indicate that several more than this number cited work-related and financial anxieties. In addition to fearing loss of their position, some clerks also reportedly suffered from overwork, a cause that Suzuki has argued was usually monopolised by middle-class men and women in mid-nineteenth-century psychiatric discourses.[43]

Reporting physicians at Richmond were particularly inclined to associate clerks' working life with their illness during the 1890s. Admitted in 1900, James L., a bookkeeper and clerk, was diagnosed with acute melancholia and the assigned cause was unknown. The case notes, however, attributed his illness to 'hard work and study. Little games or amusement of any kind'. James also cited overwork as a cause, believing that 'he let himself get run down and work too hard' and blamed himself: 'thinks that if he had taken a holiday and rest he might have recovered without coming to the Asylum'. The pressures to excel in his profession had clearly taken their toll: 'I had regrets that I had not got on as well as I might have done—as I had intended to get on'. As a result, James feared the loss of his rank and respectability, stating that 'he had an idea that he was going to turn into a low class character and lose his situation—also feared that he might take to drink (though never drank in his life)'.[44] Although not a clerk, Thomas B., a melancholic army sergeant, also supposedly fell ill due to clerical responsibilities:

> a large amount of work, of an exceptionally worrying and responsible nature, including manipulation of stock to the value of £7000. For two months past this played on his mind, he made errors of calculation; unduly forgot things which he had just done, was very much worried by

> this, feeling that his mind was breaking down, contemplated suicide very frequently.[45]

Financial worries continued to trouble Thomas, who later told the medical officer that 'the prospect of his return to his family with only his pension for support, and his inability to increase the monies by any effort of his causes great depression'.[46]

These cases mirror the arguments put forward by MacCabe in his 1875 article:

> In the competition of the present day the struggle of life is in itself a sufficient strain; and when we remember that, notwithstanding hard work, such a degree of success as would insure freedom from pecuniary care rarely comes to the young professional man, it is highly probable that the *res angusta domi* of the present, combined with the feeling of uncertainty as to the future, favours other conditions constituting a minor form of mental strain.[47]

MacCabe did not just cite competition as a cause of mental strain, but the nature of work itself:

> Sometimes, even with moderate success, if the work imposed is very constant, men of scrupulous temperament suffer from a feeling of morbid anxiety as to the proper discharge of their duties; they take their work too much to heart, and a distressing feeling of being unequal to their responsibilities is very liable to supervene, and to pass into a form of strain that is particularly difficult to deal with, and that occasionally deepens into a state of mind but little removed from melancholia.[48]

Both James L. and Thomas B. were apparently plagued with anxieties about their ability to discharge their duties properly. While the case notes suggest that asylum physicians often defined patients' identity in relation to their former occupation, they also imply that relatives and patients placed immense importance on the capacity to work.

Other work-related factors were also said to take their toll. Suzuki has found that patients and relatives expressed resentment or anger towards their employers. He ties this to a working-class 'resentment of aristocratic frivolity' as labouring men were seen to be overworked with little regard for their physical or mental health.[49] Richmond paying patients also became embittered with their former employers, although these

instances resulted from job loss rather than perceived exploitation, most likely reflecting better working conditions for the social cohorts examined in this study. Joseph Patrick O'B., admitted to Richmond in 1891, had worked as an Inland Revenue clerk in London and then Donegal. Following four consecutive periods of three months' leave, he was dismissed permanently, an episode which:

> affected him a good deal: At home he is always 'abstracted', will do nothing and has turned against every member of his own family: full of delusions of conspiracy against him on the part of the Inland Revenue Board, his family and 'others' whose identity appears to be indefinite.

Joseph Patrick's disillusionment with the Inland Revenue was so marked that he apparently refused to accept the pension he was offered 'as he said he had a right to stay on in the office'. Whether this pension was applied to his maintenance is impossible to ascertain, although his fees were £20, suggesting that either Joseph Patrick or his relatives had some source of disposable income.[50] Edward S., who had previously worked as a commercial traveller, was also committed to Richmond in 1891. Edward had allegedly been 'an industrious, anxious man generally sober but now and again indulging in "spirits"'. In consequence, Edward's employer had been obliged to dismiss him on more than one occasion but repeatedly reinstated him in periods of recovery due to his 'business capacity'. Ultimately, Edward was dismissed and:

> this affected his spirits, and the depression this set off was markedly increased when he failed to get any employment. He then developed such active symptoms that he was confined in Dr Patton's private asylum [Farnham House].

Edward's eventual transfer to Richmond from a more expensive private asylum implies a descent down the social scale. While in Richmond, Edward was maintained at £27 per annum, though he died in the asylum six months after admission.[51]

The Richmond case notes also record the anxieties of those who had failed to excel in a professional capacity. Edward K., the son of an architect, was committed in 1892. Prior to admission, he had secured employment as solicitor's clerk. However:

> his constant mistakes… led to his discharge after about 2 years, and he was then without employment for a considerable time. When he again took work, this time in another solicitor's office – he failed to give satisfaction, and left his occupation after a row with his employer. Since this time, about 12 months ago – he has been without work, nor has he sought any.[52]

A more bizarre manifestation of professional failure was David Charles S., who was admitted to Richmond in 1898. As a student, David Charles had been removed from his university due to his 'dislike of the hats of the professors. Whenever he found one lying about he would hide it'. Following this, David was appointed as clerk in the Railway Office. However, after about two years he was discharged for 'irregularity in his work'. This apparently constituted doing 'anything other clerks told him to do such as standing on his head or going on foolishly'.[53]

White-collar professionals in voluntary asylums were also identified as having fallen ill due to their working conditions. In 1891, Joseph McC, a railway clerk, was noted on admission to Bloomfield to have had 'long hours and irregular meals'. After just four months, Joseph was discharged 'cured' and clearly deemed capable of resuming his occupation: 'left and is to return to business. Is quite well'.[54] An inability to work was an important determinant for a patient's admission. As Houston has found, the alleged incapable were judged according to their ability to carry out the tasks required of their occupation or their station in life.[55] The same can be said for patients in this study, for whom such incapacity was perceived as evidence of mental illness. For example, Stewarts patient and former office clerk, Thomas McD B., was admitted in 1889 after he 'became listless and would not occupy himself and was dismissed'.[56] In 1896, another clerk, George J., was admitted to Stewarts after he 'became "odd" in manner, fearful of having made mistakes in his books'.[57]

