UNIVERSITY OF STRATHCLYDE

DEPARTMENT OF HISTORY

MADNESS AND INDUSTRIAL SOCIETY.

A Study of the Origins and Early Growth of the Organisation of Insanity in Nineteenth Century Scotland c. 1830 - 70

Volume II

Thesis submitted for the Degree of Doctor of Philosophy by

FRANCIS J. RICE, B.A. (Hons)

1981

CONTENTS

LIST OF TABLES

ABBREVIATIONS

E.R.H.	Edinburgh Royal Hospital
G.G.H.B.	Greater Glasgow Health Board
L.R.H.B.	Lothian Regional Health Board
Med. Hist.	Medical History
M.L.	Mitchell Library
S.R.O.	Scottish Record Office

PART III

THE CARE AND TREATMENT OF THE INSANE IN NINETEENTH CENTURY SCOTLAND

CHAPTER 9

THE CARE AND TREATMENT OF THE INSANE IN MID-NINETEENTH CENTURY SCOTLAND

The Royal Commission as we have seen, was established primarily as a result of humanitarian pressure. Much of that interest was influenced by ideas which had emerged from the 'moral management of the insane' school of the early nineteenth century. The reformers were understandably shocked by reports of life in the asylums, but it should be recalled that many of the institutions, particularly the Royal Asylums, were built at the time of the 'age of improvement'. In considering then the state of lunacy care and treatment in 1830-57 before reform, the crucial question will be concerned with the extent to which moral management was practised in Scotland. In pursuing this objective, the artificial distinction between 'care' and 'treatment' will be utilised. Hence this Chapter will be concerned with the environment in which the patient was placed, while the last Chapter will deal with actual methods of treatment.

I

Despite the insight and clarity of Pinel's early nineteenth century thoughts on the constitution of insanity, it was not until the end of the century, that the first glimpses could be detected of the formal

nosologies of contemporary psychiatry. There was much that was problematic prior to that time. A central issue is the way in which Victorian medicine diagnosed insanity. In present day practice, a diagnosis is made by an observation of the symptoms presented. Treatment is then prescribed on that symptomatic basis. The cause, or aetiology of what has been observed is regarded as specialist endeavour. In contrast, early and mid-Victorian medical thinking made considerable use of an aetiologic base for diagnostic classifications. As Dr. David Skae of Edinburgh put it:

> ....wherever we have a very distinct natural history of any form of Insanity, we at present refer always to its natural order, without reference to the character of the mental disorder.[1]

As will be illustrated in Chapter Ten, the physician usually cited one contingency, such as intemperance, pregnancy or grief as the 'exciting' cause of insanity,[2] but to this, he would add a variety of 'predisposing' causes which, in his observation of the patient, had been detected. This practice was not unsound, and corresponds to the contemporary psychiatrists' usage of the terms distal (or long term) and proximal (or short term) in current aetological investigations. Unfortunately, as Chapter Ten also indicates, the interpretations made from this procedure led many physicians to propose, in some cases, unfounded and bizarre 'causes' of insanity.[3]

But it would be wrong to imply that Victorian

nosologies of insanity were monopolised by aetological explanations. Thinking on this topic was diverse. Many local physicians proposed their own classifications, flavoured by personal experience. Moreover symptomatic typologies were certainly developed. Physical manifestations of what was thought to be insanity were noted and recorded. Moreover, in the medical records consulted, there appeared to be an element of confusion over whether certain characteristics were a cause or a type of insanity. General paralysis of the insane, for example, was noted in both categories.

Hence attempts to characterise Victorian ideas on insanity would be difficult. There was no uniform set of criteria used. Aetiologic nosologies competed with, but also in some cases, worked alongside, symptomatic diagnoses. Moreover, localist traditions remained strong. With these problems in mind then, what can be said about definitions of insanity during the middle of the nineteenth century?

During the eighteenth century, a number of advances in the medical knowledge of insanity had been made. Hermann Boerhaave, Erasmus Darwin, and Benjamin Rush, the 'father of American psychiatry', had been concerned with treatment. George Cheyne and Robert Whytt became fascinated by what we would today call neurotic behaviour. Another initiative, born of the work of Giovanni Morgagni, was the use of autopsies of the brain as a means of deciphering the 'cause' of

insanity. But, according to Alexander and Selesnick, the 'most comprehensive' classification of 'mental illness' attempted in the middle of the eighteenth century, came from the pen of an Edinburgh man, William Cullen.[4] Part of the second of his four volume First Lines of the Practice of Physick (1777) was devoted to mental disorders. Apart from the catholicity of his work, the importance of Cullen lies in the fact that he exercised a considerable impression on Pinel. Pinel simplified and reduced Cullen's classifications and introduced terms widely used in nineteenth century medicine.

In his Traité médico-philosophique sur L'Aliénation Mentale, Pinel offered a theory of the aetiology of insanity. In Ackernecht's traditional interpretation, Pinel's argument is significant for its psychological bias. Among the factors which the French physician thought were important were the patient's hereditary constitution, his previous emotional life, a faulty education, 'irregular life', 'spasmodic' passions such as rage and fright, 'enervating' passions exemplified by grief and fear, and finally certain physical contingencies such as alcoholism, fever and head injury.[5]

Alexander and Selesnick adopt a different, and seemingly contradictory approach to Pinel. They write that he believed that:

> ....the basis of mental derangement might

> be a lesion in the central nervous system, since he maintained traditional notions about the physical cause of mental disease.[6]

Yet these scholars then go on to refer to 'Pinel's outspokenly psychological orientation and his rejection of 'meaningless physiological fictions'.[7]

But whereas debate may exist over Pinel's aetiological considerations, there is little doubt about his symptomatology. In the Traité, Pinel, having offered his explanation of the 'cause' of insanity, then went on to describe the symptoms. In this regard, he recognised 'only four forms of mental illness, mania, melancholia, dementia and idiocy'.[8] Mania was apparently the major defect, covering all types of agitation. According to Pinel, one saw 'bizarre, abnormally jolly and also sad behaviour'.[9] Pinel restricted melancholia for cases in which the mind was concentrated on a single idea, which could be either sad or grandiose. It could degenerate into mania and was characterised by muteness, obsessions and delusions. Dementia was the cessation of all thought processes, where thinking became totally incoherent as opposed to the false but coherent ideas of the manic. Finally, idiocy was characterised by an absence of all intellectual faculties, usually accompanied by alterations in the shape of the brain.[10]

These terms were to become widely used throughout the nineteenth century as reference to an asylum record will show, but unfortunately, we cannot

even use this terminology as much of a guide since local interpretations were widely made. Moreover, the aetiological-symptomatic dichotomy automatically coloured a physician's reading of Pinel's work. There were other problems involved. Perhaps the most difficult is that, certainly by the middle of the nineteenth century, Pinel's four-fold classification was being used alongside another more general typology, known as moral and physical insanity.

Fish is correct when he says that 'a good deal of confusion'[11] surrounds the term moral insanity. According to him, it was introduced in 1836 by Pritchard to distinguish a variety of insanity where 'the emotions and feelings are disordered in the absence of intellectual aberrations'.[12] As such, it had nothing to do with the concept of moral management of the insane, nor was the term initially used in an ethical sense. Pritchard wrote that moral insanity consisted in a:

> ...morbid perversion of the natural feelings, affections, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing or reasoning faculties and particularly without any insane illusion or hallucination.[13]

Skae brought out clearly the distinction between a moral insanity, in which the 'propensities, emotions and desires alone are morbidly excited' and an intellectual (or physical) insanity 'in which there are actual delusions or hallucinations'.[14] Reference to asylum reports indicate that the terms moral and physical

insanity developed a wide usage. In time, however, the term 'moral insanity' was to form the base out of which emerged the concept of psychopathy.[15]

Some idea of the nature of the problem facing the historian when he looks at early and mid-nineteenth century ideas on insanity should now be manifest. Pinel had drawn up a nosology clear and precise in its meaning, but, while his classification was widely applied, its usefulness was limited by different interpretations and local perversion. Moreover, while his category was being used, another was introduced which was used alongside, rather than to replace Pinel's.

It was, in fact, not until the mid and later decades of the nineteenth century that this 'chaos and lack of specificity'[16] as Henderson sees it, subsided to some extent. There are two important threads to be tied up in this context. Firstly, scientific research on the structure of brain and the nervous system, being carried out particularly in the German states, increasingly identified a somatic basis for insanity. Among the more notable researchers here were Westphal, Maynert and Wernicke, but the man most closely associated with this pioneering work was Wilhelm Griesinger. In 1845, he published his major work Pathologie und Therapie der Psychischen Krankheiten. In Alexander and Selesnick's eyes, Griesinger felt that his 'mission was to free German psychiatry from the speculation of the Romantics'.[17] He felt that Romantic poetical

implications about madness had produced confusion, and in its place, he wished to propose a positive aetiology. Demonstrations that some mental derangements had an organic base had already been made by earlier researchers such as Bayle and Calmiel. Hence Griesinger went on to propose that:

> ....the first step towards the knowledge of the symptoms (of insanity) is their locality: to which organ do the indications belong: what organ must necessarily and invariably be diseased where there is madness? Physiological and pathological facts show us that this organ can only be the brain; we, therefore, primarily and in every case of mental disease, recognize a morbid action of that organ.[18]

Griesinger then, with his famous proposition Geisteskrankheiten sind Gerhirnkrankeiten (Diseases of the mind are diseases of the brain) clearly stated that the brain was the seat of mental disorder, and this somatic basis for insanity was to become increasingly influential towards the end of the century. It should, however, be noted that Griesinger's clearly medical approach was marked by 'opposition to any inhuman measure, including bleeding, purgatives, emetics and restraints',[19] a view not shared by Griesinger's eighteenth century medical predecessors.

The second trend to be detected here, was the general tightening up of, and improvement upon, the earlier classificatory system. Both the reformulations of Pinel's early method, and the neurological stress on clinical observation, heavily developed by Grie-

singer, had resulted, by the end of the nineteenth century, in such a mass of classificatory data that some systematizing was required. The man most credited with that achievement was Emil Kraepelin, known as the 'Chancellor of Imperial German psychiatry'.

In the development of a comprehensive clinical observation, published in his Kompendium der Psychiatrie (1899), Kraepelin took the results of some recent research and reformulated them into clinical states familiar with us today. He concurred with aspects of earlier work done by Morel on adolescent, or 'precocious' insanity (demence precóce), the result of which was the establishment of the 'dementia praecox' syndrome. Moreover, while that particular term has passed from use, the sub-classifications developed by Kraepelin are still used. Thus Kahlbaum's earlier work on 'catatonia' was used to describe the alternatively mute and violent patient with catatonic dementia praecox. Another researcher, Hecher's, term 'hebephrenia' was utilised for these patients displaying silly and generally inappropriate behaviour in the hebephrenic version of the disease, while those with delusions of grandeur were regarded as suffering from the 'paranoid' type. But the syndrome becomes more familiar to modern eyes when it is learnt that, while the prefixes were retained, the general term 'dementia praecox' was replaced by the word schizophrenia in 1911 as a result of Bleuler's observations.[20]

Moreover, a distinction was drawn between the intellectual decay implicit in the use of the term 'dementia', and disorders of mood. The result was Kraepelin's description of the manic depressive syndrome. Whereas Kraepelin felt that the prognosis for dementia praecox was not good, he thought a patient could recover from manic depressive illness. Kraepelin also made the important observation that extremes of depressed and elated behaviour were not all that mattered in this particular condition, but that such moods would easily alternate with apparently 'normal' activity.[21]

As a result of the work of Kraepelin, and others such as Mayer, Wagner-Jauregg, and Bleuler, many of the confusions in nineteenth century psychiatry were clarified. Modern psychiatry began with the two major functional disorders, the manic depressive and the schizophrenic reactions, being described. The next step was to be the work done by Freud and his colleagues on the neuroses.

In drawing this look at nineteenth century thinking on the nature, as distinct from the treatment, of insanity to a close, it has been shown that diagnoses were arrived at, more from causal rather than symptomatic approaches. But no hard and fast distinctions can be made here. Local interpretations abounded, and the line between cause and type was often blurred. Pinel had given Victorian medicine a nosology of

insanity which was widely used, but upon this was superimposed the moral-physical classification. In effect, it is no exaggeration to state, that while some examples of insight can be noted, the majority of early and mid-Victorian doctors were at a loss when confronted with insanity. It was not until the later decades of the nineteenth century, with the work of Griesinger and Kraepelin, that modern concepts of what was coming to be known as mental illness were formulated. The next task, in developing this understanding of medical history, is to look in greater detail at ideas on care and treatment.

II

The crucial importance of the developments in the treatment of the mad during the late eighteenth and early nineteenth centuries has already been explained in Chapter Two. It was pointed out that, during this time, a tension developed between the protagonists of two distinct models of madness treatment. The non-medical 'moral managers' of the insane developed their methods out of the practice of an earlier medical system. But the supporters of the latter 'counterattacked', and, as the nineteenth century drew on, the treatment of madness was to be increasingly seen as a preserve of medicine.

As has been shown, the method of treatment

used in most eighteenth century houses was, according to Scull[22] and Jones,[23] distinctly 'medical'. The 'mad doctors' possessed a variety of procedures by which madness could be demonstrably 'cured'.

In making the claims, the doctors were acting within the traditions of eighteenth century medicine. At this time, as we have seen,medicine did not proceed according to the diagnosis - specific treatment methodology of today. Instead, medicine 'possessed a number of things which were regarded as useful weapons against any and all types of bodily dysfunction'.[24] In Scull's eyes, 'adherents of almost every one of the eighteenth-century medical systems',[25] used such things as purges, vomits, bleeding, and various mysterious coloured powders as cure alls.

