Psychiatry’s emphasis on employment went beyond assigning causes of illness to encompass treatment. Work therapy was a key facet of moral treatment, which remained a dominant form of therapy in nineteenth-century asylums. Asylum doctors stressed the usefulness of work therapy for patients, including distraction from their malady, rehabilitation and their eventual resocialisation following discharge.\(^1\) However, by the 1860s, asylum doctors’ optimism about moral treatment was gradually replaced by a therapeutic pessimism.\(^2\) The benefits of moral therapy were most famously expounded by Samuel Tuke, in his *Description of the Retreat* published in 1813.\(^3\) These included the distraction of patients from painful or disturbing thoughts through providing them with occupations and pastimes. The York Retreat’s therapists believed that the proper regulation of the mind was connected with disease prevention and, stemming from this, work therapy was intended to ‘encourage the growth of mental abilities and especially the power of concentration’.\(^4\) This reflected the influence of the Society of Friends’ discipline on the Retreat’s therapists, which aimed to inculcate habits of Christian self-denial, moderation and uprightness of character in its youngest members.\(^5\) In the absence of these habits, patients were provided with a domestic setting, in the form of the York Retreat, where they could be resocialised.\(^6\)

Unsurprisingly, for women in this study, work therapy was exclusively confined to domestic occupations, further underscoring a gender bias in Irish non-pauper asylum care. In voluntary and private asylums, doctors counteracted the difficulties they faced in delivering appropriate work therapy for wealthier patients by offering more varied and stimulating recreations.
PRODUCTIVE EMPLOYMENT

In Irish district asylums, as elsewhere, work was considered essential as a therapeutic regime and fundamental to Victorian concepts of respectability. In Ireland, asylum medical staff perceived patients’ failure to work as a ‘refusal to join the ranks of the “respectable” poor’. A number of the doctors in this study clearly subscribed to the therapeutic benefits of occupation and recreation. However, they often struggled to find suitable employment for their wealthier patients. This was not a uniquely Irish problem. Digby has noted the difficulty in employing private patients at the York Retreat, contending that resistance to manual labour stemmed from a perception that it was menial and degrading. She has also highlighted the problem of ‘matching possible work to previous life habits’ for this social cohort, a pursuit which was vital to the provision of moral treatment. Nevertheless, asylums could provide outlets for skilled and semi-skilled workers. For instance, at Staffordshire asylum in England, male paying patients who were tailors and shoemakers occupied themselves at these trades. In Irish district asylums, employment was as much part of asylum life for paying patients as their pauper counterparts and many were given work that was related to their former occupation. The degree to which individual paying patients were willing to engage in work varied a great deal. Some reportedly did no work, a point which was frequently noted by the reporting physician. However, there is no evidence that paying patients who refused to work in district asylums did so due to a sense of social superiority.

Physical labour was considered an especially appropriate tenet of moral treatment in Ireland due to the large numbers of agricultural labourers in the asylum population, and several paying patients who were previously farmers worked on the asylum farm. Other patients deemed physically fit, such as soldiers, were sent to work on the farm in Richmond. In Britain, work therapy has been attributed to an ethos of political economy in asylums, making savings on maintenance costs and staffing, especially where asylums were understaffed, to accomplish a degree of institutional self-sufficiency. At the Norfolk asylum, food was produced directly, using patients’ labour on the gardens and farm.

Paying patients in this study often contributed to the economy of the asylum, performing tasks at which they were skilled. For example, at Enniscorthy, Harvey Henry M., a boot and shoe shopkeeper, was reportedly ‘very fond of polishing boots’ and asked the attendants to allow him
to polish theirs. When William Henry P., previously a carpenter, broke a window sash while trying to escape, he was employed at fixing it ‘and being a carpenter he had no difficulty in mending window’. Following this, William Henry asked Drapes to allow him to work and was sent to the carpenter’s shop where he ‘worked steadily’. Ellen W., who had been ‘6 years in America as waitress in a hotel’, was sent to work in the kitchen, and Teresa C., a tailor’s wife, did ‘a little needle-work’. John B., a painter suffering from acquired epilepsy, was ‘put to work at painting during this month and he kept fairly well at it, but has to stop at times if he has had a fit’. At Richmond, Francis F., a porter, was ‘retained as a ward worker in hospital’. Christopher O’K., a painter, was employed at painting and ‘working with the farm gang’, while Thomas G., a civil service pensioner, worked as a clerk. These examples clearly illustrate that paying patients, a number of whom were skilled, could be employed advantageously by the asylum, which benefited from the influx of skilled workers, capable of painting, mending and crafting as the authorities desired. Furthermore, working in familiar areas could be considered therapeutic and even rehabilitative for patients, putting them on a road to recovery and fostering self-reliance outside the asylum.