In addition to those recorded as being unable to work properly, during the last decade of the nineteenth century, several Stewarts patients were admitted expressing business anxieties. Richard M., a tailor, had reportedly been 'brooding over business affairs, cannot settle his mind to any employment although heretofore was a very busy man doing a large trade'.[58] Grocer, Charles Alfred M's mental illness was 'said to be induced by adversity in business'.[59] Finally, Eli S., a single, Jewish, dental mechanic was admitted to Stewarts suffering from mania. The 'supposed

cause' in the admissions register was business disappointment and, in the case notes, business worry. Eli had reportedly been 'bad for about 10 weeks' having 'taken into business with another man in Limerick as dentist and as the partnership turned out a failure he lost all the money he had'.[60]

In their discussion of work and recreation in the Norfolk Lunatic Asylum, Steven Cherry and Roger Munting have emphasised the importance placed on rehabilitation and self-reliance in the outside world.[61] In the Irish context, Cox has found that capacity or willingness to work could predicate a patient's discharge from the asylum.[62] In this study, ability to return to work was generally seen as a sign of recovery. The progress of Joshua L.W., a twenty-two-year-old clerk admitted to Bloomfield in 1895 was clearly measured against his ability to resume employment: 'says he is not well enough to think of leaving or doing any business. Mopes about most of the day'.[63] Similarly, Frederick James H. was first admitted to Stewarts in June 1899, at which point his occupation was recorded as being a mercantile clerk and the cause of his disorder as 'alcohol'. While at Stewarts, Frederick James was eager to return to work. One evening he informed the medical superintendent, Frederick E Rainsford, 'he was off as he had to do stock taking' and the following day urged the doctor to consider that 'Findlater & Co. could not get on without him'. The following month he was allowed home on thirty days' leave of absence, after which he was discharged recovered in October 1899.[64] However, in February 1900, Stewarts readmitted Frederick James, now recorded as a bookkeeper. Rainsford wrote that 'since his discharge has kept well and able to attend to business. Says that he was at work up to Monday Feb 19th but he was latterly making mistakes in his books & could not put them right so that on that date his master sent him home'. Frederick James' inability to perform his job seemingly upset him and his difficulties continued at home. The case notes continued:

> He is now apparently in a state of active melancholia. Laments his fate. Trembles and weeps. Says he will never be well again and that he is greatly to be pitied. Says his wife treated him badly and that he has not seen her for months.[65]

Frederick was again discharged cured after just two months in Stewarts.[66]

There is no record that either private asylum patients or their relatives cited economic failure as a cause of illness. Nevertheless, employment was seen as an important part of their identity and many allegedly evinced an eagerness to resume employment. For instance, Thomas M., a priest admitted to St John of God's in 1899, reportedly 'never ceases to be highly indignant at his enforced detention here, claiming he is still perfectly well able to earn his living if only granted his liberty'.[67] The reporting physician, P.O'Connell, placed emphasis on patients' desire or ability to resume employment. In 1885, he wrote of one patient: 'he is now 20 years away from business and evinces no anxiety to return to business. Does this indicate weak-mindedness?'[68] Securing employment after discharge, meanwhile, was viewed as a justification for discharge.[69] In 1900, O'Connell wrote of another patient: 'he is well recovered. A situation has been secured for him'.[70]

Hampstead patients were less inclined to cite work or financial pressures as a cause of illness, or to be attributed these causes. This complicates Houston's findings concerning wealthy madmen in eighteenth-century Scotland, whose mental health was judged according to their capacity to conduct their affairs.[71] One exception to this was George C., a married grocer admitted to Hampstead in 1892, who repeatedly spoke to John Neilson Eustace about his business anxieties:

> He began to refuse food, said he was 'the ruin of his family' 'had ruined the business', was 'bankrupt'. He threatened suicide but said he had 'not sufficient courage' 'shd have performed the act long ago' 'was not half a man' & c. 'His people would all soon' be dead & c … Refers chiefly to financial affairs 'that he is bankrupt', 'has destroyed or will destroy thousands of people', he 'has been an awful fool & sh. have killed himself long ago & c'.[72]

George's characterisation of his business failures highlights his anxieties about his status as a breadwinner and, in turn, his masculinity. Suzuki has identified similar anxieties among mid-nineteenth-century London labourers, where male heads of households crumbled under the pressure to provide a stable income for their families. Cox has corroborated Suzuki's findings that 'medical officers attributed male anxiety at failing to fulfil gendered economic roles as causes of insanity' such as being able to provide for their families. However, while Suzuki has argued that new working-class notions of manhood were a factor behind 'anxiety-driven

cases of madness' and both Cox and Suzuki have focused primarily on pauper asylum populations,[73] it is clear that conditions of employment could also trouble wealthier business owners. In his case notes, Eustace recorded the cause of George's illness as 'business and domestic trouble', suggesting that he too believed these factors were responsible for George's breakdown. Although in this study there is little record of wealthier businessmen overtly citing failure to provide for their families as a source of anxiety, these sentiments may have been generally understood or accepted. Certainly, while anxieties concerning the pressure to remain economically productive were evident among the poor, MacCabe highlighted these anxieties among the wealthier classes in language couched in social Darwinism:

> It is true that in this contest for civil employment and professional preeminence the 'survival of the fittest' may possibly result; but the struggle itself is, I believe, attended with such serious risk to the mental integrity of the competitors that it occurs to me as not inopportune for this [Medico-Psychological] Association to raise a warning voice against the evil effects of mental strain and overwork.[74]

At least for male urban populations, evidence exists that there was a very real danger of mental breakdown resulting in committal when an individual could no longer function in an occupational capacity. The comparatively predominant discussions of work and finance in the Richmond and Stewarts case notes suggests that these anxieties were greater, or at least perceived by asylum physicians as being so, for those lower down the social scale. Patients maintained at lower rates of maintenance were more likely to have experienced financial difficulties. It is also plausible that Stewarts' 'middle-class' patient population and white-collar workers in district asylums, anxious to assert their respectability, drew their identity at least in part from their occupations and financial prowess. Reporting physicians from similar social backgrounds to these patients probably shared these sentiments. As Suzuki has pointed out, middle-class doctors sympathised with their social peers in their characterisation of them as 'too sincere followers of a rigorous work ethic'.[75] MacCabe's emphasis on the wealthy suggests the existence of comparable sympathies in the Irish context.