This practice of medicine, was particularly applicable to the 'disease' of insanity. As has been shown, madness was by no means peculiar to the modern age. Nor was the idea of madness as a disease susceptible of treatment without precedent before that time. But one can agree with Scull when he argues that, historically, the 'medical approach to lunacy had either been ignored or been forced to compete with theological and demonological perspectives'.[26] But the deathknell of the dogmas had been sounded in the Age of Reason. Within that cultural context, man's ability to reason, it has already been suggested, was elevated into his highest attribute, and conversely, the failure

of reason, madness, came to be seen ultimately, as a loss of humanity.

Hence, it was out of this cultural atmosphere, that insanity ceased to be seen as the work of God or demons, and became, instead, a 'disease' of the mind or the brain. Being a disease, it followed that insanity would be as susceptible to medical treatment as any other disease. Thus, armed with this logic, the eighteenth century doctor was well placed to diversify into the 'mad business'. Respectable institutions, then, had to be set up under physicians to treat medically, and hopefully to restore, those suffering from the 'disease' of insanity.

Kathleen Jones has demonstrated this eighteenth century custom. From a basis that treatment should consist of removing humoural excesses by 'evacuation', a number of procedures were used. The 'most readily accessible means of evacuation, were 'simples';[27] purges, vomits, and emetics. These were given to the patient in order that he be rid of the offending excess. Burton, a pioneer in this area, suggested, 'laurel, white hellebore, antimony and tobacco'[28] and wrote:

> ....divine, rare, super - excellent tobacco, ... a sovereign remedy to all diseases. A good vomit, I confess, if it be well qualified, opportunely taken and medicinally used; but as it is commonly abused by most men ... hellish, devilish and damned tobacco.[29]

Senna, aloes, herb mercury and half boiled cabbage, according to Jones, were also employed.[30]

In addition to purging, other means of evacuation were available. Blood-letting was very common, as was the use of horse-leeches 'and the practice of raising blisters through the application of plasters and hot irons'.[31] According to Burton, 'cauteries and hot irons are to be used in the suture of the crown, and the seared or ulcerated place suffered to run a good while'.[32] It would appear that Burton also referred to the efficacy of trephining which involved boring a hole in the skull to allow the humours affecting the brain to escape. Early 18th century physicians such as Boerhaave, Erasmus Darwin and Rush had advocated the use of the gyrating chair, because diseases arose out of 'disordered motions' which the chair would correct. In further evidence of the durability of these practices, we could cite Dr. Thomas Munro of Bethlem's evidence to the Select Committee of 1815:

> Patients are ordered to be bled about the latter end of May or the beginning of June, according to the weather, and after they have been bled, they take vomits once a week for a certain number of weeks, after that, we purge the patients.[33]

There was, finally, a last resort if the inmate continued to be obstreperous and dangerous. He could be placed in seclusion, or mechanically restrained. This involved chaining, handcuffs, muffs, strait-waistcoats and cages, and in less extreme cases, cold baths and rotating chairs.

Care must be exercised over the interpretation

of these customs lest they be seen as gratuitously cruel. As Parry-Jones points out, the use of restraint and 'cruelty' in the treatment of lunatics 'had been in conformity with contemporary attitudes and theoretical concepts'.[34] William Cullen, for example, advocated restraint on an essentially neuro-physiological basis. The logic of the method lay in the fact that 'evacuations' were designed to lower and hence make amenable the patient. The dilemma was best stated by Munro when he said that these had 'been the practice invariably for years - I do not know any better practice'.[35]

Ironically, however, at the time when the medical orthodoxy was at its height, a new body of opinion arose which directly challenged this way of treating the insane. By the early nineteenth century, 'Reason', if not exactly banished had certainly been dethroned and its cultural pre-eminence superseded by the Romantic stress on sensitivity and feeling. Within this environment, the eighteenth century 'animalistic' view of the mad yielded increasingly to a new concept emphasising the humanity of the insane. Chaining and physical treatment competed more and more with the idea that the insane be given maximum freedom.

However, it would be wrong to correlate these innovations too closely to the "Romantic movement". For, with respect to the new thinking, the important date appears to be 1758. In that year, Dr. William Battie published his Treatise <u>On Madness</u> based on his

work at St. Luke's Hospital, London, which had opened seven years earlier. In this book, Battie, claiming that 'this distemper is as little understood as any that afflicted mankind',[36] advocated 'natural' forms of treatment, without violent vomits and purges. The practice of vomiting he described as 'a shocking operation'[37] and he advocated purges only in small doses. He believed that his patients' state of mind would be 'alleviated by diversions' and 'amusements'.[38] The second important stage in this process was the opening of the Manchester Lunatic Hospital in 1765, which, while practising many of the 'eighteenth century customs' described earlier, nevertheless, introduced innovations such as gardens, rewards for self control, separation of the sexes and convalescent wards.

However, despite these earlier pioneering ventures, it is certainly to the late eighteenth and early nineteenth century that one looks for the major developments in the insanity reform movement. In 1792, the York Retreat was founded by the Society of Friends. As Jones suggests, 'it was unique in two ways';[39] firstly in that 'it was neither a subscription hospital nor a private asylum, being financed - on a non-profit basis by a body of restricted membership',[40] and secondly 'because it evolved a form of treatment based, not on the scanty medical knowledge of the time, but on Christianity and common sense'.[41] The guiding light of the project was William Tuke (1732-1822), a tea

and coffee merchant and head of a York Quaker family. The principles on which the Retreat was run were later published by Tuke's grandson, Samuel, in his Descriptions of the Retreat (1813).

While these changes were being gradually introduced in England, Philippe Pinel, at his hospitals, the Salpêtrière and Bicêtre in Paris, was, during the French Revolution, in 1793 striking the chains from the insane. This was no mere dramatic gesture. Pinel consolidated his ideas in the Traité, a translation of which was published in England in 1806. It was out of a mixing of these diverse sources, from Battie, Tuke, Pinel, and others such as Esquirol and Duncan that what came to be known as the 'moral management of the insane', and later 'the non-restraint movement' was born.

Great prudence must be exercised in discussing this particular chapter in the history of the insane. Firstly, as has been suggested, moral management did not exactly sweep all competitors out of its way. The older, eighteenth century medical orthodoxies held their ground. Secondly, it would be simplistic indeed to view this process merely, 'as the replacement of wanton cruelty with new, enlightened and humane methods',[42] as Parry-Jones expressed it. Many practitioners of the old regime acted in good faith. Finally, in a movement as diverse as the moral management, generalisations are hazardous. However, time and space dictate economy,

and hence the following observations will be made.

Firstly, it would appear safe to assume that the moral management movement was, strictly-speaking, non medical in its thinking and approaches. Although earlier pioneers such as Battie, and many firmly associated with the movement such as Pinel and later Conolly and Gardiner Hill, were medical men, many others involved were not so trained. In particular, William Tuke had no such training and set up his Retreat precisely to get the insane away from the hands of the doctors. As Skultans has it, 'moral management offered the promise of a cure by non medical means'.[43]

Notwithstanding this anti-medical atmosphere, the moral managers did make their own distinct contribution to psychological thinking. According to Skultans, Pinel was particularly interested in the emotions rather than in mental activities. The emphasis should be on 'balancing' the emotions, rather than 'opposing' them.[44] This interest was termed 'moral' to distinguish it from a concern with the intellectual faculties, and was taken up by Samuel Tuke, William's grandson, in his Description of the Retreat. In contrast to the eighteenth century idea, which saw mental 'disease' as partly stemming from uncontrolled emotion, Tuke saw the emotions as being among the chief weapons in combating insanity. He writes:

> If we adopt the opinion that the disease originates in the mind, applications made immediately to it, are obviously the most

> natural -
> If on the contrary, we conceive that mind is incapable of injury or destruction, and that in all cases of apparent mental derangement, some bodily disease - really exists, we shall still readily admit - that the greatest attention is necessary to whatever is calculated to affect the mind,[45]

and again:

> Insane persons generally possess a degree of control over their wayward propensities - it happens not infrequently that one faculty only is affected - On all others, the mind appears to retain its wanted correctness.[46]

What appears to be being stated by Tuke then, is that, as a mental source of insanity cannot be found, a bodily or indeed environmental agent is responsible. Consequently, the older methods designed to purge and restrain the mind were not only useless, but very dangerous.

Also, the methods of 'treatment' devised by the moral managers followed from this premise. As Skultans wrote, Pinel freed his lunatics 'precisely because (he) felt their passions could be regulated and trusted'.[47] Emphasis was placed on the value and ability of self-control on the part of the patient. Restraint was reduced to a minimum. Fear and brute force were explicitly rejected, and kindness substituted by the attendants. A pleasant, creative, environment was planned in which the inmate's better self could be appealed to.

In order that this 'milieu therapy' be better appreciated, a brief look at the functioning of the

Retreat is called for. Jones writes that the patients there 'were never punished for failure to control their behaviour'.[48] Tea parties were given, and the patients 'encouraged to wear their best clothes'.[49] There were airing courts and 'each court was supplied with a number of small animals - rabbits, poultry and others - so that the patients might learn self control by having dependent upon them creatures weaker than themselves'.[50] The patients were always occupied, caring for the animals, helping in the garden, knitting and sewing. 'Writing materials were provided and books were carefully chosen to form a patients' library'.[51] Religious meetings were held and parties sometimes taken to the Quaker meetings in the city. 'In short, the patient was given no excuse for feeling that his mental condition precluded participation in normal human activity, or cut him off from the outside world'.[52]

The windows were specially designed to look like ordinary windows, 'the iron sashes being painted to look like wooden ones'.[53] 'Restraint was seldom used' except to prevent injury to the patient or his fellows',[54] 'chains were never used', and 'the strait-waistcoat only as a last resort'.[55] Medical treatment was given a subordinate place at the Retreat and drugs 'seldom used'.[56] 'The diet contained a generous amount of milk and meat, regular supplies of fruit and an extra small meal in the afternoon',[57] when the women got tea and coffee. The household expenditure included such

luxury items as wines, oranges and figs.[58] Finally, in the early days at least, the entire operation was conducted almost on an 'extended family' basis.

Now what emerges from this brief look at the Retreat is a picture of an idealised, religious, humanitarian community. In its work, the Retreat represented a revulsion against the earlier methods of treatment. As Skultans wrote, 'There is no medical content to this position, rather it is a rediscovery of the humaneness of the insane'.[59] Certainly, the Retreat did become a model for others to follow. Following the publication of Samuel Tuke's book, the ideas of moral management of the insane, which became the basis of the 'non-restraint movement' were taken up elsewhere.[60] In England, restraint was totally abolished for the first time by Mr. Gardiner Hill at Lincoln, between the years 1835-38, and by Dr. Conolly at Hanwell in 1839,an event attended by 'the fear and astonishment of medical men and the world at large'.[61]

Hence it would appear that the early decades of the nineteenth century were an age of improvement in the lunacy services. Based on a logic which claimed that insanity was caused not by mental dysfunctioning but probably by bodily ill-health or environmental pressure, the moral managers were not only able to 'prove' that evacuation and restraint were both wrong and dangerous, but to suggest that a cure was possible. It was clearly an optimistic time in the history of

the insane, during which confidence in the patient, acknowledgement of his humanity and the creation of a pleasant and creative environment for him were the ideals.

'Yet', as Jones writes 'things went wrong'.[62] For a variety of reasons, 'the clear vision of the early reformers faded in a welter of local politics and medical inertia'.[63] Skultans suggests that the asylums could not keep pace with the numbers and writes:

> With the swelling numbers of incurables, pretensions to moral management of the patients were abandoned and institutions became increasingly custodial. The deterioration in treatment was matched by the increasing size of the asylum.[64]

while Scull agreed that:

> The collapse of the asylum's pretensions to provide cure was matched by the decay and disappearance of all the crucial features of moral treatment - these elements which were supposed to distinguish the asylum from the prison.[65]

As one contemporary critic wrote 'individual interest in patients is all but dead'.[66]

Clearly then, the asylum was swamped by numbers and lost its restorative role, but it should not be forgotten that moral management had only a limited application anyway. As has been suggested, the older, medical, orthodoxy was by no means destroyed. Indeed, what probably happened in most asylums was a mixing of the two traditions. As the nineteenth century wore on, the older medical school, while shedding much of its, by then antiquated humoural theory, had its claims

to be the orthodox method of treating 'mental disease' heavily reinforced by neurological research. Towards the end of the century, a somatic base was increasingly advocated in what was coming to be known as mental illness, and a pessimistic prognosis followed. In this context, moral management appeared not only practically impossible but objectively wrong. Ironically, we have yet to decide whether 'nature' or 'nurture' 'cause' madness.

III

The lineages of the treatment given to the insane during the nineteenth century have now been drawn and the contrast between the medical orthodoxy and moral management brought out. We are ready now, to investigate conditions and methods in Scottish asylums, and, the original question posed in the introduction, can, in the light of what has been said, be reformulated in the following manner, - how far, if at all, was care and treatment in the Scottish asylums differentiated between medical and moral imperatives. In addition, however, the extent to which class demarcation effected methods will be considered. In prosecuting this enquiry, the care of the insane will be considered firstly through an examination of

the milieu created for them.

It need hardly be mentioned that the reformers placed great emphasis, not only on the pleasantness of the structures, but on their situation. Institutions for the insane should be kept at a distance from the nearest large community, and, if possible, acquire acreage, thus providing the ambience of a 'retreat', a 'home' for the insane.