Work therapy was manifestly seen as rehabilitative at St John of God’s, where its medical superintendent, O’Connell, noted frequently when patients performed tasks linked to their former occupations. For instance, O’Connell recorded that patient Daniel C., a priest, ‘read at least part of the divine office’ almost daily. However, he ‘still absents himself from chapel’ and was ‘at times, cranky and quarrelsome as well as insulting to his fellow priests … he has been somewhat more disagreeable to his fellow priests, in their special sitting-room, during the winter’. Eventually he was ‘left much to himself in the priests’ sitting-room where he has no one with whom to quarrel’ until ultimately the priests’ sitting room was described as ‘the special room formerly set apart for priests’. James C., a lay brother, was more devout: ‘he frequents the chapel as usual … never forgets to go to chapel privately, every day after dinner’. Another priest, Patrick B., reportedly often attempted to give sermons, saying that he was ‘a most elegant preacher’. When asked to preach, Patrick would ‘say something and repeat it several times, giggling at his own words’. O’Connell’s motivation for recording such information can be inferred from his notes on patient Michael K., a farmer:
He takes much interest in cattle and horses of which he is a very good judge... He is easily roused from these thoughts to take him to a fair or market to buy or sell cattle is sufficient... While there is any excitement for him, as the recent Horse Show, at Ballsbridge, which he delights to visit, or a race at Leopardstown, he is in excellent spirits. He takes keen delight in farming affairs of all kinds and is thoroughly skilled at all that pertains to agriculture... If he can engage from time to time in anything pertaining to farming it acts as a great stimulus to rouse him and to keep him from thinking of himself – from interpretation... I often fancy that if he had constant mental occupation, such as his farm must give, he could take care of himself and do his business well. 

This extract suggests that O’Connell considered employment a worthy means of distraction for his patients. O’Connell also viewed lack of work as problematic, writing of Louis de L.V.W., who was admitted in 1885: ‘no mental change except that he is rather stupid and sleepy, due, no doubt, to not being employed’. This was not confined to fee-paying patients. Medical staff in district asylums found any resistance to work in the asylum particularly troubling, interpreting such refusals as symptoms of continuing poor mental condition.

Although they stressed the importance of useful work, district asylum doctors did not force paying patients to stick to one form of employment, especially when they did not appear to enjoy or excel at it. James L., was therefore allowed to give up weaving ‘because he disliked noise of looms’ and was moved to gardening. A sixteen-year-old schoolboy, Charles L., worked in several areas during his patient career including the tailor’s shop, the smith’s shop, the shoemaker’s shop, the weaving shop, the bookshop and the farm. He was also employed at driving one of the carts.

Voluntary and private asylum patients were accorded relatively few opportunities to work, as asylum staff found it hard to provide class appropriate employment. As early as the 1830s, Bloomfield’s managing committee commented on the ‘difficulty of finding employment or amusement as would be beneficial to the patients’ and issued an appeal to the asylum’s subscribers for any suggestions they might have. The issue of how best to employ patients continued to daunt the committee. In the same decade, they noted that one patient had been removed to ‘another asylum, where greater facilities were afforded for agricultural employments, which it was hoped might in his case be attended with
In 1850, Bloomfield’s managing committee was pleased to report that ‘in the course of the past year the manifest benefit arising from out-door employment, and the steady improvement in the order and discipline of the house which has kept pace with the introduction of means to amuse and employ, have been very gratifying’. ‘Employments of an industrial character, together with suitable recreations, and an enlarged supply of newspapers, periodicals, and useful and entertaining books’ were not only credited with rendering Bloomfield’s patients more comfortable and having ‘fostered habits of self-control and propriety of demeanour’ but also with contributing to the ‘improvement of their bodily health’.