Rural Economies

Fears about livelihood and economic productivity were by no means exclusive to urban communities. In rural populations, tensions existed between familial loyalty, marriage and business interests. Many Irish paying patients came from apparently loving familial and spousal relationships. However, these relationships often eroded when land and property interests were at stake. This conforms to commonly held representations of rural Ireland.[76] Although historians have emphasised the detrimental impact of issues such as the consolidation of landholdings, emigration, land hunger and Famine memories on emotional familial bonds, which produced families that were 'devoid of emotional gratification', Cox has identified a 'range of familial emotional contexts' among those committed to Enniscorthy and Carlow asylums. This broadly corresponds with Guinnane's contention that rural Irish families shared a strong sense of familial obligation, which extended to encompass celibate farmers.[77] Likewise, Oonagh Walsh has demonstrated that at Ballinasloe, families sent letters, querying treatment, offering advice and enclosing food and money for patients.[78] In the English context, Melling and Forsythe have noted that the families of pauper patients in Devon frequently visited and demonstrated intense anxiety about their treatment, while MacKenzie has provided a comparable characterisation of the relatives of upper-class and aristocratic patients admitted to Ticehurst.[79]

The complexity of rural familial relations is particularly visible among the property and business owners in the Enniscorthy asylum. Despite the disproportionate number of single and widowed paying patients, the themes of love and marriage remain dominant in the case notes, providing insight into contemporary concerns regarding courtship and marriage among the non-pauper mentally ill. Intimately linked with these concerns are issues of property and financial gain, which also played a decisive role in family relationships and the experience of mental illness. The case of John D. is exemplary. Aged seventy-seven, John was admitted to Enniscorthy in 1891 with 'senile insanity'. Reportedly a 'healthy old man', his personal history was provided by his two sons. The first symptoms noticed were that he 'wanted to marry a girl of 20, who was a servant to him':

> Says if he doesn't marry her his soul is lost and that he'll burn in hell … he is very supple and has often tried to take away across the country to get to

> this girl … Son says he won't allow bedclothes to be changed or bed made since the girl left, as he says no one can make it but her.[80]

While in the asylum, the girl visited John in the guise of his niece. Following this, the patient's sons instructed the medical superintendent to prevent any further communication between the girl and their father. They were very much against John's planned marriage, stating that 'she and her family are a designing lot and that they all encourage her to get him to marry her'. One son informed Drapes that 'it is his opinion that his father would have married "anything in petticoats" for the past two years or so'. Allegedly, the girls he proposed to were 'not at all suitable, and "streelish" in appearance and habits'.[81]

Underlying this narrative were anxieties about John's property. A farmer and a shopkeeper, John certainly had some degree of wealth. His maintenance was £18 per annum and, while in the asylum, he presented Drapes with a further £16 'to keep for him'. On one visit, John's son stated that 'latterly he was not capable of properly doing business in his shop' and elaborated with a description of the confusion this caused among the customers. This portrayal is in keeping with that of the urban professionals and white-collar workers, outlined above. It also supports Houston's findings concerning the social construction of madness in eighteenth-century Scotland.[82] John's sons' motivations for having him committed, however, became apparent when the patient later informed Drapes that 'he gave his sons up his land, but wished to retain his shop himself and get a wife to mind it for him'. John also provided what Drapes termed a 'rational explanation' regarding his romance with the servant girl:

> the girl had been so spoken of in connection with him that her character had suffered, and that if he did not make her the only reparation he could by marrying her, he would suffer in the next world.[83]

Just two months after his committal, John was discharged. Drapes noted that this was 'greatly against the wishes of his sons, but I have not been able to find any distinct evidence of his insanity'. According to the census, by 1901, John, now aged eighty-seven, had married a woman of twenty-seven, possibly the servant girl.[84] However, ten years later his son resided at John's address with his own wife and six children, suggesting that he had ultimately inherited the property.[85] The most plausible

reason for this was that John's wife had not borne his children, which would have prevented her from being entitled to property rights following his death.[86]

This case is important in two respects. Firstly, it highlights contemporary fears among the public about the wrongful confinement of asylum patients for the pecuniary gain of their relatives. That John's sons professed to have committed their father to protect their family business is clear. Whether they actually feared for his mental state is less likely. Secondly, this case demonstrates that in instances where the asylum doctor identified wrongful committal by relatives, he could and would intervene.

Notably, while this case portrays the public's anticipated behaviour of relatively comfortable landed families, far more evidence can be gleaned of familial love and emotional bonds. For example, James S., a sixty-six-year-old farmer diagnosed with recurrent mania, informed Drapes: 'I cry all night for my wife and home'.[87] Fanny K., on the other hand, 'did not cry or seem affected at all parting with husband' when she was admitted.[88] The very fact that Drapes commented on Fanny's behaviour suggests that many other spouses did display an emotional reaction at being separated from their family upon committal to the asylum. Beveridge has found similar in the Scottish context, where patients committed to the Morningside asylum exhibited feelings of despair.[89] Like other patient populations, family visits also played an important role in the lives of paying patients in Enniscorthy and, to a lesser extent, Richmond.[90] The case notes for several paying patients at Enniscorthy recorded a visit from a least one relative.[91]

Letters from concerned relatives further corroborate the care and affection they exhibited. When Margaret K. was admitted to Enniscorthy as a paying patient, her husband informed Drapes that 'he would have sent her here long ago but her mother wouldn't allow it'. While she was in the asylum, Margaret's mother Sarah wrote the following letter to Drapes:

> I write to ask you how is my child Margaret K. Would you think if she was brought home the change might do her good or cheer her up. She wrote a letter to me a few weeks ago … The first of her trouble came on from torments this is why she got into a nervous state. I being ill at the time and not able to go to her she was left alone by herself and got into a low

> state… She asked me to send for her in the letter she wrote me. I sent it to her husband when I got it [sic].[92]

The 'child', a married woman of thirty, was discharged relieved within two months of the letter's receipt

Yet, in instances where property or business interests were at stake, these factors tended to eclipse those of familial devotion. Indeed, the high numbers of paying patients who had displayed an inability to control their business or function in their profession suggests that this was a major reason for committal. Oonagh Walsh has asserted that people in the west of Ireland would go to great lengths to secure property as it became a measure both of citizenship and stability.[93] Yet, with the exception of the case of John D., this study has revealed very little evidence to support this contention. While the extent to which John D. struggled in his shop is difficult to ascertain, it is conceivable that other relatives' claims regarding patients' incapacity to work were justified. In these instances, families may have viewed committal as a last resort to protect their resources or livelihood. This is especially true of paying patients in Enniscorthy, whose relatives would have little control over the actions or interactions of a lunatic positioned behind the shop counter or at a farmers' market. As Suzuki has maintained, families in England feared for the lunatic and his or her property as they would be 'easy prey to unscrupulous wretches' in the public sphere.[94] This implies that the extent to which wrongful committals occurred may have been exaggerated in the public imagination. As Walsh has argued, many patients with a 'genuine mental illness' accused their relatives of confining them for pecuniary gain.[95]