According to Fish, Dr. Skae of Edinburgh believed that an asylum was 'a therapeutic organisation, not simply a custodial institution'.[67] In his eyes, the patient was to be 'surrounded by experienced attendants', permitted 'the greatest liberty', and in so far as safety allowed 'treated with utmost kindness'.[68] He also stressed the need 'for the healthy occupation of the mind'[69] and the good organisation of the asylum. Indeed Skae's definition of a well-run asylum was one of idyllic harmony. He wrote:

> Such a house subserves a variety of ends: it is a place for the isolation and safety of the dangerous; it is a retreat and home for the hopeless and incurable, it is a great hygienic hospital for the restoration of the insane to physical and mental health; a home for moral and physical education; it is also a school for elementary, artistic, scientific and religious education, and an industrial establishment where the busy crafts of artisans and gardeners, and all the homely occupations which can employ the hands and hearts of men and women, are called into systematic and daily activity.[70]

This indeed was a sentiment well in accordance with the ideas of Tuke, Conolly and Gardiner Hill, and

they were certainly shared by the Glasgow executives. Thus Dr. William Hutcheson, the first Physician Superintendent of Glasgow, writing in the Annual Reports, averred that:

> All the patients are addressed and treated as rational and accountable beings. Harsh words and gestures are avoided.[71]

The patients, 'under proper restrictions', were encouraged to 'congregate together' for work, exercise, entertainment and religion. There is much to suggest that these were no mere delusions on the managers' part, and, in looking at the application of these ideas, the environment in which the patients found themselves will first of all be considered.

These criteria the Royal Asylums, with their greater resources, were mostly able to fulfil; the poorhouses and private madhouses, generally, were not. With the single exception of the Montrose' house, which, in 1857 was built on the Links, close to the harbour,[72] all the Chartered Asylums, when visited by the Royal Commissioners in 1855, were situated at a distance from built-up areas. Thus Aberdeen's building was erected in the city suburbs,[73] while Edinburgh's was to be found two miles to the south-west of the city centre, at Morningside.[74] Both establishments at Glasgow were at a distance from the city, the early one (1814-43) being constructed at the then northern boundary while the later house (1843-) stood three miles away from the city at Gartnavel.[75] The Asylum at

Dundee was built on a piece of rising ground overlooking the Tay, about a mile to the east of the city,[76] while both the Perth and Dumfries regimes appear to have been truly rural ones. The Murray Royal was built a mile from Perth, in a situation described by the Commissioners as 'beautiful'[77] while the Crichton Royal was erected a similar distance from the town of Dumfries, overlooking the valley of the Nith.[78]

The amount of land owned by the directors ranged from the very small, at Montrose, with five-and-a-half acres,[79] to the expanse of Glasgow's sixty-six acres on the new site.[80] All lands were put to constructive use. Thus even Montrose's small holding was used as an airing ground and garden, and, in addition to their own acreage, the Directors held a lease of about twelve acres[81] of arable land in the neighbourhood for farming. Likewise, both Dundee and Perths' twelve acres were laid out as kitchen gardens, promenades, bowling green, cricket ground and such like.[82,83] At Perth, however, the Directors diversified extensively into farming, purchasing the house and new grounds of Pitcullen Bank, immediately adjacent to the grounds of the Asylum, in the early 1850s, for £5,500 and shortly afterwards a thirty-six acre farm costing £6,950.[84] Six of Aberdeen's twenty-three acres were occupied by airing grounds and nine were cultivated as gardens or were let or leased.[85] Dumfries' forty acres were roughly divided between pleasure grounds and cultivated

land[86] while Edinburgh's forty-three acres (in 1855) were apportioned to the east house (private) four and to the west house (pauper) thirty-nine.[87] Of the total, twenty-five acres were given over to arable farming, and the remainder divided between airing yards and gardens. At Glasgow's Gartnavel estate, a full-scale farming operation was in progress, with those parts of the sixty-six acres not used for pleasure grounds put to tillage.[88]

Their environment then permitted the Royal Asylums to develop their role as therapeutic communities. The physicians felt that the extensive lands, and their location, contributed to the cure rate. Moreover by diversifying into farming, running costs were not only reduced, but, by employing patients as agricultural labourers, a rudimentary type of occupational therapy was developed.

This ideal, the poorhouses and private madhouses could not meet. It should of course be realised that lunacy care was very much a second option for the poorhouses; non-insane pauper provision was their main objective and the parochial authorities felt, with some justification, to be under no obligation to attend to the finer aspects of lunacy care. As it was, only two of the poorhouses listed by the Royal Commissioners were in 'truly rural' settings, namely those at Easter Ross and Rhinns of Galloway,[89] while certain of the newer houses, in the Royal Commissioners' view,

'generally occupy pleasant sites in the suburbs of towns,[90] but the lands attached to them were described by the Commissioners to be 'generally much too limited'.[91] The older houses, such as Edinburgh City and St. Cuthbert's, Paisley Abbey and Glasgow's City, Barony and Govan, were situated in the centre of developing urban-industrial complexes, as were almost all the private madhouses with the possible exception of Ayr, Bothwell and Tranent.

In turning now to look briefly at the architecture involved, considerable insight can be gained into the Victorian thinking on asylums. This can be best summed up by William Stark, architect of the original Glasgow Royal, and a great admirer of the York Retreat, who published a book Remarks on the Construction of Public Hospitals for the Care of Mental Derangement, in 1810,[92] in which he advocated two principal criteria - strict separation of the sexes, and effective class division. It would appear, judging by the way in which the Royals were built, that Stark's views were widely shared.

If we look at all seven regimes, it can be seen that either separate buildings were constructed, within the overall plot, to house pauper and private patients separately, or within the single edifice, effective divisions were established. Although Glasgow, Edinburgh and Dumfries started out as single units, they eventually became dual ones, while the remaining four remained as single entities.

When the Edinburgh management finally agreed to admit paupers, in 1842, they built a new structure, to be called the 'west house' which became the pauper depository for about 500 persons, while the original building, then known as the 'east house', was reserved for about 60 private patients.[93] In contrast, both the Glasgow and Dumfries 'Royals' started as single unit institutions admitting both the private and the fee-paying patient. However, when the Glasgow operation removed to Gartnavel in 1843, the Edinburgh model was applied with an 'east house', for about 290 paupers and a much smaller 'west house' for the 'private' patients.[94] At Dumfries, the construction of the Crichton Royal reflected the wishes of Mrs. Crichton and hence, in the early years, an attempt was made to integrate both the private and the pauper patients. But this experiment in integration ended with the opening of the Southern Counties Asylum in 1849 and the transfer there of the entire pauper load. From then onwards, Dumfries had two distinct buildings and administrations for the private and pauper patients. Division between the sexes was maintained in all three cases, although more forcibly, it would appear, among the paupers.[95]

The remaining four institutions practised rigid sex and class demarcation under one roof. Thus the model for both Aberdeen and Montrose was of a central complex, with extension wings on both sides,

each leading in turn to lateral wings. Aberdeen was a two storey building, the first floor consisting solely of the bedrooms and sitting rooms of the private patients, while the second was reserved for the paupers. The extension wings in both houses served to maintain the sex division,[96] but the class division at Montrose was slightly different from that at Aberdeen. Here, the private patients' dayrooms and bedrooms were apparently to be found at the central complex, while the pauper apartments were in the wings.[97] The Royal Asylum at Dundee presented the idiosyncratic structure of a number of storeys alternating as private and pauper departments,[98] but it was at the Murray Royal at Perth that the social stratification, inherent in the planning of the 'Royals', appeared quite clearly. The institution consisted of a main front building of three storeys in height divided into two equal parts (one for the males, the other for the females) by a central staircase. Those paying the highest rate of board were accorded service and accommodation in the third floor. Those paying the lower rates were to be found on the middle floors while the paupers were incarcerated on the ground floor.[99]

Further evidence of this state of affairs can be gained by looking at the actual accommodation for the patients in the houses. Aberdeen provided 'bedrooms' for its 'better' class of paying patients, with eight three-bed 'dormitories' for the other paying patients and sixteen large 'dormitories' for the

paupers.[100] At Dumfries, the Commissioners wrote that suites of two rooms were allowed 'to patients of the upper classes, a bed room and the use of two public rooms' to patients of the middle classes', and a common dormitory and public room to patients of the lowest class.[101] The Edinburgh private east house consisted of seven rooms in a wing and five rooms on the ground floor, while the pauper west house was composed of three galleries each including dormitories of sixteen, eighteen and nineteen beds.[102]

Any doubts about the management's thinking in this area is dispelled by reference to both the Perth and Glasgow Royal Asylums' accommodation design. At Perth, the first class, ironically the paupers, were housed in gallery A, with one public room and patients sleeping in 'dormitories'. The second class were housed in gallery C, with one public room, and patients sleeping in 'comfortably furnished' dormitories. The third and fourth classes in gallery B had only one public room, but enjoyed 'separate sleeping rooms, handsomely furnished' while the fifth class had separate apartments, with parlours and bedrooms <u>en suite</u>, again 'handsomely furnished'.[103] At Glasgow, many of the pauper wards were described by the Commissioners as 'dark, damp, and smell offensively'. They noted that, in some places, the bedding was made up on the floor, without actual bedsteads, while in others, beds made of iron and mattresses of straw were the norm. The

coverings were ample, but each bed had only one sheet changed once a week. The procedure for coping with refractory patients (noted elsewhere) included canvas bottom beds stood over troughs sunk in the floor.

This state of affairs can be contrasted with the 'service' offered the highest fee paying patients at Glasgow. One notes first of all that the sleeping rooms were all 'fully and comfortably furnished', the walls 'variously papered' and the corridors 'carpeted throughout'. Most of the latter contained pianos and timepieces. Most windows had curtains, and the general effect was 'one of elegance and comfort'. In one such corridor were to be found three gasfires, two rosewood tables, a piano, ottomans, small tables for occasional use, Elizabethan and other chairs.[104]

Now there was much in this state of affairs which appealed to Victorian tastes. While the sex division was to them manifestly hygienic, the class division ensured that the refined natures of the genteel were not exposed to the 'lower orders'. It is doubtful if the Royals could have attracted as many private patients into their environs without such a guarantee. However, to what extent class division appealed to the moral managers as such is problematic. But, in the long run, the division made medical sense in that, as the century progressed, and numerical pressure made life more problematic in asylums, a division for the

functions therein into 'curative' and 'depository' roles became essential. As has been shown, the latter were increasingly associated with pauper wards and later pauper asylums. For these reasons then, the Royal Commissioners expressed themselves satisfied as to the planning and execution of the Royal buildings.

In contrast, the Commissioners were almost entirely critical of the private madhouses in this respect. They pointed out that, with one exception, Saughtonhall, none of the private madhouses in existence then had been originally built for the purpose.[105] Certainly there had been some examples of proprietors incurring expenses to ensure suitable accommodation for their charges, but generally a private house had been rented or bought, and afterwards altered or enlarged, to fit its new role. The sole aim, suggested by the Commissioners had evidently been to 'accommodate the greatest possible number at the smallest outlay'.[106] In some cases, outhouses had been fitted up with beds and used as accommodation for patients. In other asylums, such as Langdale, large dormitories had been built, sufficiently spacious for the number of occupants, but in the Commissioners' words, 'bare, comfortless and insufficiently furnished'.[107] Other criticisms which the Commissioners made was that there was insufficient means of avoiding overcrowding, and that there was no proper division for male and female patients.

The Royal Commission was no less critical of the accommodation offered the pauper insane in those poor houses which provided for them after 1845. In the poorhouses where no special provision was made for the insane, those admitted mixed with sane paupers in 'large dormitories, barely furnished' and 'day rooms, equally bare'.[108] Conditions appeared little better in the poorhouses with separate lunatic wards; the Commissioners concluded that 'the lunatic wards are small and ill-contrived and do not permit a proper classification of the patient'.[109] In some houses, for example the Barony in Glasgow, the patients were placed in a large dormitory, making classification impossible.[110] In others, they were to be found in rooms of smaller size and packed so closely together that the noise of the refractory patient disturbed the peace of the rest.[111] Little attempt was made to afford the inmates a 'cheerful prospect', the rooms were usually badly furnished, often containing only benches and a table, and, in general, there was no separate sick room or infirmary.[112] However, in detailing these criticisms, it should be borne in mind that poorhouses were not built with lunatics principally in mind, and that the less eligibility principle extended as much to the insane pauper as the non-insane.[113]

Turning, finally, to such basic essential services as the ventilation and warming of the asylums, the Royal Commissioners felt that this problem 'does

not appear to have as yet received a satisfactory solution' in the Chartered Asylums. At Dundee for example, warming was dependent upon fire-places and the only means of ventilation were the windows. As a result, during the winter nights, it became so cold that restless patients had to be clothed in bed.[114] At Glasgow, the proper working of the heating apparatus, by piped hot water, necessitated keeping the windows shut,[115] whereby the atmosphere became close and oppressive, while at Edinburgh, the Commissioners felt that the ventilation of several rooms was 'defective'.[116] Generally, however, the Chartered Asylums were 'well lighted with gas' and the supply of water, 'with few exceptions', was 'abundant'.[117]

In the poorhouses, ventilation varied. Occasionally, it was dependent simply upon windows and open fire-places. In some houses, however, there was direct communication with the open air, with apertures above doors, while in others, an opening between the dormitory and the corridor sufficed. The heating systems were operated, either by introducing air 'by the suction of a flue' or 'pumped in by steam engine'.[118] The Commissioners were tolerably satisfied with this matter, but drew attention to some drawbacks. At Barony, for example, the medical officer reported that the ventilation system did not operate, stating that:

> ....when the windows are closed, the patients complain of the closeness and oppression of the air, and

> when they are open the action of
> the apparatus is apt to be damaged
> and the current to flow backwards.[119]

The Commissioners were generally critical of the private houses. In these crowded buildings, absence of any adequate warming and ventilation system, 'engendered a highly contaminated atmosphere'.[120] In many, the windows, even in summer, were almost always closed during the night and the fireplaces were generally boarded up 'so that ventilation was impossible'.[121] At Hillend as in other houses, the sleeping rooms had no fireplaces, while at Lilybank there were such essentials but they were boarded up.[122]

Thus far, having considered the external aspect of the asylums, it would appear that the Royal Asylums can be regarded as progressive institutions. They were, in most cases, set in semi-rural settings, extensive lands were used for cultivation and recreation, and the buildings were adequately constructed. In particular, the insistence on rigid sex divisions was considered highly laudable, and indeed, as regards architecture, a direct connection can be seen between York and Glasgow as the latter's architect derived many of his ideas from the Retreat. The Royals' reputation in this sphere can only be enhanced, when compared with the private madhouses and poorhouses, urban, small, and inadequately constructed. What is problematic, however, was the policy of the Royals towards the pauper insane, which appears to have been as cavalier

as the parochial authorities. Whether or not the demarcation referred to was in the best traditions of the moral managers, it should be recalled that Victorian society was rigidly class-conscious. The Royal Asylum managers merely reflected their values in this respect. In their eyes, the division was both morally correct and economically sound.