Predictably, the committee noted that several male patients were employed in the garden and grounds, while female patients tended to perform fancywork and needlework. This is corroborated in the house steward’s casebook for this period, where he documented many male patients assisting the gardener, sweeping up leaves in the shrubbery, moulding cabbages, painting and undertaking ‘trellis work’. Others raked and trimmed the walks in the ladies’ field, pumped water, chopped wood and helped in the laundry. As with paying patients in district asylums, while those at Bloomfield were actively encouraged to engage where possible, they were not confined to one occupation and clearly had at least a measure of freedom in how they spent their time. One patient, David S., reportedly ‘adopted the coachman as he own’ and stated his intention to retain his services when he left the institution. In the meantime, he performed various jobs to assist the coachman. The following week he was found busy in the garden, ‘with the idea that it was assisting the groom’. The employment of male patients in the vegetable garden hints at the ethos of economy and self-sufficiency outlined earlier. Nonetheless, as will be seen, far more attention was paid to occupying Bloomfield patients at recreational pursuits, suggesting that distraction rather than economy was the principal regime for patients at this asylum.

Despite improvements in providing occupational therapy during this period, Bloomfield’s managing committee was still concerned with how best to occupy patients. Bloomfield’s visiting physician, Dr. Valentine Duke, wrote in his 1863 report of his difficulties in engaging patients in employment, which he argued were ‘increased rather than diminished, as the patient occupies a higher position in the social scale’. In later
reports, Duke juxtaposed the industry witnessed in district asylums with the relatively poor output of Bloomfield’s patients:

In those Asylums intended specially for the accommodation of the working classes, the entire range of manual and mechanical employment can be called into aid, but with us these are scarcely, if at all available: a little carpentry, some painting and working in the garden and grounds, being all we can adopt.\(^{37}\)

Duke elaborated the following year:

For farming or other rural employment our resources are but limited, and the general sphere of life, and antecedents of the greater number of our patients, would render mere manual labour an unsuitable and inadequate occupation. We must therefore seek other resources.\(^{38}\)

In fact, in that year, two patients had angrily objected to the notion that they might assist in the garden moulding cabbage plants. When Stanley asked Joseph R., to do so, Joseph retorted that ‘he was not of that trade and wouldn’t do anything of the kind’.\(^{39}\) A month later, Stanley asked former grocer David S., to perform the same task and ‘at first he declined saying his dignity would be reduced if seen in my [Stanley’s] company’. However, he eventually agreed to work in the garden, albeit for ‘a short time’.\(^{40}\) This mirrors the behaviour of non-pauper patients at the Morningside asylum in Scotland, where a sense of social superiority was common and posed challenges for asylum authorities.\(^{41}\)

By the 1890s, Stewarts’ managing committee was also commenting on the complexities they faced in this regard. This committee, however, did not appear worried, reporting that ‘an excellent dietary, pure air, cheerful associations, and such entertainment as can be provided … are powerful factors in bringing about recoveries’.\(^{42}\) Case notes for Stewarts’ patients contain few specific examples of patients actually carrying out work. As was the norm for patients in nineteenth-century asylums, those who did work were employed largely in line with traditional gender roles.\(^{43}\) Reports of female employment detailed needlework, sewing and ‘household work’,\(^{44}\) though these occupations might equally be deemed as recreational activities for wealthier female patients. For example, at Staffordshire asylum in England, first-class women ‘knitted and sewed for pleasure’ rather than work.\(^{45}\) Stewarts’ medical superintendent, Frederick
E. Rainsford, stressed the gendered divisions of patient labour when he wrote of Eliza Edith A., making ‘senseless requests such as being allowed to work on the farm’. Like patients in Enniscorthy and Carlow, Stewarts’ patients also engaged in housework. However, male patients employed indoors tended to undertake ‘masculine’ activities such as working with the carpenter, in the engine room at ‘various mechanical works’ or raking gravel. Notably, patients carrying out these jobs were paying lower fees of £50 or £60 per annum, suggesting that those who paid higher rates were not expected to carry out manual labour. It is highly unlikely that wealthier patients who did not work in civilian life were employed in asylums.