Again, mirroring Houston's findings concerning incapacity to work,[96] several paying patients were committed to Enniscorthy following an inability to conduct their affairs. James S., the man who had cried all night for his wife and home, was committed in 1897 because he

> Goes out at night and hunts his sheep by the light of a candle and insists on his wife coming with him … He often would go out in pouring rain, and stay about until his clothes were soaked. One night he stayed out (with her) … from 12 to 4am trying to drive sheep into a house they never were in before. Mrs S left him for a few minutes and went into the house thinking he might follow her, but he did not, and when she went out again she found him sitting in a pool of water.[97]

While in the asylum, James continually wrote to his wife enclosing small presents he had managed to appropriate in the asylum. Drapes listed the gifts he sent, which included 'a ball of yarn', 'a ball of twine', 'a broken head', 'thimbles', 'sweets' and 'tobacco'. Sadly, James was not reunited with his wife, but died in the asylum after a residence of four years, aged about seventy.[98]

Laurence D. was admitted in 1896 with chronic mania. The first symptoms noticed were 'sleeplessness' and 'no ability to manage his business'. Like James, Laurence had been 'a good business man in the first part of his career, but since he began to drink 6 years ago, has failed in capacity for doing any'. Laurence was a family man who clearly had affection for his children. In a letter to a neighbour, Laurence wrote, 'I wish you to inform me how my two dear children are'.[99] While in the asylum, Laurence repeatedly insisted upon his sanity and often asked Drapes to re-examine him. Laurence's incapacity, however, appeared to be legitimate:

> He had a mania for ordering goods far more than he wanted, then couldn't pay for them, so had to get brother's assistance and in this way was induced to sign this deed … Was very unmanageable at times: used to shut shop door and turn his family out in the street … Memory has been failing: often gave directions twice over, and would mark things in shop over again at prices below what they cost, and would go to customers and tell them they had been overcharged by his wife and brother … he accused [his wife] of 'stealing' goods out of the shop during his absence from home, at the time that his brother William was managing the business … Whereas wife states that she had a perfect right to take anything she required (clothes &c) for her own, or her children's use: and what he referred to was a piece of cashmere, some tablecloths and woollen and cotton goods which she took for that purpose.[100]

Laurence had managed his business up to three years before he was committed to Enniscorthy. Despite the alleged difficulties and even threats Laurence posed to the family business, it is striking that his relatives cared for him for three years prior to committal. When his family decided he was no longer capable of handling his affairs, a deed was drawn up handing management over to his brother, William. Following this, Laurence visited several solicitors in Dublin but failed to break the deed. When his brother died, his wife, Ellen, took up management of the business and, at the time of Laurence's committal, had been running the

shop for six months. Laurence took especial offence to this, complaining to Drapes that his business had been taken out of his hands and mismanaged by his wife. It is unlikely that Ellen would have adopted a managerial position had it not been for her husband's absence, in keeping with Cox's finding that mental illness could 'disrupt gendered domestic roles and boundaries' and place women in a position of authority in the household.[101]

In this case, Drapes favoured Laurence's family, and especially his wife. On admission, he was stated to have 'violently assaulted wife on several occasions'. However, Laurence 'denied having ever hurt his wife, but says he did strike her lightly with his foot across her legs, which he had every right legal or divine to do if she did wrong and that he considered she had acted very badly'. Based on his observation of an interview held in the asylum between Laurence, his wife and her brother, Drapes noted that the patient's manner toward her was 'nasty and overbearing, all through adopting the style of a cross-examining lawyer'. Drapes appeared shocked by his patient's behaviour:

> At commencement of interview his demeanour towards [brother-in-law] was similar to that towards wife, and in fact he began by ordering him out of the room peremptorily (probably thinking he could bully his wife more easily). This I did not allow. [The brother-in-law] impressed me as an honest, straightforward fellow, patient and good tempered and to have certainly not the slightest hostile feeling towards D: and before the interview was over (after wife had left the room, not feeling well) – D, although knowing that she has been subject to some internal painful affect, in speaking of it as 'that convenient pain that she gets' – the two men were conversing in a quite friendly manner, D calling him Willie and even joking and laughing.

Laurence was discharged on probation after just over a year's residence in the asylum. He was sent in the charge of an attendant to his family home as his wife 'would not send for him, and refused to be responsible for him'. Drapes noted that he had 'conducted himself sensibly here' and the Board ordered his discharge on probation 'on condition that he was not to touch drink, and not meddle with the business'. Drapes' interest in the case continued after discharge, noting four months later: 'heard he went to America and was found dead in his bed at an hotel: Death believed to be due to an overdose of whiskey'.[102] This appendage is

particularly grim, given the man's affectionate references to his daughters while in the asylum and it suggests that, although discharged, the former patient failed to put down roots following emigration. Four years later, Laurence's widow Ellen was listed in the census as a draper and 'head of family', living with one daughter and a draper's assistant, apprentice and manager. By 1911, Ellen had retired and lived with her two daughters who had both become governesses.[103]

In addition to tradesmen, several farmers admitted to Enniscorthy referred to the unfavourable state of their financial affairs. The first symptoms of illness noticed in Martin B, a cattle dealer, shopkeeper and farmer, were that he 'got notice to leave his home, took this to heart thinking he wouldn't get another'.[104] Fear of eviction or the state of one's farm reportedly dominated some patients' thoughts. Like female patients in Enniscorthy and neighbouring Carlow,[105] Marcella J. expressed severe anxieties regarding her status as a paying patient, becoming 'rather agitated now as a rule: thinks all her money is gone: that we are running up a big bill against her here which she will never be able to pay'. A few days later she got 'depressed and agitated: has no money: no use my writing a bill against her' until finally she became 'very agitated: keeps crying out: "I can't I can't: I've no money, no money at all"'. The primary cause for Marcella's apprehensions might be that, on admission, she had delusions that 'the cattle on the land have been burned'.[106] In the case of Francis R., who owned a farm of 110 acres, the economic hardships he experienced were attributed to his mental breakdown:

> He has been farming for past 10 years or so, but did not know very much about it as he lived at home up till then (father was sessional crown solicitor … now retired) … Found it hard enough … that it did not pay and added that was what sent him in here.[107]

It is therefore plausible that, for some, the impact of the agricultural hardship which continued into the early 1890s may have contributed to or been exacerbated by mental illness. Even later in the century, these issues were referred to. As late as 1899, 'the only cause' of illness that the sister of paying patient, Kate K., could give Drapes was that 'they lost a grass farm and this appeared to prey on her mind'.[108]