The extent to which the Royal Asylums can be regarded as progressive, enlightened institutions, and the comparison with their 'competitors' will now be investigated further by reference to internal aspects of care. Five topics will be considered, patient hygiene, exercise, occupation and amusements, and diet.

IV

The patients in the Royal Asylums were essentially well clothed although it would appear that Montrose was an exception. 'Several dirty and refractory patients had no bedding' except loose straw and a blanket'[123] and the Commissioners ascertained that:

> ....it is the custom in this Asylum when patients are violent and destructive, to remove all their clothing and to supply them with no clothes, coverings or beddings, except blankets and straw.[124]

In several of the asylums, locks and straps were used to fasten the dresses of patients who stripped themselves.

Beds were found to be generally clean and comfortable, with mattresses or sea grass, but, in frequent cases, provided with only one sheet. Straw was in some cases used as bedding, but was regarded as both objectionable and expensive as it required frequent change. It was noted, on the other hand, that some of the asylums allowed private patients to provide their own bedding, which was usually 'of a good description'.[125]

The problem of the refractory patients was 'solved' in most Chartered Asylums by the use of straw mattresses and canvas bed bottoms. Thus, in Glasgow, beds for the wet patients were stood over leaden troughs, sunk in the floor, into which passed the urine from the beds and they were cleared by being flushed with water.[126] 'All the Chartered Asylums were provided with fixed lavatories and personal cleanliness was generally well attended to', wrote the Commissioners, although in some houses, the supply of warm baths was deficient.[127]

This reasonable state of affairs contrasted with those pertaining in the poorhouses. Although clothing generally appeared to the Commissioners as being 'sufficient' and clean, the beds 'tolerably comfortable' and personal cleanliness 'tolerably well attended to'[128] there was much that was negative in the poorhouses. Thus, for example, most beds had only one sheet and the blankets were far from clean. The practice of placing two patients in one bed,

both in male and female dormitories prevailed in many poorhouses, and the bedding of wet patients, usually straw, was frequently not changed for considerable periods.[129]

At Dunfermline, the bedding was found to be 'in a very foul condition, drying in the yard',[130] while at Jedburgh patients of dirty habits were placed to sleep in common dormitories with healthy paupers.[131] Many of the poorhouses in the Western districts appear to have adopted the Glasgow Royal's model of coping with refractory patients, a practice the medical officers at Barony regarded as conducive of rheumatism.[132] At Falkirk, it was stated that 'the bedsteads are of iron, the bedding consists of a straw mattress, chaff pillow, blankets and one sheet'[133] while at Aberdeen, it was noted that 'the bedsteads are of wood or iron, the mattresses of straw and the pillow of chaff. Each bed had only one sheet'.[134]

Conditions in the private madhouses were no better, if not worse. Bedding consisted of straw mattresses and usually only one sheet to a bed. The provision made for refractory patients was generally very bad indeed, with the mattresses, although soaked in urine, being left, in some cases, for several days unchanged. In certain houses, the inmates were put to sleep on loose straw alone.

At Hillend, there was no provision for preventing the urine dripping on the floor, which, as a

consequence was constantly wet. Patients who were incontinent had night shirts which reached to the waist only, or were made to sleep naked, often two or three in a bed. These beds rarely had sheets, while the blankets and coverings were often found to be scanty.[135] At Eastport House, Musselburgh, the bedding of the dirty patients was found by the Commissioners drying in the yard outside. The mattresses, used by such patients, were 'not changed', although the straw was said to be renewed 'once a week'.[136] At Hallcross House, again in Musselburgh, where a patient was discovered sleeping in a press under a wooden stair, 'through which apertures are bored to give him air', it was stated that there 'was no change of mattresses for wet patients; they are simply dried and replaced' and the straw renewed once a week.[137]

With a few exceptions, the licensed houses did have the means of giving their patients a warm bath which was generally a shower bath, although used partly to calm excitement and occasionally as a punishment. But washing accommodation was extremely defective, with frequently no basins and patients having to bath in tubs, or at the pumps.

In proceeding now to the second issue to be discussed here - exercise, the Royal Commission questioned the pretensions of the Royal Asylums in this respect. It will be recalled that, the Royals, with their extensive lands, were well placed to

provide exercise for their patients. Much was made of this facility by the management. However, on investigation, the Royal Commission noticed that the necessity to separate the classes placed great strain on this 'service'. Double sets of airing courts were required, and hence, at Perth, Dundee and Aberdeen, numerous small courts were found, divided from each other which, to a great extent, shut out views of the surrounding countryside. In some circumstances, mounds had been erected, so as to enable the patients to look over the enclosure walls. But what was regarded as a specific injustice by the Commissioners was the fact that, in most cases, the numerically smaller number of private patients had larger courts than their more numerous pauper patients.

Thus for example at Dundee, there were, when the Royal Commission visited, 38 private and 175 pauper patients to 10 airing courts, but while one private patient had the sole use of one court, about 60 to 70 paupers were crowded into another of the same size.[138] At Glasgow, it was found that there were two airing courts for 87 private patients and 3 courts, one of them very small, for 329 paupers.[139]

The poorhouses did have airing courts but they were very small, and usually shut in by very high walls. At Falkirk, for example, the courts were 20 yards long by 10 yards broad, surrounded by 18 feet walls, while at Paisley the airing court for men

measured about 25 yards by 14, for women 16 by 12, and both were surrounded by walls 15 feet high.[140] At Greenock, both courts were 30 yards long by 20 broad with high walls, while at Stranraer the measurement was 12 by 8.[141]

In private houses, the Commissioners found a few of the airing courts of fair size and 'tolerably cheerful',[142] but, in general, they were found to be very small, gloomy, surrounded by high walls and without any views. At Hallcross, the same court served for both sexes.[143]

Thus far, in this discussion on aspects of care, three ingredients - patient hygiene and exercise, along with essential services, have been discussed. However, the extent to which one can cite these cases as being examples of moral treatment, or otherwise, is limited, as all three were necessary in regimes for the insane. What is disturbing, however, is the degree to which the poorhouses and private madhouses failed in even their very basic aspects, while the Royal Asylums were not blameless. The other insight to emerge is of course the continuing flavour of the class division, with, for example, private patients being permitted their own bedding, and private airing courts being larger than pauper ones, in the Royal Asylums. The generally higher quality of service in the Royals, compared with their competitors, is of course also indicative of this state of affairs. But

the debate over moral management can be more effectively prosecuted over occupation and diversion.

V

Writing in the Annual Reports, Dr. Balmanno of Glasgow expressed the view that occupation was one of the 'most beneficial means in the treatment of the insane'. It prevented the mind from dwelling on its delusions, and also put an end, frequently, to the restlessness which Dr. Balmanno felt attended forms of the disease.[144] Dr. Skae agreed with this view. Indeed in appending his first report to the Edinburgh Annual Reports he wrote that occupation of the patients was 'among the first subjects' which engaged his attention. This doctor felt that, as a result of these innovations, many of the inmates were 'induced to exchange a listless and inactive mode of life for one of greater freedom and variety'.[145] In this context the gap between the Royals and their competitors was very wide, with the former approximating, to a reasonable degree, to the moral management ideal.

All seven Chartered Asylums put their varying acres of land to productive use. For example, Aberdeen had 'nine acres cultivated by the labour of the patients',[146] while at Dumfries, part of the lands 'were cultivated by the patients of the (pauper) Southern Counties Asylum'.[147] At Montrose, the

Directors had on lease twelve neighbouring acres which were 'cultivated by the poorer class of patient'[148] while at Glasgow those lands not already taken up by building and airing courts 'were under tillage'.[149] However, the Royal Commissioners expressed some dissatisfaction on this score. They felt that whereas the land in occupation was good soil and very productive, 'full benefit in this respect, and also as means of exercise is not derived'.[150] Instead, too much attention was paid to the laying out of roads and gardens which tended to reduce the amount of land under crop.

The Commissioners were equally dissatisfied with indoor occupation. It was noted that, in most of the asylums 'a few were employed at tailoring, shoemaking and carpentry',[151] 'The females find some occupation in the washing house and laundry, and also in sewing, knitting and making underclothing'.[152] But the Report stressed that 'sufficient means of suitable employment', was not provided and that workshops were required.[153]

The Commissioners' comments do appear somewhat harsh. Reference to the Appendix to the Report shows that, for example, at Aberdeen there were two workshops,[154] and at Dundee weavers' workshops.[155] In the latter 'a considerable number of the pauper patients were employed in weaving coarse packing-cloth'.[156] At Glasgow, the Annual Reports refer to the opening of extensive workrooms in which carpentry,

joinery, basket-making and various other trades were followed. Indeed, in contrast to the Commissioners' scepticism, these Reports paint a lyrical picture of patients relaxing in the evening, after their long day's labour. In fact, as far back as 1817, the Glasgow Asylum was busy putting these ideals into practice. At that time:

> ....2 looms and 5 spinning wheels are generally left at work. Clothes are made or mended. Stockings or worsted gloves are knit and occasionally a little muslin is flowered.[157]

By 1821, male patients were working at tailoring, shoemaking, joinery or bookbinding, while spinning, sewing and washing were the main female occupations. At first the work done was for the use of the Asylum alone, but after 1839, some of this produce was marketed. There is no need to doubt that some of the work was of good quality. Hence, for example, in 1840, the weaving department produced 200 yards of handkerchiefs, the tailors made 15 frock coats and 17 dress coats while the wrights made 21 beds and articles such as rosewood work-boxes, bookstands, a mahogany work box, writing desks and 10 chests of drawers.[158] At Edinburgh, Dr. Skae averred that:

> ....gardening, carpentry, shoemaking, tailoring, bookbinding and basket making have in particular, been prosecuted with a degree of success beyond any sanguine expectations.[159]

The extent to which one can trust these somewhat idyllic, and also self-congratulatory state-

ments is problematic. Certainly, as Chapter Eight reveals produce marketed by the Glasgow and Edinburgh Asylums made a small but not insignificant contribution to the institutions' finances. Moreover, one learns that, in Glasgow, 'in order to extend this most important means of moral treatment'[160] the Directors instructed the Weekly Committee, on the 14 September 1837 to build full workshops, which were opened in the following year. But Glasgow, in particular, had very extensive lands, and, the Royal Commission is perhaps correct in saying that not enough was done by the Royal Asylums to maximise this resource.

Hence, while obviously much more could be done in this respect, it would appear that, with variations, of course, the Royals could be classed as progressive institutions as they did practise a rudimentary form of occupational therapy. It will have been noted, in passing, that paupers appeared to be the class most attended to in this respect; as the Royal Commissioners conclude:

> In none of the asylums, with the exception of that of Dumfries, have the efforts to prevail on the private patients to engage in manual labour been attended with any great success.[161]

The contrast, however, between the Royals, and the other two regimes with respect to 'occupational therapy' was, not surprisingly great.

As far as the Commissioners could discern, only two poorhouses had sufficient land to allow

occupation for the patients - the Barony with thirty acres and the Abbey, Paisley with eighteen.[162] In some of the other houses, such as at Paisley Burgh, several of the patients were employed in weaving, but in general, there was an 'almost total lack of the means of occupation'.[163]

In some of the private houses, a certain amount of garden ground was attached, which furnished a small amount of occupation to the patients, but only in one, at Langdale, was the quantity of land sufficient to afford proper employment. Nor, it would appear, was there much effort expended to provide indoor employment. The females did have an advantage as they assisted in the house and laundry, but otherwise, there was little in the way of occupation.[164]

In turning to the penultimate topic in this area - recreation, the Commissioners, in contrast to their opinion on occupation, were most enthusiastic about the Royal Asylums. 'Very much',[165] had been done to provide recreation and amusements. Various sports and games had been introduced, and in most of the houses, there were 'frequent excursions and occasional pic-nics, concerts, lectures, evening parties and dances.[166]

The Commissioners felt that the asylum which had done least in this respect was Aberdeen. There were occasional concerts and a few excursions, and a Christmas Ball, but little seems to have been done to

'break the routine and monotony of the asylum'.[167] At Dundee, there was a billiard room for the males, and in summer, there were frequent dancing parties in the grounds.[168]

At Glasgow, games such as draughts, backgammon, billiards and bowls were provided. A library was eventually opened, use having been made provisionally of a travelling one, in which books on religion, history and travel, along with magazines, were particularly popular. A significant aspect of the patients' life in the Asylum was their letter writing and works of prose and poetry, described, in one case, as having a 'wonderful degree of consistency and acuteness'.[169] Entertainments were also provided for the patients during holidays and national events. At Edinburgh, similar games, a library, stocked with newspapers and periodicals, music, dances, excursions and lectures were laid on. It would appear that these provisions, at least, were not reserved for the 'higher' patients solely. Perhaps the best (although idealised) evocation of this aspect of asylum life, in the literature, comes from the Directors of the Glasgow Royal who wrote in 1839 that:

> In the evening, after the labour and exercises of the day, the patients may be seen in the well-lighted parlours, billiard-room and galleries, cheerfully employed in reading, playing backgammon, cards and billiards, or solacing themselves and their companions with the flute, the violin and the pianoforte.[170]

Certainly, the institution which did most in this respect was the Crichton Royal. According to the Commissioners, patients of both houses (i.e. those belonging also to the pauper Southern Counties Asylum) had 'abundant means of recreation and amusement'.[171] An 'omnibus' and other carriages were provided, which enabled the patients to make frequent excursions, and there was a small theatre, with seating for 110, in which concerts and plays were performed. Writing and drawing materials, and books were supplied and courses of lectures delivered, on such topics as botany, chemistry and natural history. There was a library of 5,000 volumes, and an extensive museum of Natural History. During the summer, a house was taken 'at the seaside' for the benefit of patients.[172]

There can be little doubt then, that in the enterprise of providing a 'quasi-normal' recreational milieu, most of the Royals were successful. Indeed, if the accounts given to the Commissioners of recreation at Dumfries were representative, this institution must rival the York Retreat, but, once again, the contrast with the rest of lunacy organisations in Scotland was stark.