This is corroborated by an exploration of the case notes for Hampstead and Highfield patients. There is no record whatsoever of Hampstead’s exclusively male patients carrying out any work. Similarly, Highfield’s all-female patient population seemed to engage in very little housework. While Lucy D., ‘did some serving’, she reportedly showed ‘very little enthusiasm for her work’. Another patient, Kate L., ‘did some needlework’ and was ‘useful in the house and garden’ but she also ‘read steadily’ and was able ‘to play a good game of whist’. Yet, at the less expensive St John of God’s, patients were strongly encouraged to work. Several worked in the laundry, the poultry yard, the linen room, peeled fruit and vegetables in the kitchen, cleaned and dusted the ‘cells’, the refectory and the ‘agitated division’ and one patient polished his boots, a task which he reportedly insisted on doing himself. Michael D. was said to be outstandingly helpful and assisted in looking after his fellow patients:

is always most willing to do light jobs of work and to assist old and feeble patients... he always dusts the furniture in the day-room after the floor has been swept... He makes himself useful especially in leading Mr G to and from the refectory etc... He also goes to the agitated division at times to play the piano for the patients in it.

These accounts suggest that the patients in St John of God’s were willing to assist in the running of the asylum. One patient, Joseph H., was ‘perpetually insisting on looking for work and will steal away to some part of the House and fuss there. When not given work to do, he will go out in the garden and fist up grass blades growing in the walks’. The relatively industrious characters of Richmond and Enniscorthy district asylums and
St John of God’s, compared with Bloomfield, Hampstead and Highfield, suggest that work therapy was very much an occupation for less wealthy asylum patients.

**Recreational Activities**

Given the strong emphasis on productive occupation in the district asylums, it is, perhaps, unsurprising that paying patients there had less time to engage in amusements. Recreational pursuits in district asylums were often limited as overcrowding resulted in the conversion of dayrooms and exercise yards into dormitories. In relation to recreational activities, there are very few accounts of district asylum paying patients doing anything more than reading or playing cards. At Richmond, there is an isolated reference to one female paying patient playing the piano. While another patient, Frances N., would ‘do no work of any kind’, when she informed a medical officer that she had won prizes for some of her paintings at various exhibitions, she was ‘supplied with paints & c but she is unable to fix her attention so as to produce a picture. What she paints one day she spoils it the next’. In addition, the hospital grounds at Richmond were open to patients every day and sports, picnics and entertainments were sometimes organised.

In more expensive asylums, patients were encouraged to occupy themselves in a wide range of amusements and entertainments. Comparably wide-ranging activities were on offer to patients at the Crichton Royal Asylum in Dumfries, where the superintendent, William Alexander Francis Browne (1837–1857), ‘devoted enormous energy and ingenuity to the moral discipline and treatment of his charges’. Browne was concerned with restoring his well-to-do patients to sanity and later confessed that activities such as these combated the monotony of asylum life. Annual reports and case notes for Bloomfield and Stewarts patients abound with evidence that recreation, rather than work, was considered a vital part of the therapeutic regime in voluntary asylums. In 1863, Duke alluded to the reasoning behind this. While he highlighted the difficulties inherent in finding socially appropriate employment for Bloomfield’s patients, Duke opined that:

> It is not possible to compel the mind which has been educated, and accustomed to activity either to rest completely, or remain idle. Mental repose
cannot be insisted on, there is no forcing the intellectual faculties to lie fallow.

Duke therefore stressed the importance of creating sufficient ‘diversion of thought, and to secure a healthy interest in surrounding objects’. He counted among the most useful ‘party evenings’, when patients could ‘enter into the spirit of the scene, enjoying the presence of strangers, performances of music, acting of characters, &c.’ and pronounced himself gratified ‘to think that their happiness is even temporarily prompted by inducing a forgetfulness of self’. Party evenings, dances and other evening entertainments became a frequent element of voluntary and private asylum life. However, the gaiety of such evenings could be disrupted by patients, as is evidenced by the report on St John of God’s patient, Richard A.P., who, at an evening entertainment, became ‘quite excited’ and required ‘four men to remove him from the recreation hall’.