For landlords, excessive spending or even charity were viewed as indications of illness. John Neilson Eustace wrote of Henry O.B.:

> His philanthropy is excessive, some beggars in the village have their rents paid by him, all the children look to him for pence, a pedlar used to receive 2/6 a visit & was told by him not to come more than once a month. Needless to say, during the man's lifetime he came as often as he sd. An att who married & left for Australia asked for some money & was lent £80 & given £10. This appeared at the time & has since found (I believe) to be an exceedingly bad investment.[109]

Similarly, 'gentleman' patient, George Leslie K reportedly:

> gave away a great deal of property to his tenants & on the Lord Chancellor taking care of his estates he extorted money to the extent of £600 from his wife in order 'to buy more property for the poor tenants'. The money was kept in his trousers pocket & he always slept with this garment under his pillow.[110]

These narratives, most likely supplied by relatives, once again highlight the importance placed on land in rural communities. Like the paying patients admitted to Enniscorthy, failure to properly conduct property or business interests eclipsed family ties resulting in committal.

The influx of paying patients with property and business interests into district asylums like Enniscorthy supplied asylum doctors with new challenges. In many ways, the doctor was cast in the role of judge or mediator between family members, as they attempted to uncover the motivations behind individual committals.[111] Drapes appeared to embrace this role as he endeavoured to get to the bottom of complex familial conflicts. This could work in favour of the patient or the committing party, depending on the facts he accumulated, and did not appear to be gender-based. While many families exhibited affection and care for their mentally ill relatives, the outcome for patients who had ceased to conduct the family business efficiently was usually bleak.

Policemen, Violence and Alcohol

Like white-collar workers, another group whose conditions of employment were seen to affect their mental health negatively was members of the police force. The private lives of Royal Irish Constabulary (RIC) men were often subject to intense scrutiny, due to the wide-ranging codes of regulations imposed on them. When a policeman married, he was

forbidden from serving in his wife's native county, meaning that marriage was a major cause of transfer within the RIC.[112] Several policemen admitted to Enniscorthy as paying patients had been forced to live separately from their wives. In February 1895, William H., aged 36, married Margaret in Tipperary. Margaret remained there for five months before her husband asked her to join him in Enniscorthy. Their cohabitation was cut short just eleven days later when William's station was changed and 'he said there was no accommodation for her'. Enforced separation from a spouse was also assigned as a cause of illness, implying that at least a degree of spousal affection had existed. Bernard C., an RIC constable and paying patient at Enniscorthy had moved '2 years ago from Ballywilliam where his wife resides: felt this separation a good deal and attributes this state of his mind to this'.[113]

The pressures of a position in the RIC also affected the wives of policemen. When Anne McC. was admitted to Richmond in 1892, she said she had not seen her husband, a detective inspector in the RIC, for about ten years. Prior to this, she had travelled around with him before being committed to Stewarts asylum and eventually transferred to Richmond. Anne stated she did 'not know exactly who sent her here [Richmond], if her children, they must have been instigated to do so by the constabulary or the Lord Lieutenant'. She later reiterated that 'the constabulary must be the cause of all her suffering'.[114]

The personal histories of paying patients from the police force, sometimes admitted as dangerous lunatics, are characterised by violence and make for vibrant, although at times disturbing, accounts of the lives of mentally ill Irish policemen. During their short time together, William H. exhibited numerous signs of violence towards his new wife. On admission, it is recorded that he threatened to shoot her and 'once took a knife and made the movement of sharpening it, and when she asked him what he was doing that for he said, "oh, for business"'.[115] Perhaps more harrowing, however, is the case of Sergeant K. The sergeant, a forty-four-year-old married policeman, was admitted to Enniscorthy as a dangerous lunatic in April 1897, before being named a paying patient. The warrant stated that he had attempted 'to locate a revolver' with the intention of killing a bird 'that was annoying him', as well as threatening to shoot the head constable. When his wife, Mary Jane, a ladies' nurse in Dublin, came to visit him, he 'received her affectionately', kissed her and they walked in the grounds together. However, Mary Jane informed

Drapes of her husband's history of violence, from which he compiled the following:

> They are 17 years married. Was only 4 days married when he threatened to kill her. Before he was married he beat her when in drink. About 3 years ago wife spoke to him about the company he was keeping, and he tried to kill her with a hatchet … tried to smother wife 2 years ago in the night and she got up and left him finally … She has often to rush out of the house in her night-dress.[116]

Just four months after his admission, Sergeant K. was discharged 'recovered'. Yet, the family's relationship with the asylum and Drapes did not end there. A newspaper clipping from an unidentified source was appended to the case notes, detailing the man's disappearance. Sergeant K.'s whereabouts was eventually detected and his wife wrote to Drapes in desperation:

> Dear Sir,
>
> The old trouble has come to me again. What I am to do with my husband I do not know … On discharge he disappeared and for ages I knew nothing of him. Now he comes to the house and swears he will murder me … I dare not sleep at night fearing my life, the hatchet as his constant companion.[117]

In Richmond, policemen were frequently associated with violence. John K. reportedly 'took up a poker to his daughter', while the warrant for Edward B., a pensioner from the Dublin Metropolitan Police, stated that he 'did assault his wife'.[118] So apparently ingrained was violence among the police force, that police constable Peter C., who was not violent, believed he would never be fit to return to duty 'as any fighting or drunken row affects his nerves very much and "makes him all a tremor"'.[119]

The ties between policemen and violence are especially significant, given their role in law enforcement. However, the high social status afforded to this group was undermined by their unruly behaviour, causing public scandals and spectacles. Mary Jane K. was shocked by the erosion of her husband's social values and struggled to come to terms with her plight. The remainder of her letter to Drapes read: 'I gave him a good home and he had not anything to do except keep respectable,

live honestly and off he has gone … Pardon my troubling you so much. Yours, Nurse K.'