In the poorhouses, in general, no means of amusement was within reach of the patients. Occasionally draught boards and a few books were provided, but otherwise, 'nothing whatever is done to afford the patients either amusement or occupation'.[173] In

some of the licensed houses, patients were supplied with books and newspapers, and had the use of billiard tables and bowling greeens, but, like the poorhouses, very little of consequence was done in this respect.[174]

Leave cannot be taken of this area of discussion without briefly probing the extent of religious succour offered in the houses, again, a hallmark of moral treatment. The Commissioners noted that chaplains were appointed to all Royal Asylums. Dundee and Aberdeen had gone so far as to build chapels, while at Dumfries, Episcopalian and Roman Catholic clergymen attended, in addition to the established minister.[175] In the poorhouses, there appeared to be little uniform provision, and variations were made according to the views of the parochial board and house governor. In some circumstances, the governor read prayers while in others, non-licentiated officials attended. The Commissioners drew attention to the fact that, in some cases, the insane paupers were actually excluded from this poorhouse service.[176] The religious function appeared almost entirely absent in the licensed houses. It was thought that a missionary attended the Musselburgh houses occasionally, but it did appear to the Commissioners, that no clergyman of the established church ever visited the house.[177]

At this point in the analysis, it should come as no surprise to the reader, in discussing the final topic - diet, that the difference between the classes

was profound. In looking, first of all, at the private patients' fare, the Commissioners wrote that it was 'varied and abundant'.[178] An analysis of the various diet tables submitted to the Commissioners showed that their insights were broadly accurate. For breakfast, paying patients, depending on their fee, could enjoy tea, egg, fish, bread, oatcakes and butter. At Dumfries, cold meat was also served. For dinner, there was much variety but it would include, in most cases, soup, fish or meat, vegetables, potatoes, puddings, bread and cheese and coffee, while for tea, there was tea and bread. The day was rounded off with a supper of eggs or pudding, tea and bread.[179]

The regimen varied, of course, in variety and amount, according to the rate paid, but some understanding of just how luxurious, in Victorian terms, the diet could be, particularly for those paying the highest rates can be gained from the following data. Dumfries had wine on the menu and game in season.[180] Aberdeen provided beer for its better classes,[181] while Dundee ordered wines, malt liquors and spirits for this class.[182] Both Dundee and Edinburgh refrained from drawing up a diet sheet for its better patients, as they were accustomed to giving their 'own directions regarding the furnishing of their table',[183] while the latter's inmates got five meals a day.[184] In this respect the Commissioners were perhaps correct when they inferred that

the bill of fare for the highest class at Dundee was similar to that of an hotel.[185]

And indeed we can appreciate precisely why the Commissioners took this view when we look at one particular private diet sheet, namely that of Glasgow's in 1855. For breakfast, the private patient received coffee, 14 ounces of bread, 1 pint of tea, 1 egg or 3 (female 2) ounces of ham, 1 ounce of fresh or salt butter, 1 gill sweet milk, and, if taking porridge 1-1½ pints with skimmed milk. For dinner there were 1½ pints of soup, 8 ounces (female 6) of cooked meat, in the form of roasts, stews, fowls and pies, with either 2½ ounces (female 2) of rice or one pound of potatoes, and one pound of split peas, with extra vegetables, mustard and pepper. There were puddings twice a week, usually tarts, jellies or fruits in season. For supper, there was beer and cheese.[186]

In addition, although the pauper diet in the Royal Asylums was both less varied and less in quantity than that of the private patients, it was, however, above the dietary standard of the Scottish working class and peasantry at the time.[187] Beyond individual variations, the routine of the pauper diet was as follows. Breakfast consisted of porridge and milk or tea and bread. For dinner, the staple food was broth with vegetables, potatoes and bread and 'a small quantity of boiled beef every day, or a larger quantity on alternate days'.[188] For supper there was again

porridge and milk. Working patients usually had their diets increased with extra bread and cheese, and beer.[189]

Again, we can gain a more full appreciation of pauper diets by looking at Glasgow's provision. For breakfast, 2 pints of porridge, ½ pint of butter milk, and 4 ounces of bread (2 if female) were given. At dinner, 2 pints of peas soup was provided on Sundays, followed by 2 pints of broth for the rest of the week. 4 ounces of cooked meat and 3 ounces of rice formed the basis, with sweetmilk and bread occasionally offered. At supper, the males received 2 pints of porridge and ½ pint of butter milk, and females 1 pint of tea and 6 ounces of bread.[190]

This, in some respects, luxurious private diet, and adequate pauper regime has to be contrasted with the bill of fare offered in the poorhouses and private madhouses. In order to obtain some uniformity with regard to poorhouses, the Commissioners referred to the dietary rules and regulations drawn up by the Board of Supervision on 3rd July 1850, which was obligatory on all poorhouses in which insane or fatuous paupers were maintained. Examination of that list, which related to seven different categories of pauper age and conditions, indicated that, with two exceptions, the staple for all three meals was meat, bread, milk and broth. The exceptions were working adults, category C, who received boiled beef, while category D, the infirm, received their milk skimmed.[191]

porridge and milk. Working patients usually had their diets increased with extra bread and cheese, and beer.[189]

Again, we can gain a more full appreciation of pauper diets by looking at Glasgow's provision. For breakfast, 2 pints of porridge, ½ pint of butter milk, and 4 ounces of bread (2 if female) were given. At dinner, 2 pints of peas soup was provided on Sundays, followed by 2 pints of broth for the rest of the week. 4 ounces of cooked meat and 3 ounces of rice formed the basis, with sweetmilk and bread occasionally offered. At supper, the males received 2 pints of porridge and ½ pint of butter milk, and females 1 pint of tea and 6 ounces of bread.[190]

This, in some respects, luxurious private diet, and adequate pauper regime has to be contrasted with the bill of fare offered in the poorhouses and private madhouses. In order to obtain some uniformity with regard to poorhouses, the Commissioners referred to the dietary rules and regulations drawn up by the Board of Supervision on 3rd July 1850, which was obligatory on all poorhouses in which insane or fatuous paupers were maintained. Examination of that list, which related to seven different categories of pauper age and conditions, indicated that, with two exceptions, the staple for all three meals was meat, bread, milk and broth. The exceptions were working adults, category C, who received boiled beef, while category D, the infirm, received their milk skimmed.[191]

Unfortunately, we are frustrated in attempts to build up a picture of diets in the private madhouses, as no tables were kept. But reference to the Appendix to the Report did throw some light on the problem, in situations where the Commissioners had observed mealtimes. Thus, at Hallcross House, the fare for the paupers was 'porridge and coffee for breakfast, ox head broth for dinner, and porridge again at night', while the private patients were said to have both 'coffee and toast for breakfast and broth and beef for dinner'.[192] At Millholme House, again at Musselburgh, porridge and milk were served at breakfast and supper, and broth and bread for dinner.[193] The same applied to both Tranent[194] and Langdale asylums,[195] although, in the former, coffee was given and in the latter some meat. Once again, diet clearly throws light on the distinctions both within the Royal Asylums, and between them and their rivals.

VI

When these factors are taken into account, it can be seen that the Royals' pedigree as a progressive institution is, on balance, advanced. While the Commissioners were correct, when they criticised the Royals for under-utilising their resources with respect to recreation and occupation, nevertheless, the fact that the institutions were engaged in such practices

was indicative of good intention. Moreover, while aspects of the essential services and patient hygiene clearly needed improving, the Chartered Asylums, by Victorian standards, were by no means backward in this area. Furthermore, the extent to which the Royals offered both recreation and religious succour is clear evidence that the houses were, in these areas, practising moral management. Their limitations notwithstanding, the Royals, as least as far as 'caring' for the insane, was concerned, can be seen as more or less part of the moral management movement. In contrast, the evidence from the Royal Commission indicates that very little was done in the poorhouses and private madhouses to humanise the insane. Basic essential services and patient hygiene were, in many cases, appalling even by Victorian standards, while little was done to occupy, amuse and entertain the inmates. Finally, the class division which existed within the organisation of insanity in nineteenth century Scotland is by now patently obvious.

REFERENCES AND NOTES

1. Quoted in Fish, op. cit., 39.
2. See Ch. 10, p. 492.
3. See Ch. 10, p. 492 and Note 13.
4. Alexander & Selesnick, op. cit., 110.
5. E.Ackernecht, A Short History of Psychiatry (New York, 1959),37
6. Alexander & Selesnick, op. cit., 112.
7. ibid., 113.
8. Ackernecht, op. cit., 38.
   The interpretation of Alexander & Selesnick, op. cit., 38, is slightly different.
9. Quoted in Ackernecht, op.cit., 38.
10. ibid., 38.
11. Fish, op. cit., 42.
12. Quoted in Fish, op.cit.,43.
13. Quoted in Fish, op.cit.,43.
14. Quoted in Fish, op.cit.,43.
15. See Ch. 1, p.29.
16. Henderson, op. cit., 120.
17. Alexander and Selesnick, op. cit., 152.
18. Quoted in Alexander & Selesnick, op.cit.,152.
19. ibid., 153.
20. ibid., 163-4, & see Ch. 1, p.26.
21. 164 and see Ch. 1, pp. 24-25.
22. Scull, op. cit., 127. 'Throughout the eighteenth century a major way of drumming up trade and attracting clients - was by publishing small books - making considerable claims for the author's success in curing lunatics.'

23. Jones, op. cit., 6-7.
24. Scull, op. cit., 127.
25. ibid., 127.
26. ibid., 125.
27. Jones, op. cit., 7.
28. ibid., 7.
29. Quoted in Jones, op.cit., 7.
30. ibid., 7.
31. ibid., 7.
32. Quoted in Jones, op.cit., 7.
33. Quoted in Jones, op.cit., 16.
34. Parry-Jones, op. cit., 171.
35. Quoted in Jones, op. cit., 16.
36. Quoted in Jones, op.cit., 41.
37. Quoted in Jones, op.cit., 41.
38. Quoted in Jones, op.cit., 41.
39. ibid., 45.
40. ibid., 45.
41. ibid., 45.
42. Parry-Jones, op. cit., 171.
43. Skultans, op. cit., 57.
44. ibid., 54.
45. Quoted in Skultans, op.cit., 57-58.
46. Quoted in Skultans, op.cit., 58.
47. ibid., 54.
48. Jones, op. cit., 49.
49. ibid., 49.
50. ibid., 49.

51. ibid., 50.

52. ibid., 50.

53. ibid., 50.

54. ibid., 50.

55. ibid., 50-51.

56. ibid., 52.

57. ibid., 52.

58. ibid., 52.

59. Skultans, op. cit., 61.

60. There is an interesting connection between York and Glasgow in that William Stark, the Glasgow Royal's Architect, praised and claimed to be influenced by the Retreat. See Ch.8, pp.376-377.

61. Skultans, op.cit., 59.
Jones, op. cit., 115, also points out that Dr. Charlesworth, visiting physician at Lincoln, gradually reduced restraint before Mr Gardiner Hill between the years 1829-35.

62. Jones, op. cit., XII.

63. ibid., XII.

64. Skultans, op. cit., 122.

65. Scull, op. cit., 194.

66. Quoted in Scull, op.cit., 199.

67. Quoted in Fish, op. cit., 48.

68. Quoted in Fish, op.cit., 48.

69. Quoted in Fish, op.cit., 48.

70. Quoted in Fish, op.cit., 48.

71. Glasgow Annual Reports, op. cit., No. 28 (1842), 44.

72. Royal Commission Report, op. cit., Appendix, 84.

73. ibid., 41.

74. See Ch. 8, pp. 378-79.

75. See Ch. 8, pp. 374-378 and pp.403-405.

76. Royal Commission Report, op. cit., Appendix, 55.

77. ibid., 91.

78. ibid., 48.

79. ibid., 82.

80. ibid., 72.

81. ibid., 82.

82. ibid., 53.

83. ibid., 89.

84. ibid., 89.

85. ibid., 38.

86. ibid., 45.

87. ibid., 62.

88. ibid., 72.

89. See Ch. 5., p.239.

90. Royal Commission Report, op. cit., 134.

91. ibid., 134.

92. See Ch. 8, pp. 376-378.

93. Royal Commission Report, op. cit., Appendix, 62.
The planned accommodation in the west House was 370; when the Commissioners visited, they counted 471 pauper patients.

94. ibid., 72, 73.
Further details on the architecture of the Glasgow and Edinburgh 'Royals' are included in Chapter 8.