From the 1880s, Pim detailed the recreations on offer at Stewarts, which were promoted in the asylum’s annual report. These included the availability of daily papers, books from a lending library, books and periodicals donated ‘from some of our kind friends’, a billiard table which was ‘a great source of amusement to those who can play’ and a piano ‘for the ladies, many of whom are very good performers’. The woods and pleasure grounds were continuously being enlarged and additional walks were constructed by male former pupils of the imbecile branch, who were engaged in gathering fallen leaves and digging. In the summer of 1898, Stewarts organised carriage drives for patients to ‘places of interest’. During the winter months, various forms of indoor entertainment were adopted, including ‘magic lantern exhibitions, conjuring, cinematography, Punch and Judy, Concerts, & c’. Stewarts’ managing committee was keen to point out the benefits of the asylum’s small population and attractive location. Overcrowding was guarded against, while the grounds were said to be ‘fully taken advantage of for recreative [sic] purposes’.

Physicians writing case notes on Stewarts’ patients in the 1890s took care to note the sorts of amusements they enjoyed. Frederick James H., took an ‘interest in books and reads a good deal’, while Maude Frances C., could ‘enjoy a dance’. H.P., an architect, ‘employed himself making architectural drawings and worked with neatness and precision’. Several attempts were also made to occupy patient Henry Richard Q.,
a professor of music. In the asylum, he played his ‘harmonium a little’. Sadly, however, the professor, who had been diagnosed with ‘senile decay’, was unable to enjoy his music:

Tried American Organ in Dining Hall yesterday but could make very little of it owing to the weak state of his legs being unable to work the bellows … Attends Divine Service, attempts to sing gets out of time and loses his place.70

During the 1890s, Bloomfield’s patients were kept busy with games, outings, visits, reading and various other amusements. Among references to amusement in the case notes, Joshua L.W., was allowed to take ‘tea in the parlour with his sisters’, William G., ‘reads the papers, plays chess, ball, croquet, and such like’ and Henry Jacob H., spent ‘a good deal of time painting or drawing various things about the place’.71 Patients also went out for drives, played billiards, walked in the garden, smoked, played the piano, read books, spent a month at the seaside, sewed, knitted and played ‘Haluna’.72

Patient amusements at St John of God’s were less varied. In this asylum, patients read newspapers, played cards, chess or billiards, the violin and piano, walked in the garden, or went on country walks.73 Some patients also pursued their own pastimes. Frederick K., was reportedly ‘fond of postage stamps and … glad to get some … he amuses himself at times by pasting old postage stamps into an old Dublin City directory’.74 Thomas K., was ‘fond of being out of doors hunting rats or shooting’, while James M., amused himself caring for a parrot.75 Recreation was clearly important at St John of God’s though. In the early twentieth century, additional arrangements were made including the establishment of a library in 1904 and a handball court a few years later.76 At Hampstead during the 1890s, frequent references were made to recreation in the casebooks, where patients played chess, cards, draughts, billiards, croquet, tennis, walked on the farm, cycled, played handball, had long walks and ‘carriage exercise’, read novels and newspapers, and watched cricket, tennis and football matches.77 It is important to note, however, that patients were not always willing to engage in recreational activities. For example, John Neilson Eustace wrote that Palms S.M., an army lieutenant, sometimes had ‘to be stimulated to walk as far as the garden but the sight of the wheelbarrow to wheel him in is usually enough of a stimulus!’78
Given the more common characterisations of asylum life as ordered, monotonous and isolating, the degree of freedom accorded to voluntary and private asylum patients was refreshingly large. In the Staffordshire asylum in England, freedom to go beyond the asylum complex ‘was a prerogative of wealth’ and patients visited a dairy farm, the theatre, relatives and the seaside. In keeping with the practice at the York Retreat, in Irish voluntary and private asylums, carriage drives and day trips were organised for those considered suitable to attend. For example, in 1864, Stanley accompanied three of the male patients to the Botanic Gardens and Glasnevin Cemetery in Dublin, where they visited Daniel O’Connell’s tomb. Voluntary asylum patients were also allowed to walk outside the grounds of the institution, sometimes unattended. In addition, other excursions were organised from the 1860s, including visits to ‘popular exhibits, to launches, reviews, &c.’. In some cases, patients chose their own entertainment. When Bloomfield patients William G., and James H., saw an advertisement for the Christy Minstrel’s concert at the Rotunda Lying-In Hospital in Dublin, they sought permission from Bloomfield’s superintendent, Mary Pryor, to attend, which they were granted and went in the charge of two attendants. They later told Stanley that ‘they were particularly pleased that it was a rich treat and that the singing was performed with good taste and ability’.