Recognition by asylum doctors of the high levels of violence these men displayed towards their wives complicates McCarthy's contention that 'male violence against women and children was hidden and condoned' by the state and that female victims of domestic violence were often committed to Enniscorthy in the early twentieth century.[120] In addition to violence, 'excess of alcohol' was frequently given as a cause of insanity for policemen in this study, as outlined above. Like other patients assigned this cause, policemen stayed for a relatively short period of time in the asylum; almost 70% were discharged before six months and 84.6% before twelve months. The case of Michael D., a thirty-five-year-old, single, RIC constable who was admitted to Enniscorthy in 1897 with *mania a potu* was typical:

> Seems always nervous, hands trembling and voice hesitating. Denied that he drank much, says the police are mostly blackguards and told lies of him … Admits he has a bad record in the police, but attributes it to false charges against him, and his nervous manner being attributed to drink.[121]

Michael was discharged recovered after just one month in the asylum. Seeing as several of the policemen who were dismissed from the force were allowed to re-join,[122] it is conceivable that patients in this study might be permitted to do so following recovery. Certainly, Sergeant K., who had been in the police force for twenty-five years when committed, told Drapes he was 'once punished for drink when he had been 8 years in the force but never since'.[123]

Women, Work and Domesticity

Links between conditions of employment and mental illness were far more tenuous for female patients in this study. Eustace II's notes on women admitted to Hampstead in the 1840s reveal an early medical alignment of women's mental illness with failure to fulfil domestic duties.[124] Anna Maria D. was admitted to Hampstead in 1845, after she 'became gloomy and reserved and neglected her husband and children, desiring to be alone'.[125] This behaviour continued while Anna Maria was at Hampstead and Eustace recorded: 'some of her family have called to see her, their visits have not improved her. She received them

unkindly'.[126] In the same year, Helen B., who railed 'very much against her husband & threatens him very much', was admitted with 'habitual intoxication'. Her husband informed Eustace that 'in consequence of her conduct to him he has not slept with her for two years'.[127] While commentary on a woman's failure to fulfil conjugal duties was obviously confined to married women, single women were expected to behave appropriately towards family members, especially when they relied on them for financial support. Refusal to do so was also viewed as a sign of illness. In 1846, Eustace II reported that Florinda C.'s monomania was 'manifested in the most violent dislike to her brother where kindness to her had been for years her almost sole support'.[128] Almost half a century later, Drapes wrote of Catherine S., a paying patient in Enniscorthy: 'husband states that her mind began to be affected about ? months. Has done no work in the house since then (except a little knitting)'.[129]

As Chap. 3 discussed, the relatives of Ennis patients who were called upon to contribute towards maintenance frequently referred to their straitened circumstances. Family friends, writing in support of these claims, also blamed female 'domestic trouble' for mental illness. In 1889, James Frost JP wrote to Gelston concerning the financial condition of a potential patient's husband:

> A neighbour of mine, Mrs G[-] of Ballymorris has become insane and she must be placed in the Lunatic Asylum. As to the capacity of her husband to pay for her while she remains an inmate, I would say it is very slight. He holds about thirty acres of land, and has a few cows, but he is up to his ears in debt. He owes two years rent, and I do not see him to possess any adequate means to meet the payment of it. For a long time past, he was not even able to pay the wages of a maid servant and his poor wife had to do all the work of the house besides taking care of the children.[130]

Richard Studdert, a governor of Ennis asylum, also wrote to Gelston concerning Mrs. G.:

> she seems to have been respectably brought up and educated and was doing well until a sad succession of misfortune came upon her – 5 of her 9 children having died within a few weeks, also her father in law at the same time a hitherto comfortable man became quite otherwise from reduced circumstances. All resulted in her going out of her mind.[131]

These representations succeeded in convincing the Ennis asylum board to admit Mrs. G. as a pauper patient.[132] Ten year later, a parish priest, James Cahir, wrote to Gelston about the financial affairs of another female patient, Mrs. K. According to Cahir, twenty-three years earlier, Mrs. K.'s husband:

> owing to money difficulties left his family and went to America where I believe he is still living although he never writes home. When he left, his stock was reduced to one cow and his poor wife in struggling to maintain herself and three young children was so worried by difficulties that she lost her senses and had to be sent to the Asylum leaving only one cow on the farm and rent in arrears.[133]

In this case payment was also 'remitted'.

These letters reveal lay interpretations of factors which precipitated female mental illness. Those writing in support of patients' families pinpointed financial decline resulting in increased housework, childcare, farming duties and family bereavement as the cause of their illness. These lay opinions differed from those asserted by Eustace II in the 1840s and Drapes in the 1890s; while failure to perform domestic duties was viewed as a *symptom* of mental illness by medical observers, increased domestic duties and 'domestic trouble' were characterised as a *cause* of illness in lay explanations.

'Domestic trouble' also reportedly featured for women in paid work. Several female patients admitted to Stewarts exhibited fears about their financial condition and their family businesses. Ann Elizabeth Ellen M. had allegedly 'suffered great domestic trouble thro' bankruptcy of her husband' and the cause of her illness was attributed to adverse circumstances.[134] Jane D., whose husband was a butcher with a shop on Moore Street in Dublin City, 'was associated with her husband … in business and as such was kept a good deal indoors … got very silent and fretted a good deal about business wh. was then dull. Slept badly'. The 'supposed cause' of Jane's illness was not 'business worry' but 'domestic bereavement', suggesting her role in the business was considered domestic rather than commercial. This was reflected in the admissions register, where her occupation was recorded as 'butcher's wife'. When she recovered, Jane's husband clearly appreciated that she needed a rest from the butcher's shop and took her home 'with a view to sending her to the seaside'.[135] Even when female patients had a designated

occupation, such as Eliza Jane K., a single woman and shopkeeper who was 'greatly concerned about money matters', or Elizabeth Jane M., a married draper, who had 'had great business anxiety thro' boycotting', business worry was not cited as a cause of their illness.[136] Instead, Eliza Jane was assigned no cause and Elizabeth Jane was assigned 'hereditary'. Disparities between male and female aetiologies most likely stem from contemporary attitudes towards women's work. From the mid-nineteenth century, official interpretations of productive labour shifted and influenced how women's occupations were enumerated in the census returns. By 1871, married women who worked with their husbands and single women who engaged with the family business were classified as being in domestic occupation.[137] It is plausible that asylum physicians were likewise inclined to characterise female business concerns as domestic rather than commercial.