95. Easterbrook, op. cit., 13.
At the time of its opening, the institution had accommodation for about 120 beds, of which the trustees originally allocated 54 for paying and 50 for pauper patients. But it was emphasised that the institution was a charitable establishment for the treatment of fatuous or furious persons and lunatics according to their previous station

in life, and that a portion of the institution was appropriated for the insane poor from the parishes in the three southern counties.

The centre-point of the three-storey, red sandstone building was a large staircase, with galleries radiating from it, which passed through the wards built there. Each ward consisted of two dayrooms, a sickroom and a large number of small bedrooms.

96. Royal Commission Report, op. cit., Appendix, 41.

97. ibid., 84-85.
The Commissioners descriptions are somewhat misleading here.

98. ibid., 55.

99. ibid., 92.
On the second and third floors were to be found small bedrooms laid out on one side of the corridor, while on the other side were dayrooms, lavatories and water closets. The wards for the paying groups consisted of individual rooms, 'comfortably furnished,' and measuring 10 feet x 8 feet x 10 feet. The paupers were placed beside kitchens and offices.

100. ibid., 41.

101. ibid., 48.

102. ibid., 62-63.

103. ibid., 90.

104. ibid., 79-80.

105. Royal Commission Report, op. cit., 101.

106. ibid., 101.

107. ibid., 101.

108. ibid., 134-135.

109. ibid., 135.

110. ibid., 135.

111. ibid., 135.

112. ibid., 135-6.

113. ibid., 135.
In this respect, the Commissioners pointed out that although it may be right for the Commissioners of the Poor Law to make the poorhouses as unpalatable as possible, in the case of the insane 'no such reason exists for supplying them with merely the barest necessities of life and depriving them of everything that may tend to alleviate their heavy lot.'

114. ibid., 80.

115. ibid., 80.

116. ibid., 80.
Ventilation appeared to constitute a problem for both managements. In some of the pauper wards at Edinburgh, lacking a piped heating and ventilation system, reliance had to be placed in open fireplaces and windows unglazed at the top. Other rooms were warmed and ventilated by an apparatus which however the Commissioners felt did not work properly. The system in the private building seemed equally imperfect. The corridors and bedrooms were heated by hot air, but lacking any open fireplaces, had little means of exhalation. The only aid was small openings at the bottom of each door. At Glasgow, the Commissioners averred that the pauper rooms 'can never be properly ventilated,' while the private apartments,(heated by warm air,) the use of windows for ventilation was rendered impossible since the fresh air inverted the action of the hot air flues!

At Aberdeen,there was 'no artificial means of warming and ventilating' the front building, but most of the rooms have open fireplaces. The wings were heated by 'hot water circulating in pipes.' In the Dumfries wards, an 'aperture about a foot square above the doors' and 'hot air introduced into the corridors' sufficed. The ventilation in the Montrose rooms was 'bad', while at Perth, heated air was introduced and there were openings above doors.

117. ibid., 80.

118. ibid., 139.

119. ibid., 140.

120. ibid., 106.

121. ibid., 106.

122. ibid., 107.

123. ibid., Appendix, 85.

124. ibid., 85.

125. Royal Commission Report, op. cit., 81

126. ibid., 81.

127. ibid., 81.

128. ibid., 140-142.

129. ibid., 140.

130. ibid., 141.

131. ibid., 141.

132. ibid., 142.

133. ibid., Appendix, 149.

134. ibid., 165.

135. Royal Commission Report, op. cit., 108.

136. ibid., Appendix, 112.

137. ibid., 114-115.

138. Royal Commission Report, op. cit., 86.

139. ibid., 86.

140. ibid., 143-144.

141. ibid., 144.

142. ibid., 111.

143. ibid., 111.

144. Glasgow Annual Reports, op. cit., No.26, (1840), 10.

145. Edinburgh Annual Reports, op. cit., (1846), 2.

146. Royal Commission Report, op. cit., Appendix, 38.

147. ibid., 45.

148. ibid., 82.

149. ibid., 72.

150. Royal Commission Report, op. cit., 87.

151. ibid., 89.

152. ibid., 89.

153. ibid., 89.

154. ibid., Appendix, 43.

155. ibid., 56.

156. Royal Commission Report, op. cit., 89.

157. Glasgow Annual Reports, op. cit., No.3 (1817), 4.

158. ibid., No. 27, (1841), 29.

159. Edinburgh Annual Reports, op. cit., (1840), 1.

160. Glasgow Annual Reports, op. cit., No. 25 (1839), 9.

161. Royal Commission Report, op. cit., 89.

162. ibid., 144.

163. ibid., 144.

164. ibid., 112.

165. ibid., 89.

166. ibid., 89.

167. ibid., Appendix, 43.

168. ibid., 57.

169. Glasgow Annual Reports, op. cit., No.7, (1821), 14.

170. ibid., No. 26 (1840) 12-13.

171. Royal Commission Report, op.cit., Appendix 49.

172. ibid., Appendix, 49.

173. Royal Commission Report, op.cit.,144.

174. ibid., 112.

175. ibid., 90.
In most arrangements, the sexes were kept apart, but in view of each other except at Perth where a partition completely divided the two compartments, leaving half of the pulpit in each.

176. ibid., 145.

177. ibid., 113.

178. ibid., 84.

179. ibid., Appendix, passim.

180. ibid., Appendix, 187, and see Appendix XXII.

181. ibid., 185.

182. ibid., 188.

183. ibid., 188.

184. ibid., 189.

185. ibid., 189.

186. ibid., 190.

187. See Ch. 3(B), pp. 178-180.

188. Royal Commission Report, op.cit., 82.

189. ibid., 82.

190. ibid., Appendix, 191.

191. ibid., 197-98.

192. ibid., 115.

193. ibid., 123.

194. ibid., 131.

195. ibid., 140.

CHAPTER 10

TWO COMMUNITIES' CARE AND TREATMENT OF THE INSANE IN NINETEENTH CENTURY SCOTLAND: THE GLASGOW AND EDINBURGH ROYAL ASYLUMS 1830-70

The local perspectives developed relative to organisation elsewhere, will now be continued with a look at procedures through which the care and treatment of the insane was accomplished, particularly in Glasgow and Edinburgh. As such, what follows should be seen both as a further exercise in local history and as a development of certain themes explored nationally in the previous Chapter.

As we have seen, while there were certain aspects of the work of the Royal institutions which were unsatisfactory, nevertheless, on balance, they can be described as progressive, enlightened asylums. The environment in which the patient was placed, and the extent to which that milieu was used creatively as a means of therapy, must place these houses within the moral management sphere. That the best of this service was reserved for the fee-paying patient, was a reflection of the prevailing customs of the time. Moreover, as was shown in Chapter Nine, the alternatives to the Royals, namely the poorhouses and private madhouses, were grim indeed. But, in looking at treatment, the moral management 'pedigree' of the Royals is some-

what tarnished. In this respect, a study of the medical records in Glasgow and Edinburgh indicate that while the doctors were willing to practise moral management, where therapy was concerned, they had different ideas about treatment.

In considering this issue, aspects pertaining to the 'description' of insanity, along with the actual methods of treating cases, will be included to create a broader perspective on 'treatment'.

I

As the nineteenth century wore on, the extent and quality of medical supervision in the Royal Asylums improved. With the exception of the Crichton Royal, the remaining six Chartered Asylums had opened with only visiting physicians. The daily medical supervision was initially in the hands of a Superintendent whose work the Physician inspected, but the 1830s saw almost all the Royals equip themselves with fully-paid, full-time resident Physicians Superintendent. The first appointment was probably that of Dr. Alexander Macintosh at Dundee in 1833, followed, in the next year, by Dr. W.A.F. Browne, at Montrose. Sometime during the decade, a similar position was granted to a Dr. Malcolm at Perth and a Dr. Macrobin at Aberdeen, while in 1839, Dr. William Mackinnon was appointed to Edinburgh. Dumfries, emphasising, once again, its elitist image, made two appointments at the opening in 1839 - Dr. Browne,

previously of Dundee, to the post of Medical Superintendent and Sir Andrew Halliday, M.D. to that of Consulting Physician. The last Royal to gain a resident medical executive was Glasgow, with Dr. William Hutcheson's promotion from Superintendent in 1841.[1]

While many of the men who took charge of the Royals during the nineteenth century played a predominantly functional role, there were notable exceptions to that rule. Research was instigated by certain of the doctors in their asylums, and some distinguished themselves. Among this category are to be mentioned Dr. Browne, of both Montrose and Dumfries, who became one of the first Commissioners in Lunacy in 1857, and Dr. Robert Jamieson of Aberdeen, who initiated a course of extra mural lectures on insanity in 1852 with the approval if not the recognition of the University. Dr. David Yellowlees, who was responsible for the Glasgow Royal from 1871 to 1901 became the first Lecturer in Mental Diseases at the University of Glasgow,[2] but, bearing in mind the Edinburgh Royal Infirmary's prestigious reputation, it should come as no surprise that most of the advances in this field should come from that city. The first important name here was Dr. David Skae (1846-73) who initiated extensive research on insanity and during whose time, the title of Lecturer in Medical Psychology and Mental Diseases was assumed by Professor Thomas Laycock of the Chair of Medicine in the University.[3] In 1876, Skae's

successor, Dr. Thomas Clouston (1873-1908) combined the post of Physician Superintendent with that of Lecturer in Mental Diseases at Edinburgh.[4]

This tendency on the part of the Chartered institutions to initiate research is contrasted with the merely custodial role practised in the other parts of the lunacy organisation. At the time of the Report, it was noted that there were resident medical officers at only two poorhouses, City and Barony. The remainder were attended by the parochial surgeons. The Commissioners pointed out that, in contrast with the Royals, whose medical executive was all powerful, the medical attendants in the poorhouses were 'too dependent upon those appointing him'[5] to be able satisfactorily to perform their duty. The officer was in the highly unfortunate position of having little authority over the attendants, and, while they could complain to the Board, the latter body was free to disregard his advice.

An even more dubious state of affairs was to be encountered in the private madhouses. There were, according to the Report, two or three instances of proprietors being medical men. In the rest however, doctors were appointed by the proprietors and were 'liable to dismissal'.[6] As the Commissioners saw it, most doctors attending the private houses did so at the pleasure of the proprietor and hence the physician's powers of remedying abuses were 'highly circumscribed'.[7]

Moreover, it transpires that, in addition to their lack of independence, the doctors' duties were not defined. In most houses, they were not allowed to regulate clothing, exercise, or bedding, but had to confine themselves to prescriptions. Hence, the medical man's role in the private madhouses was reduced merely to treating physical ailments; the whole range of lunacy care was regarded as beyond his competence.

A stark contrast is then revealed between the three regimes, in respect of the practice of medicine. Provision in the Royals was, certainly by the mid-nineteenth century, clearly responsible and indeed in some cases innovatory. The service provided in the poorhouses and madhouses was severely lacking. The extent of that dichotomy is clearly shown as we proceed now to look in detail at treatment in Edinburgh and Glasgow.

II

Dr. Skae of Edinburgh was very much in the forefront of research being undertaken. As early as 1844, a year before Griesinger's great work was published, Skae wrote in the Annual Report for that year that 'insanity is a bodily disease affecting the brain, the organ of the mind'.[8] In a later lecture on 'the legal relations of insanity' read to the Royal College of Surgeons of Edinburgh in 1861, Skae postulated

insanity as being 'a disease of the brain affecting the mind'.[9] Dr McIntosh of Glasgow, while a less distinguished figure than Dr Skae, nevertheless had something similar in mind when he wrote in 1860 that 'hereditary tendency, and the condition of the brain induced by previous attacks are probably the two most frequent sources of this predisposition (insanity)'.[10]

Three main conclusions can be drawn from this position occupied above all by Skae. In developing his clearly somatic approach to insanity, he was moving away from the theories of Pinel, Tuke and other moral managers who had given the environment a much more important role than the brain in their aetiology of insanity. Moreover, it is clear that Skae was at the forefront of research in his field, developing ideas very similar to those evolved by the German somaticists. Finally, as Fish expressed it, it was Skae's 'clear medical approach to insanity which led him to classify mental illness according to aetiology'.[11]

It is essential to remain with this last point and develop its meaning. As we saw in Chapter Nine, Victorian nosologies of insanity tended towards an aetiological rather than a symptomatic base. In the development of that position, Dr Skae played an important role. In his Presidential address to the annual meeting of the Association of Medical Officers of Asylums (the forerunner of the Royal Medico-Psycholo-

gical Association) in 1863, Skae pointed out that, as the same physical disorder would cause quite different mental symptoms, a symptomatic classification was not very useful in practice.[12] Hence it was necessary for the physician to trace the natural history of the disease. What is fundamental, however, is that Skae, in common with many of his contemporaries was led, by this position, to postulate some very tenuous causes of insanity.

Thus far, then, it has been suggested that the medical management at Edinburgh and Glasgow, in its thinking on the nature of insanity, moved away from the position developed by the moral managers to a more medical perspective. In this respect, the Physicians Superintendent at both houses, in common with many of their colleagues, looked to 'cause' rather than 'symptom' in their classification of the insane, although the latter distinction was most certainly also used. The task now, is to look at the practical implementation of these ideas in some length.

Before approaching the Case Notes, it should be pointed out that these particular sources are, not surprisingly, voluminous. Moreover, they were only made available to the student towards the end of the studies and thus any attempt to impose a statistical order upon them was beyond consideration. However, in the hope of obtaining some sense of numerical frequency, data entitled 'the supposed causes of

insanity', lodged in the Annual Reports of both Asylums, were consulted. Unfortunately, little confidence could be placed in this material. Statistical analysis showed that, in some years, there was no correlation between the total figure for 'causes' and the same for admissions. Hence the question arose as to precisely what these series referred. More seriously, however, it was noted that certain causes listed were either far too general as to lack any clinical meaning, or were totally inexplicable.[13] But while these deficiencies clearly prevent the student from utilizing these sources to any real extent, nevertheless, it was noted that a number of 'causes' were cited with great frequency continuously over the years. Among these were a condition known as 'anonymous approach', and such clearly recognisable factors as intemperance, hereditary predisposition, pregnancy and associated conditions, religious fanaticism, general paralysis and masturbation.