This substantial liberty was also accorded to private asylum patients. In August 1908, a party of thirty, comprised of St John of God’s patients and attendants, went for a picnic to the Glen of the Downs, County Wicklow, while patients in that asylum were permitted to go on country drives, walks, excursions and picnics. Highfield patient, Elizabeth B.P., attended two garden parties where she played croquet. Fellow patient, Christina McF.S., went to the Gaiety theatre in Dublin ‘several times since admission in company with her husband & always conducted herself in a perfectly rational manner’ and was allowed home for Christmas. At Hampstead, Mosley C.S., an army captain, was granted parole to attend entertainment in town accompanied by an attendant. He visited the Zoological Gardens and the Botanic Gardens in Dublin. These visits reflected Mosley’s keen interest in botany; he was said to spend ‘most of his days walking about observing farm and garden interests’ and ‘gathered and refined special garden seeds’ for John Neilson Eustace. Eustace also had a house in the seaside town of Killiney and patients sometimes stayed there in the summer.
Just as the dangers of patients working in district asylums could bring about further disruption, allowing patients to leave the asylum did not always go to plan. Robert P., a Hampstead patient diagnosed with alcoholic insanity, frequently went into town and to the theatre. On these occasions, he was accompanied by an attendant partly on account of his alcoholic tendencies and partly due to his nervousness at venturing far alone. His liberty was eventually reduced when ‘it was suspected that patient has been taking some drink on his visits to Dublin’. At St John of God’s, O’Connell did not always support his patients’ liberty. In 1905, he wrote of patient James M.:

In the intervals between his attacks he goes about far too much. I do not understand why he is permitted to go where he pleases and when he pleases … He has taken to motor driving during the past six months and goes out too much for his good. Motor driving is far too exciting for him and to this I attribute the frequent recurrence of his attacks. He should be kept under more restraint – confined more to the grounds.

In spite of the enhanced sense of liberty among voluntary and private asylum patients, these excursions were not always dignified or enjoyable. When Maria Jane E.T., was taken along with other Stewarts’ patients to a picnic in Howth, she became quite excited, ‘kept screaming out “go away”, “don’t annoy me”, when no one was near her, spitting all round her &c’. When Joshua S.B., was taken to the park to see a royal visit, he ‘wanted to throw stones at King’s horses’, believing he was ordered to. These examples illustrate that, contrary to the positive tone of annual reports for voluntary asylums, which championed patients’ excursions, the reality of providing recreational activities for asylum patients was often more challenging.

CONCLUSIONS

Moral therapy remained the dominant ideological framework for treating insanity throughout much of the nineteenth century. Although this framework was initially developed for patients at the York Retreat private asylum, it met with challenges both at York and for asylums caring for Irish paying patients. The key issue was to find class-appropriate occupations for those who had not engaged in manual work in the outside world. While asylum doctors placed emphasis on employing paying
patients, those who had not worked prior to committal were not forced to do so. Nor were patients who refused to work punished, but instead they were encouraged to distract themselves in other ways. In the asylums studied, there is evidence that asylum doctors allowed patients to engage in pursuits they enjoyed, even when these might be considered meaningless. For wealthier patients, amusements provided an alternative means of occupation. Providing patients with suitable distractions therefore overtook institutional economy or self-sufficiency as the principal regime for fee-paying patients.