Although not engaged in commercial work, women in wealthier households played a significant role in maintaining the household budget, deciding where to shop and seeking credit.[138] Accordingly, women committed to Highfield were sometimes measured against these functions. Like men who were deemed fit to resume employment, female paying patients who demonstrated an ability to resume domestic roles were seen as improved. John Neilson Eustace wrote of Margaret W., a sixty-year-old widow with no recorded occupation, 'she is a capable business woman & frequently goes into town shopping'.[139] Eustace clearly viewed Margaret's ability to shop as a sign of improvement. On the other hand, an inability to manage one's financial affairs could be viewed as evidence of insanity. Emily H., who was maintained at Stewarts at £50 per annum, was 'said to have had grandiose ideas and that she went into Arnotts [department store] and bought £40 worth of goods'.[140]

Conclusions

Historians have been curiously reluctant to emphasise the importance asylum doctors placed on patients' working life prior to committal and the potential this had to cause mental illness.[141] This chapter has argued that greater historiographical significance should be accorded to factors such as alcohol, employment, and financial and domestic troubles in the aetiologies attributed to fee-paying patients. In this study, both lay and medical commentators commonly recognised these factors as having triggered mental illness in paying patients. Like labouring men in

Victorian London,[142] urban life reportedly held challenges for Irishmen who fell prey to the anxieties generated by employment within the commercial sector. The working life of certain occupational groups, including clerks, was often identified as precipitating insanity. Policemen were another group whose working conditions attracted psychiatric attention. Subjected to an extremely regimented lifestyle, RIC men suffered marital problems and displayed a tendency towards alcohol abuse and violence, resulting in committal. This association between working life and insanity speaks volumes about contemporary society's interpretations. In relation to social status, those unable to maintain their position within a given occupation were defined in terms of this failure.

Both Cox and Oonagh Walsh have emphasised the presence of familial bonds in the rural south-east and west of Ireland respectively.[143] This chapter has revealed that, among paying patients, land disputes and an inability to manage one's affairs threatened to shatter these bonds, often resulting in committal. Discussion of women's reproductive functions did not tend to occupy lay or medical narratives of female insanity in this study. Instead, patients, their relatives and their doctors discussed the mental strain of domestic circumstances, which could even include business anxieties. That domestic causes were often applied to female mental illness in place of work/finance is to be expected, given contemporary understandings of productive employment and female occupations. Nonetheless, lay explanations of female illness indicate awareness and even appreciation of the potential strain—both domestic and economic—of women's work in late nineteenth-century Ireland.

Notes

1. MacCabe was the resident physician to the State Criminal Asylum at Dundrum in Dublin and honourable secretary to the Medico-Psychological Association and had previously been resident medical superintendent at the Waterford district asylum.
2. Cox (2012, pp. 56, 62–64). Tuke was the editor of the *Journal of Mental Science* for seventeen years during the economic depression and published several articles in it on the alleged increase of insanity in Britain and Ireland. Drapes was a 'notable Irish asylum physician'. Educated at Trinity College Dublin, he was a licentiate of the Royal College of Surgeons in Ireland, member of the British Medical Association, editor of the *Journal of Mental Science* during World War I

and one of the few Irish asylum superintendents who published on the causes of mental illness in Ireland. See Cox (2010, pp. 281–282). For more on Drapes' career, see Kelly (2016, pp. 93–96).

3. Suzuki (2007, p. 118).
4. Ibid.
5. Cox (2012, pp. 59, 121).
6. Digby (1985, p. 212).
7. MacKenzie (1992, p. 152).
8. Suzuki (2007, p. 121).
9. Levine-Clark (2004, p. 123).
10. Cox (2012, pp. 121–122) and Cronin (2010).
11. See Bourke (1993) and Luddy (2000).
12. Digby (1989) and Oppenheim (1991, pp. 181–232).
13. Suzuki (2007, p. 118).
14. The reporting physician, at times, openly refuted these lay narratives. For example, Clinical Record Volume No. 3 (WCC, St Senan's Hospital, Enniscorthy, p. 264); Clinical Record Volume No. 4 (WCC, St Senan's Hospital, Enniscorthy, p. 208).
15. Cox (2012, p. 220).
16. Ibid., pp. 60, 220.
17. In cases where patients were assigned both physical and moral causes, both are included to illustrate their statistical significance.
18. Walsh (2004, p. 262).
19. MacKenzie (1992, p. 152).
20. Malcolm (1986, p. 332).
21. Ibid., pp. 328, 331.
22. Harrison (1971 pp. 298–347).
23. Malcolm (1986, p. 326).
24. Finnane (1981, p. 147).
25. Ibid.
26. Kelly (2016, p. 95).
27. Cox (2012, p. 221).
28. Finnane, pp. 146–150, Cox (2012, pp. 60–61, 221–222).
29. The Twenty-Forth Report on the District, Criminal, and Private Lunatic Asylums in Ireland, H.C. 1875 [319] xxxiii, p. 18.
30. MacKenzie (1992, p. 151). See also Digby (1985, pp. 208–209).
31. Pick (1989, p. 197).
32. Ibid.
33. Digby (1985, pp. 208–209).
34. Digby (1989, pp. 192–220). For the American context, see Theriot (1993, pp. 1–31).
35. Levine-Clark (2004, pp. 123–148).

36. Healy (1996, pp. 314–320).
37. Cox (2012, p. 65). See also Kelly (2016, pp. 96–100). See Rosenberg (1992, p. xvi).
38. Houston (2004, p. 59).
39. Finnane (1981, p. 150).
40. Notably, after the Famine, doctors at the Carlow district asylum reported fear of subsequent famines and destitution as causes of illness in some patients, see Cox (2012, p. 121). These fears were not reported to affect paying patients in this study.
41. Hampstead Casebook 1840s (Highfield Hospital Group, Hampstead and Highfield Records, p. 11).
42. Suzuki (2007, p. 124).
43. Ibid., p. 123.
44. Male Case Book 1900–1901 (GM, Richmond District Lunatic Asylum, pp. 333–335).
45. Male Case Book 1892–1893 (GM, Richmond District Lunatic Asylum, p. 438).
46. Ibid., pp. 438–439.
47. MacCabe (1875), p. 397.
48. Ibid.
49. Suzuki (2007, pp. 123–124).
50. Male Case Book 1891–1892 (GM, Richmond District Lunatic Asylum, pp. 409–411).
51. Ibid., p. 258.
52. Ibid., pp. 897–898.
53. Male Case Book 1898 (GM, Richmond District Lunatic Asylum, pp. 275–276).
54. Bloomfield Case Book (FHL, Bloomfield Records, p. 1).
55. Houston (2004, pp. 55–56).
56. Case Book 1889–1900 (Stewarts, Patient Records, p. 6).
57. Ibid., p. 85.
58. Ibid., p. 126.
59. Ibid., p. 17.
60. Ibid., p. 175.
61. Cherry and Munting (2005, p. 45). See also Melling and Forsythe (2006, p. 192).
62. Cox (2012, pp. 156, 160).
63. Case Book (FHL, Bloomfield Records, p. 61).
64. Case Book 1889–1900 (Stewarts, Patient Records, p. 156).
65. Ibid., p. 166.
66. Ibid., p. 166.
67. Casebook Two (SJOGH, Patient Records, p. 59).