These 'causes' appear to have preoccupied the minds of the doctors to a considerable extent, as in both the medical reports contained within the Asylum Annual Reports, and the Case Notes are to be found abundant references to certain of the above conditions. We have already noted Dr. McIntosh's reference to the importance of 'hereditary tendency and the condition of the brain' as a 'frequent source' of insanity'. And, in sampling the Case Notes of Glasgow, one finds that, for example, the predisposing

cause of Miss G's insanity, for which she was admitted in July 1838, was 'second cousin insane'.[14] The mother and sister of Mrs. D, a soldier's wife incarcerated in August 1839, were insane,[15] while the predisposition of Miss R, an admission of March 1841, was 'mother and brother insane'.[16]

Drinking was frequently cited by the Physicians Superintendent. During the 1830s, almost every copy of the Glasgow Annual Reports referred to this 'cause'. Dr. Balmanno wrote, for example, in 1833 that 'among the exciting causes of mania we regret that we have still to mention the abuse of spiritous liquors - it would appear that lunacy may be occasioned from that source'.[17] Dr. Skae, in 1841, argued that 'the abuse of spiritous liquors' held a 'conspicuous place' in the causes of insanity.[18] Moreover, reference to drinking as a cause abounds in the Case Notes. In January 1831, for example, Miss N, twenty-eight years of age, and a straw hat maker, was placed in Glasgow Royal having been 'jilted in love so drinks heavily'. Hence, the exciting cause was 'disappointed affection and abuse of ardent spirits'.[19] In May of that year, Miss R, a forty-one year old domestic who 'liked drink, was described as having an exciting cause which 'appeared to be intemperance'.[20] Miss C, admitted to Edinburgh in April 1846, had suffered a previous attack due to 'intoxicating liquors',[21] while Mr R, incarcerated in May 1857, was described as 'intemperate, but not a heavy drinker'.[22]

Pregnancy and associated conditions were frequently cited as causal factors. Thus in May 1831, a woman was placed in Glasgow Royal, whose 'exciting cause' was child bearing'.[23] Menstruation was referred to frequently. In 1832, for example, the physician wrote that the exciting cause of Miss K's case, brought in to Glasgow in June 1832 was 'deficiency of menstruation'.[24] In 1864 in Glasgow, one finds a whole series of such instances. The record for Miss B, (February of that year) reads:

> ...about 12 months ago, menstruation was irregular and finally suppressed. About that time, she was depressed and gloomy and talked a good deal about religion. In this way it may have been ascribed as the cause.[25]

Miss P, confined likewise in February 1864, had not menstruated for 8 weeks and 'this has probably some connection with the cause of insanity'[26] while Miss S, entered in April of the year, had on her record, the following 'some months ago menstruation ceased and the mental symptoms became greatly aggravated'.[27]

Another significant cause of admission was religious fanaticism. Miss T, a Glasgow case of April 1839, was described as suffering from 'religious trouble'.[28] A more thorough citation was that of Mr. B, incarcerated in January 1847. This patient appeared to be suffering from religious persecution as it was stated on his record that he was 'fearful of the Jesuits and thinks they observe his actions',

and that he spoke of 'the growing ascendancy of the Catholics' who would not allow him to remain in Glasgow.[29] Perhaps the most vivid case in this respect was Miss S, admitted to Edinburgh in October 1847. This patient was a native of that city, single, highly educated, and a member of the Free Church of Scotland. Her illness was 'ascribed to the combined influence of religious dissension and disappointed love'. She had been engaged to a clergyman of the Established Church whom she refused afterwards to marry, unless he joined the Free Church following the Disruption. The conflict of feelings, wrote the doctor in charge 'gave rise to her illness' which included delusions that she was a prophetess, and incoherent talk on 'love, religion and obscenity'.[30] It should incidentally, be mentioned that a clustering of patients admitted belonging to the Free Kirk was noted in 1845 and 1846.

Finally, in this sampling of the records pertaining to numerical significance, reference has to be made to masturbation. Dr McIntosh, writing in 1861, stated that he had been 'thoroughly impressed with the conviction that masturbation is a more fruitful source of insanity than is generally supposed',[31] Dr. McIntosh cited nineteen cases of admissions in that year, as 'insanity, the physical cause of which is masturbation'.[32] In this regard, a number of cases must be cited. Mr. B, admitted to Edinburgh in January 1846, was a student

at the University there. His case record states that 'the only cause of the insanity which had existed for some time is supposed to be indulgence in solitary vice'.[33] Mr D, a twenty-four year old divinity student and member of the Free Kirk, was placed in August 1847, suffering from depression. He presented the exotic instance of a person having been haunted for many years by one obscene word, the influence of which became more than ordinarily tenacious when the patient was at religious service. Moreover, the case record states that the patient 'admitted practising masturbation for many years'.[34] Finally, Miss S, the patient suffering from religious fanaticism mentioned overpage appeared to have problems in this direction, as the case records further report that 'the muff has been ordered to be placed on her hands every night to stop her from masturbating'.[35]

These samples of Case Notes confirm that persons were indeed admitted to both asylums because of the reasons stated earlier in the Annual Reports. These 'causes' were used by Dr. Skae, and by the Glasgow medical men, as the bases for their clinical pictures of insanity. But as has been shown both the Glasgow and Edinburgh men also defined insanity according to 'type' as well as 'cause', and it is to that area that we shall now turn.

Pinel's four main categories, as illustrated in Chapter Nine, were recognised by Skae and the

Glasgow men. Of the cases admitted to both institutions, mania was regarded as the most numerically significant, followed in Glasgow's case by monomania, a concept developed after Pinel, and then by dementia, melancholia and idiocy.[36] A sampling of the case records did indicate a general correlation with Pinel's definitions.

> In this respect, it should be recalled that Pinel's view of mania was that it was the agitative state, and under this heading would be included most violent, and/or bizarre behaviour. And when we look at the case records, we do indeed see this view reflected in individual cases. Miss G, who was admitted to Glasgow in July 1838 as a manic case, although non-violent, 'raved indifferently on various subjects'.[37] Mrs. H was incarcerated in January 1842, suffering from mania, indicated by irritable temper and 'violent language, dislike of friends'.[38] Mr. S, taken to Glasgow Royal in March 1847, was in 'a state of violent mania'[39] when admitted; according to the Notes, he raved incoherently, and engaged in such actions as throwing off his clothes, rubbing the wall with his hands, tearing bedclothes, and swearing and striking anyone who came near him.[40] Mr. P was in a 'high state of maniacal excitement' when he was placed in April 1847, and, on admission proceeded to swear, dance and rave incoherently.[41] Another instance of mania, that of Mr. S, confined originally in October 1838, was described in the Notes in the following terms: 'a few days after

the preliminary symptoms of restlessness, patient has again become maniacal, highly destructive, mischievous and filthy'.[42]

A similar picture of violent and/or bizarre behaviour is seen in the Edinburgh cases. Mr. McD, entered in August 1855, as a case of acute mania, was described as 'having cut his penis off, and to have called his mother the great whore of Babylon'.[43] At the same time, another acute case began to 'strip himself and talk incessantly' on admission. He later spent 'the entire night in beating on the door and walls and tearing bedclothes', and on a further occasion, succeeded in demolishing a 'considerable extent of plaster work'.[44] Mr R, placed in keeping in May 1857 with 'acute mania', was described as not violent, but 'talked constantly in an unconnected manner, laughed, gesticulated and stripped off his clothes'.[45,46] Similarly, Mr. S, confined in April 1858, had since admission, been 'sleepless, violent, destructive and noisy, suspicious, suicidal, exhausted and with a tendency to bite.'[47]

The less numerous citations of dementia did nevertheless conform to the Pinelian criteria of complete loss of intellectual abilities. Thus, Mr. F, an Edinburgh case of May 1841, was described as being

'very confused in his ideas, and in a state of dementia'.[48] Mr. D, who was a Glasgow patient of December 1846, appeared 'sullen and dull on admission, and would not utter a word'.[49] To the physician, this patient looked like one 'far advanced in dementia',[50] while Mr. M, an Edinburgh patient of August 1855, was classed as a dement and described as being 'very vague'.[51]

There were numerous references to melancholia in the Notes, although these were less easy to categorize. It should be recalled that according to Pinel, melancholia did not necessarily mean sadness, but included that state and/or elation, but both feelings were usually associated with a single idea.

Miss A, placed in Glasgow in April 1838, exhibited great mental depression and despondency in religious matters. She believed that she was possessed of an evil spirit, under whose impulse she thought and acted.[52] This was a suicidal, melancholic case. Mrs. D, incarcerated in August 1839, with depressions, was described as melancholic and claimed that 'the devil had power over her'.[53] Miss R, placed in October of that year, similarly for depressions, had a 'constant suspicion of her neighbours injuring her by supernatural means'.[54] Miss K, confined in April 1840, again for depressions, believed that she was 'not fit for the world',[55] while Mrs. R, a patient in March 1841, suffering from want of sleep and lowness of spirits, felt that everything had gone 'wrong in

family'.[56] Pinel's inclusion of fixation on one idea in this concept is well brought out in the melancholic case of Mr. E, of Edinburgh (August 1855) who believed himself to be 'the greatest engineer in the world'.[57] A similar Edinburgh case was that of seventeen year old Mr. M (June 1858), who burst into tears and covered his face whenever anyone approached him.[58]

In addition to these classifications cited, cases of idiocy, or what could today be termed mental retardation, were looked after in the Asylums, but there is no need to dwell on this topic, as it is strictly speaking outwith the area being studied. What is much more relevant is the fact that the medical managers at both the Glasgow and Edinburgh houses, developed their own nosological distinctions. Hence in addition to the Pinelian standard types, a variety of other classifications, and sub-classifications were noted.

One such case in point was monomania. Although this was a category by no means peculiar to Glasgow and Edinburgh, it had been developed following Pinel, and was defined by Dr. Balmanno of Glasgow, for example, as 'madness confined to one subject'.[59] This definition is not very helpful as it does not make it clear whether Balmanno means one kind of madness or one kind of delusion. If the latter is the case, and the references in the Case Notes indicate this to be so, then this could be seen as a development of Pinel's concept of melancholia, as he saw this category

as being associated with one delusion. Another term used was pantomania, which seemed to indicate hysterical tendencies, laughter and grandiosity. Shortly before his death, Dr. Balmanno drew up his own nomenclature of insanity, which included both monomania and pantomania and such exotica as the tremebunda and irracunda melancholias.

But it is to Skae that we look for the significant developments in this area of classification. He first put forward his own classification in 1863. It is significant that by this time, he had dropped melancholia from his analysis, and built his nosology almost entirely around mania. He identified twenty different categories of mania, including such dubious concepts as nymphomania, post-connubial mania, climacteric mania, metastatic mania, and mania of oxalusia and phosphaturia. His other typologies were idiocy, imbecility, insanity with epilepsy, insanity of masturbation, insanity of pubescence, satyriasis and general paralysis of the insane.[60]

However, the presentation of Skae's system, to the Association of Medical Officers of Asylums was the highpoint of his career, because as Fish points out, the 'classification was rejected by most British psychiatrists'.[61] In 1875, Dr. Crichton Browne of West Riding Asylum wrote a 'scathing criticism'.[62] This was followed by an article signed 'N.M.' in the Journal of Psychological Medicine in 1876 which

attacked Skae 'most drastically'.[63] While it is unfortunate that Skae's name should be so closely linked with this episode, nevertheless, his errors, which were common, at least fuelled controversy, out of which were later to come far more adequate classifications.

But we cannot leave this question of classification without referring to one of the most problematic areas in the whole question of Victorian thinking on insanity, and that is general paralysis of the insane. As we have seen, Skae was clearly aware of the presence of this condition by 1861. Indeed, later in his career, Skae was to regard 'general paralysis as the paradigm of mental illness'.[64] In this respect, Skae was merely being as wrong as most of his contemporaries, as the large numbers of general paralytic cases noted towards the end of the nineteenth century convinced many doctors of the significance of this disease.

There is considerable doubt over the origins of general paralysis of the insane as a disease entity. Skae himself recognised Haslam as the first medical man to describe the illness[65] although Skultans suggests that Esquirol was the first.[66] According to her, the first English physicians to mention it were Conolly, Bucknill and Maudsley. Whatever its clinical source, there is no doubt that, by the end of the nineteenth century, dementia paralytica, as it was alternatively known, was endemic in most asylums. Indeed Skultans cites the English Commissioners in Lunacy Report that

between 1901 and 1911, postmortem examinations revealed that over 70% of asylum patients were suffering from general paresis at death.[67] It was towards the end of the century that the definite association between syphilis and general paralysis was established.

A reading of the Glasgow and Edinburgh Case Notes confirm this grim scenario. As the student approaches the 1850s and 1860s, he will detect in these sources more and more references to general paralysis. What made this condition so problematic was that there was no known cure for the disease at this time. This mordant state of affairs is well brought out in the following case history. Mr. F, a compositor, married with three children, was admitted to the Edinburgh Royal in January 1856. He was then described as being merely 'restless, sleepless, wandering, violent and noisy'[68] with a tendency to get confused. By the following month, however, the symptoms of general paralysis had shown themselves. The patient's speech was faltering and his gait had become unsteady. He frequently showed 'great exaltation' and was fond of showing off his singing powers. On one occasion the patient 'put on a cloak and marched about under the impression that he was a general'.[69] By May, the disease was 'steadily progressing'[70] and by August his mind was 'now much weaker'.[71] By Christmas, the Notes state that the man was 'now quite imbecile'.[72] He could scarcely speak or walk. By March of the

following year, he was confined to bed, being very noisy, 'shouting for hours at a time'[73] and tearing everything he could reach with his teeth. Finally, towards the end of June, 1857, diarrhoea set in, little food could be administered and the patient died.