**Notes**

1. Digby (1985, pp. 42–49), Cherry (2003, pp. 53–81). See also Cherry and Munting (2005, pp. 42–58).
2. Digby (1985, pp. 57–104). See also Scull (1982).
3. Tuke (1813).
4. Digby (1985, pp. 34, 42).
5. Ibid.
6. Ibid.
7. Cox (2012, p. 156).
8. Digby (1983, p. 63; 1985, p. 42).
9. Wynter (2010, p. 47).
10. Finnane (1981, pp. 134–135).
11. Cherry (2003, pp. 59, 80), Andrews (1991, p. 75). See also Cherry and Munting (2005, pp. 42–58). For the Irish context, see Cox (2012, pp. 212–216).
12. Cherry (2003, pp. 59, 80).
13. Clinical Record Volume No. 5 (WCC, St Senan’s Hospital, Enniscorthy, p. 369).
14. Clinical Record Volume No. 4 (WCC, St Senan’s Hospital, Enniscorthy, p. 4).
15. Clinical Record Volume No. 7 (WCC, St Senan’s Hospital, Enniscorthy, p. 182); Clinical Record Volume No. 5 (WCC, St Senan’s Hospital, Enniscorthy, p. 186).
16. Clinical Record Volume No. 3 (WCC, St Senan’s Hospital, Enniscorthy, p. 336).
17. Male Case Book, 1887–1888 (GM, Grangegorman Records, p. 142).
18. Male Case Book, 1891–1892 (GM, Grangegorman Records, pp. 181–183); Male Case Book, 1898 (GM, Grangegorman Records, p. 618).
19. Cherry (2003, p. 65); Cherry and Munting (2005, p. 45).
20. Casebook Two (SJOGH, Patient Records, p. 11).
21. Ibid., p. 348.
22. Ibid., p. 30.
23. Ibid., p. 38.
24. Ibid., p. 41.
25. Ibid., p. 2.
26. Cox (2012, p. 156). See also Melling and Forsythe (2006, p. 192).
27. Male Case Book, 1900–1901 (GM, Grangegorman Records, p. 335).
28. Male Case Book, 1898 (GM, Grangegorman Records, p. 194); Male Case Book, 1899–1900 (GM, Grangegorman Records, pp. 184, 956, 959).
29. Annual Report of the State of the Retreat (Dublin, 1836), p. 5.
30. Annual Report of the State of the Retreat (Dublin, 1839), p. 7.
31. Annual Report of the State of the Retreat (Dublin, 1850), p. 5.
32. Annual Report of the State of the Retreat (Dublin, 1852), p. 8.
33. Annual Report of the State of the Retreat (Dublin, 1860), p. 6.
34. Edward Hyde, Notice of Particulars (FHL, Bloomfield Records).
35. Ibid., 1 Oct. 1862, 8 Oct. 1862.
36. Annual Report of the State of the Retreat (Dublin, 1863), p. 9.
37. Annual Report of the State of the Retreat (Dublin, 1866), p. 9.
38. Annual Report of the State of the Retreat (Dublin, 1867), p. 8.
39. Edward Hyde, Notice of Particulars (FHL, Bloomfield Records, 28 May 1864).
40. Ibid., 29 Jun. 1864.
41. Beveridge, 1998, p. 50.
42. The Stewart Institution and Asylum Report (Dublin, 1897), p. 21.
43. See Showalter (1986, p. 82), Cherry (2003, pp. 61, 67), Busfield (1994, pp. 259–277). For the Irish context, see Cox (2012, p. 212), McCarthy (2004, p. 132).
44. Case Book 1889–1900 (Stewarts, Patient Records, pp. 32, 149, 97).
45. Wynter (2010, p. 47).
46. Case Book 1889–1900 (Stewarts, Patient Records, p. 71).
47. Cox (2012, p. 212).
48. Case Book 1889–1900 (Stewarts, Patient Records, pp. 57, 103).
49. Ibid., pp. 110, 64.
50. Wynter has made this argument about first and second-class women at Staffordshire: (Wynter 2010, p. 46).
51. Highfield Casebook (Highfield Hospital Group, Hampstead and Highfield Records, p. 31).
52. Ibid., p. 41.
53. Casebook Two (SJOGH, Patient Records, pp. 2, 18, 25, 28).
54. Ibid., p. 12.
55. Ibid., p. 71.
56. Cox (2012, p. 214).
57. Clinical Record Volume No. 3 (WCC, St Senan’s Hospital, Enniscorthy, pp. 212, 420); Clinical Record Volume No. 6 (WCC, St Senan’s Hospital, Enniscorthy, p. 407); Male Case Book, 1887–1888 (GM, Grangegorman Records, p. 202); Male Case Book, 1890–1891 (GM, Grangegorman Records, p. 158); Clinical Record Volume No. 3 (WCC, St Senan’s Hospital, Enniscorthy, p. 4); Clinical Record Volume No. 5 (WCC, St Senan’s Hospital, Enniscorthy, p. 190).