68. Ibid., p. 1.
69. Cherry and Munting 2005, p. 45; Cox 2012, p. 160.
70. Casebook Two (SJOGH, Patient Records, p. 73).
71. Houston (2004, pp. 54–58).
72. Hampstead Casebook 1890s (Highfield Hospital Group, Hampstead and Highfield Records, p. 26).
73. Suzuki (2007, pp. 121, 127–128) and Cox (2012, p. 121).
74. MacCabe (1875, pp. 391–392).
75. Suzuki (2007, p. 123).
76. Fitzpatrick (1985) and Guinnane (1997).
77. Cox (2012, pp. 108–109) and Guinnane (1997, pp. 142–143, 230–235).
78. Walsh (2001, p. 145).
79. Melling and Forsythe (2006, p. 100) and MacKenzie (1992, p. 215).
80. Clinical Record Volume No. 3 (WCC, St Senan's Hospital, Enniscorthy, p. 264).
81. Ibid.
82. Houston (2004).
83. Clinical Record Volume No. 3 (WCC, St Senan's Hospital, Enniscorthy, p. 264).
84. 'Census of Ireland 1901,' accessed 10 July 2012, http://www.census.nationalarchives.ie.
85. Ibid.; Clinical Record Volume No. 3 (WCC, St Senan's Hospital, Enniscorthy, p. 264).
86. See Bourke (1993, p. 272).
87. Clinical Record Volume No. 6 (WCC, St Senan's Hospital, Enniscorthy, p. 408).
88. Clinical Record Volume No. 4 (WCC, St Senan's Hospital, Enniscorthy, p. 198).
89. Beveridge (1998, p. 437).
90. See, for example, Cox (2012, pp. 108–109, 157) and Melling and Forsythe (2006, p. 100) and MacKenzie (1992, p. 215).
91. See, for example, Clinical Record Volume No. 3 (WCC, St Senan's Hospital, Enniscorthy, pp. 3, 166, 264); Clinical Record Volume No. 4 (WCC, St Senan's Hospital, pp. 208, 240); Clinical Record Volume No. 5 (WCC, St Senan's Hospital, p. 16); Clinical Record Volume No. 6 (WCC, St Senan's Hospital, pp. 112, 128, 407); Clinical Record Volume No. 7 (WCC, St Senan's Hospital, pp. 392, 356).
92. Clinical Record Volume No. 6 (WCC, St Senan's Hospital, p. 216).
93. Walsh (2001, p. 141).
94. Suzuki (2001, pp. 120–121).
95. Walsh (2001, p. 141).

96. Houston (2004, pp. 55–56).
97. Clinical Record Volume No. 6 (WCC, St Senan's Hospital, pp. 120, 407).
98. Ibid. For another example see Clinical Record Volume No. 5 (WCC, St Senan's Hospital, pp. 93–94).
99. Clinical Record Volume No. 5 (WCC, St Senan's Hospital, p. 390).
100. Ibid., p. 190, 389–390.
101. Cox (2012, p. 150).
102. Clinical Record Volume No. 5 (WCC, St Senan's Hospital, pp. 189–90, 389–90, 392, 411).
103. 'Census of Ireland 1901,' accessed 6 January 2012, http://www.census.nationalarchives.ie.
104. Clinical Record Volume No. 3 (WCC, St Senan's Hospital, p. 297).
105. Cox (2012, pp. 121–122).
106. Clinical Record Volume No. 4 (WCC, St Senan's Hospital, p. 231).
107. Ibid., pp. 317–318, 118.
108. Clinical Record Volume No. 7 (WCC, St Senan's Hospital, p. 122).
109. Hampstead Casebook 1890s (Highfield Hospital Group, Hampstead and Highfield Records, p. 16).
110. Ibid., p. 20.
111. See also Finnane (1985).
112. Griffin (1997, p. 168).
113. Clinical Record Volume No. 3 (WCC, St Senan's Hospital, p. 196).
114. Female Case Book 1892–1893 (GM, Richmond District Lunatic Asylum, pp.126–127).
115. Clinical Record Volume No. 5 (WCC, St Senan's Hospital, pp. 311–312).
116. Clinical Record Volume No. 6 (WCC, St Senan's Hospital, pp. 46, 359).
117. Ibid., p. 359.
118. Male Case Book 1890–1891 (GM, Richmond District Lunatic Asylum, p. 384); Male Case Book 1894–1895 (GM, Richmond District Lunatic Asylum, p. 65).
119. Male Case Book 1894–1895 (GM, Richmond District Lunatic Asylum, p. 436).
120. McCarthy (2004, p. 123, 135).
121. Clinical Record Volume No. 6 (WCC, St Senan's Hospital, p. 128).
122. Griffin (1997, p. 170).
123. Clinical Record Volume No. 6 (WCC, St Senan's Hospital, p. 46).
124. For the twentieth century, see McCarthy (2004, p. 134).
125. Early Hampstead Casebook 1840s (Highfield Hospital Group, Hampstead and Highfield Records, p. 16).
126. Ibid., p. 17.

127. Ibid., p. 14. For more on violence and women in Victorian England, see Marland (2004).
128. Early Hampstead Casebook 1840s (Highfield Hospital Group, Hampstead and Highfield Records, p. 18).
129. Clinical Record Volume No. 4 (WCC, St Senan's Hospital, p. 240).
130. James Frost J. P. to R.P. Gelston, 10 Jun. 1889 (CCA, Our Lady's Hospital, OL1/7 Letter 1577).
131. Richard Studdert to R.P. Gelston, date unknown (CCA, Our Lady's Hospital, OL1/7 Letter 1577b).
132. Minute Book, 1888–1891 (CCA, Our Lady's Hospital, OL1/5, p. 183).
133. James Cahir P P to R.P. Gelston, 7 Apr. 1899 (CCA, Our Lady's Hospital, OL1/7 Letter 2606).
134. Case Book 1889–1900 (Stewarts, Patient Records, p. 154).
135. Ibid., p. 168.
136. Ibid., pp. 90, 41.
137. Luddy (2000, p. 45). See also Daly, (1997) and Bourke, 1993.
138. Luddy (2000, p. 55).
139. Highfield Casebook (Highfield Hospital Group, Hampstead and Highfield Records, p. 11).
140. Case Book 1889–1900 (Stewarts, Patient Records, p. 163).
141. Digby (1985, p. 212) and MacKenzie (1992, p. 152).
142. Suzuki (2007).
143. Walsh (2001, p. 145); Cox, (2012, p. xviii, 108–9, 148–149).

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