58. Female Case Book 1895–1897 (GM, Richmond District Lunatic Asylum, p. 168).

59. Female Case Book, 1891–1892 (GM, Grangegorman Records, p. 459).

60. Scull (1993, p. 296).

61. Annual Report of the State of the Retreat (Dublin 1863), pp. 9–10.

62. Casebook Two (SJOGH, Patient Records, p. 63).

63. The Stewart Institution and Asylum Report (Dublin 1884), p. 20, The Stewart Institution and Asylum Report (Dublin, 1887), p. 22, The Stewart Institution and Asylum Report (Dublin, 1889), p. 21, The Stewart Institution and Asylum Report (Dublin, 1894), p. 25.

64. The Stewart Institution and Asylum Report (Dublin 1890), p. 21. The Stewart Institution and Asylum Report (Dublin, 1891), p. 22.

65. The Stewart Institution and Asylum Report (Dublin 1898), p. 25. Carriage drives were also organised for patients at St Patrick’s Hospital, see Malcolm, 1989, p. 161.

66. The Stewart Institution and Asylum Report (Dublin 1899), p. 24.

67. The Stewart Institution and Asylum Report (Dublin 1894), p. 24; The Stewart Institution and Asylum Report (Dublin, 1900), p. 19.

68. Case Book 1889–1900 (Stewarts, Patient Records, pp. 150, 156).

69. Edward Hyde, Notice of Particulars (FHL, Bloomfield Records, 21 Dec. 1864).

70. Case Book 1889–1900 (Stewarts, Patient Records, p. 144).

71. Case Book (FHL, Bloomfield Records, pp. 9, 19, 61).

72. For example, Case Book (FHL, Bloomfield Records, pp. 7, 14, 16, 22, 31, 45).

73. Casebook Two (SJOGH, Patient Records, pp. 1, 328, 5, 7, 11, 12, 42, 19, 32, 39).

74. Ibid., p. 7.

75. Ibid., pp. 27, 16.

76. Ibid., pp. 27, 29.

77. Hampstead Casebook 1890s (Highfield Hospital Group, Hampstead and Highfield Records, pp. 2, 6, 3, 10, 32, 17, 12, 13, 33, 56).

78. Ibid., p. 3.

79. See for example Reynolds (1992, p. 179), Cox (2012, pp. 195–239). For the Scottish context see Beveridge (1992), pp. 438, 440–441.
80. Wynter (2010, p. 46).
81. Digby (1985, p. 46).
82. Edward Hyde, Notice of Particulars (FHL, Bloomfield Records, 16 May 1864).
83. *Annual Report of the State of the Retreat* (Dublin 1867), p. 14.
84. Edward Hyde, Notice of Particulars (FHL, Bloomfield Records, 23 Nov. 1864). In the English context, Rob Ellis has argued that local townspeople displayed hostility at Epsom county asylum patients’ excursions. Ellis (2013).
85. Casebook Two (SJOGH, Patient Records, pp. 25, 53, 19).
86. Highfield Casebook (Highfield Hospital Group, Hampstead and Highfield Records, p. 51).
87. Ibid., p. 21.
88. Hampstead Casebook 1890s (Highfield Hospital Group, Hampstead and Highfield Records, p. 6).
89. Ibid., pp. 3, 10.
90. Cox (2012, p. 213).
91. Hampstead Casebook 1890s (Highfield Hospital Group, Hampstead and Highfield Records, p. 8).
92. Casebook Two (SJOGH, Patient Records, p. 3).
93. Case Book 1889–1900 (Stewarts, Patient Records, p. 38).
94. Ibid., p. 25.
95. Digby (1983, pp. 63, 1985, 42).

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