This example of the progress of general paralysis in one case clearly illustrates the nature of the problems facing the asylum doctors, and, in drawing such a discussion to a conclusion, we have one final theme to consider, that of the actual methods of treatment.

III

As we have seen, the early and middle decades of the nineteenth century witnessed a considerable debate over how the insane should be treated. The practitioners of the eighteenth century medical orthodoxy used medicinal remedies, along with seclusion and restraint. This perspective has to be contrasted with that of the early nineteenth century moral managers who cast great doubts over the older practices. The picture painted in Chapter Nine of the model York Retreat explained how restraint was used only as a last resort and medical treatment given a secondary place.

With respect to therapy, it is clear that both the Glasgow and Edinburgh Royal Asylums can, on

balance, be placed within the moral management sphere. But their reputations in that direction are somewhat diminished when we look at treatment. Specifically, whereas the Royal Commission, curiously, makes no reference to the fact, nevertheless the Case Notes establish beyond any doubt that the eighteenth century medical practices were still being used as late as the 1850s in both houses. Moreover, Glasgow's claims to be in the vanguard of the non-restraint movement has to be critically assessed in the light of the Case Notes data.

Dr. Hutcheson, the first Physician Superintendent at Glasgow, clearly indicated his commitments shortly after his appointment. In the Annual Report for 1841, he opened by saying that, in 'mere insanity' general blood-letting was never necessary. However, local blood-letting was useful. Also 'counter irritations' applied to the scalp had been found 'very useful' while 'a succession of blisters were the best means'. Purgatives were also important, while tartar emetics were also given, as were tonics, and narcotics. Finally, Dr. Hutcheson averred that 'the warm bath, with cold applied to head, in many cases, calms the patient'.[74]

Reference to the Case Notes of both houses quickly indicated that Dr. Hutcheson's remarks were grounded in reality. Thus in the history of Mr. Y's case, starting in Edinburgh, April 1841, we discover

that 'the cupping glasses were applied to the nape of the neck, but syncope came on when only 3 inches of blood had been abstracted'.[75] Mr. F. (April 1841) was 'bled from the arm, by cupping glasses, from the temples'.[76] Mr. M. (November 1841) had blood taken from his head.[77] Mrs. B, admitted to Glasgow in 1840 'was bled'[78] as was Miss L. (1841).[79]

Mr. G, confined to Edinburgh in August 1838, had his head shaved, and cold lotions, and counter-irritations used. Mr. F, originally placed in 1836, had 'leeches applied to the head'.[80] Mr. Y, incarcerated in 1841, had 'leeches to the number 12' applied.[81,82] As late as 1856, we detect two patients who had their heads shaved and leeches applied at Edinburgh.[83] Blistering was also common; blisters were applied to Mr. F's neck in 1841,[84] while Mr. D had a 'large blister' applied to 'the nape of the neck' in 1846.[85] In 1855, we hear that Mr. E's head was 'shaved and blistered'.[86]

Similarly, Dr. Hutcheson's comments about counter-irritations in Glasgow are well born out in the Notes there. For example, Miss A (April 1838) had her head shaved and a cold cloth applied, while leeches were applied to her genitalia.[87] There were many other references to leeches and blisters being used, and of shaving,[88,89,90,91] but it is important to note that these 'remedies' continued well into the 1850s at Glasgow. In January 1847, Mr. J. had '24

leeches applied over his abdomen and a blister afterwards'.[92] Mr. S, admitted in September 1851, had 'leeches used'[93] upon him, while Mr. J.K's record in October of that year, states that he had 'his head shaved, blister, cold applications'.[94] The latest comment in this area to be found was in March 1854, when a blister was applied to Mr. K's neck.[95]

Purgatives and vomits were very frequently used, according to the Case Notes.[96,97] Miss R, incarcerated in May 1831, had been 'purged freely',[98] Miss K (June 1832) had 'drastic purgatives'[99] while Miss B. (March 1836) had 'purgatives administered'.[100, 101,102] Miss G. (July 1838) had 'laxatives and purgatives' constantly,[103] while Miss G (April 1840) was 'put on nauseating doses of tartar emetic, with gentle alternatives of Gregory's mixture'.[104] Here treatments, as with the others, continued until the 1850s and 1860s. Thus, at Edinburgh, we learn that Mr. R, admitted in May 1857 received an 'emetic and slight purgative'[105] while Mr. P, incarcerated at the same time, was given a 'turpentine enema'.[106] As late as April 1863 we discern that Mr. W. was placed in the 7th ward in April 1863 and 'got a purgative'.[107]

In addition to blood-letting, counter irritations and emetics, other remedies were used such as baths, narcotics, and medicinal alcohol. Thus, for example, Miss K, a Glasgow case (1832) was given warm baths,[108] while Mr. P, admitted to Edinburgh in

August 1855 was treated with a warm bath, 'left at 100°F for most of the time', followed by a cold douche on the head.[109,110] There were also occasional references to the medicinal use of narcotics. Thus Mr. B, admitted in October 1851 to Glasgow had a 'grain of opium'[111] prescribed while Mr. W, incarcerated in June 1852 received 'three grains of opium'.[112] Mr. C, originally placed in November 1856, had to take 'enormous doses of opium and its preparations', while 'cannabis indica was tried without effect'.[113] Finally, there were frequent references to the use of medicinal alcohol. Mr. R, admitted to Edinburgh in May 1857, was given a 'glass of toddy';[114] while Mr. M. (May 1864) was given 'porter and wine'.[115] At Glasgow, Miss McM, placed in March 1838, was given a 'bottle of porter daily'.[116] Mr. S, who was admitted in March 1847, as a violent manic case was ordered to have 'a glass of whisky immediately'[117] although the treatment was later changed to gin toddy. Mr. G's (June 1847) treatment included 'a glass of brandy'[118] while Mr. B (1851) enjoyed 'two glasses of whisky' daily.[119]

Clearly then this sampling of the patient Case Notes establishes the fact that the eighteenth century medicinal remedies were widely practiced in the Glasgow and Edinburgh Royal Asylums, far into the nineteenth century. It should be stressed once again, however, that the Physicians Superintendent, in sanctioning such practices, were not being deliberately

cruel. Instead, the object was precisely to weaken, and thereby make the patient amenable. But bearing in mind the moral managers' aversion to these methods, their wide use by the Glasgow and Edinburgh doctors at this time is illustrative of these gentlemen's willingness to compromise over the practice, as distinct from the ideal of moral management.

However, in addition to the medicinal remedies, there remained one final initiative left to the medical managers in coping, particularly, with the most violent patient, and this was the use of restraint and seclusion. With respect to the Royal Asylums, the Report of the Glasgow Royal Asylum for 1820 frankly stated:

> When outrage is committed the discipline of the Asylum requires that the offender be put under some restraint.[120]

According, however, to the Royal Commission, restraint had gradually been abandoned in these institutions. Thus, by the time they wrote their Report, they could say:

> Personal restraint, by the application of the straitwaistcoat, or of straps, or muffs is almost entirely banished from the Chartered Asylums.[121]

Skae of Edinburgh believed that mechanical restraint was sometimes necessary, but he was forced to practise seclusion because of lack of adequate accommodation. Dr. Hutcheson of Glasgow was more forthcoming. In 1841 he placed Glasgow in the forefront of the non-restraint movement by claiming that

during the previous three years, personal restraint had been modified and almost abolished. During the last year, he was able to 'abolish it altogether and the result, hitherto, has been perfectly satisfactory'.[122] Consequently, not only were the patients quieter and more orderly but 'a great saving of glass, furniture, bedding, etc. had been achieved, the amount of seclusion diminished and the patients' habits much improved'.[123]

This is a crucial comment on the part of Dr. Hutcheson. His actions place the Glasgow Royal firmly within the pioneering of the non-restraint movement, bearing in mind that restraint had only been totally abolished for the first time at Lincoln in 1838. But, as with the medicinal remedies, a study of Case Notes provides grounds for scepticism about the claims of the doctors. Whereas a sampling of the Glasgow Notes did produce no evidence of such exotica as the whirling chair and straitjackets, nevertheless, there were references to some mechanical restraint being used. Thus, a record written for Mr. P. in October 1860, twenty years after Dr. Hutcheson's comments, contained unambiguous proof of the use of such methods. The record stated that the patient's 'arms and hands are under mechanical restraint'.[124] At Edinburgh, there has already been reference to the muffs used in the case of Miss S. to stop her from masturbating,[125] while the treatment given to another patient exhibiting such behaviour was 'to have a full-sized catheter

passed once a week'.[126] But on balance, there were not many references to mechanical restraint in either of the asylum's Case Notes.

However, it is worth contrasting this state of affairs with that pertaining in the poorhouses and the private madhouses. With respect to the former, the Commissioners noted that personal restraint was 'habitually had recourse to in almost all the houses'.[127] The straitwaistcoat and leather muffs were usually left in the keeping of the attendants, to be used at their discretion. Indeed, the Burgh poorhouse at Paisley was the only one in which the Commissioners found no evidence of this particular means of control.[128]

A similar state of affairs existed in the private madhouses. The Commissioners averred that instrumental restraint was in very general use in pauper houses and not infrequently in private ones. There were houses in which some of the paupers were 'constantly manacled',[129] while the straitwaistcoat appeared in daily use. In almost every house, the Commissioners found 'handcuffs, leg-locks, gloves, straps and strait waistcoats'.[130] What was equally disturbing was that most of these exotica were found in the attendants' rooms, these officers being 'without any check as to their application',[131]

Clearly then, mechanical restraint was standard practice in the poorhouses and private madhouses, while its use in the Royal Asylums was, we

must assume, from the evidence of Glasgow and Edinburgh, minimal. Perhaps one clue as to why, ostensibly, the Chartered Asylums had been able to claim to dispense with restraint is that seclusion, the third method of treatment being discussed, here, was extensively practised in the Royals. 'We have reason to believe', wrote the Commissioners, 'that seclusion for long periods is frequently used'.[132] The Asylums which the Commissioners felt were most responsible for this policy were Montrose, Glasgow, Aberdeen and Edinburgh.

The reasons which the Commissioners gave for this state of affairs were primarily, faults in the construction of the houses, which led to overcrowding, and deficiency where exercise was planned. Moreover the lack of an adequate number of attendants added to the problem.

At Montrose, for example, it was noted by the Commissioners that 11 out of 174 patients were in seclusion at the time of their visit, several of that number having been secluded for considerable periods of time.[133] Also the seclusion rooms at that house were 'mere cells, with stone floors and darkened windows'.[134] But, the Commissioners thought that seclusion was practised at Glasgow more thoroughly than elsewhere,[135] and this statement is certainly reinforced by reference to the Case Notes. Thus, Mr. M, admitted in November 1846, became so violent that 'it was necessary to seclude him'[136] while Mr. D, incarcerated a month

later, was placed in seclusion.[137] The Notes state that Mr. S (October 1838) was 'to be placed in seclusion'[138] while the histories of both Mr. P and Mr. T, admitted in Spring 1847 had written on them the comments 'let him be left in seclusion'[139,140] in both instances. There was also frequent reference to violent patients being 'sent to No. 3' which was a seclusion room.[141] In Edinburgh there was an unequivocal reference to seclusion, with this comment on Mr. S's record for April 1858, that 'he be put in a padded room'.[142]

In this respect, the Royal Asylums did not deviate markedly from the poorhouses. According to the Report, all the houses had seclusion rooms. In them, the patients lay on a mattress on the floor, or on the loose straw covered by a shirt.[143] In contrast, however, the Commissioners felt that seclusion rooms were attached to only some of the private madhouses. They were frequently to be found in the outhouses, and were, in most cases 'without the means of warming and ventilation',[144] but the apparent limited use of seclusion in the private houses has to be seen in relation to the extensive use of physical restraint. Seclusion, in that context, was not so essential.

IV

This study of thinking on, and methods of treating the insane in two Scottish Royal Asylums during the Victorian era clearly reveals that the use of eighteenth century 'medical remedies' died hard in these institutions. Purgings, blistering, the application of leeches and such procedures were used there until at least the 1850s. But this does not imply lack of initiative on the doctors' part. On the contrary, both Asylums, and Edinburgh's in particular, were to emerge towards the end of the nineteenth century as important teaching hospitals in psychiatry. Innovations (not all of them beneficial) in clinical theory emerged from the two Houses. Furthermore, as we have seen, principles of moral management governed the 'care' of at least the fee-paying patient. Despite the strong hold of older practices, therapy was practised at these and other Royal Asylums in contrast to the merely custodial role of other institutions for the insane at the time.

REFERENCES AND NOTES

1. Report of the Royal Commission, op. cit., Appendix, passim.

2. Henderson, op. cit., Ch. 3.

3. Fish., op. cit., 48.
   Dr David Skae was born on 5 July 1814, at Edinburgh. After medical training, he took up general practice in the city in 1836. He was appointed surgeon to the Lock Hospital and became interested in syphilis. Ten years later, he was appointed to the Royal Edinburgh Asylum, holding the post until 1873. Skae was a close friend of Sir James Simpson, the discoverer of the anaesthetic properties of chloroform. It is claimed that Skae was the first to inhale chloroform during one of Simpson's experiments.

4. Dr Thomas Clouston was physician superintendent from 1873 until 1908. He was a graduate of Edinburgh University, and during his tenure at Morningside, supervised the building of the new private Craig House, and was the first occupant of the Lectureship in Mental Diseases, at his alma mater.

5. Report of the Royal Commission, op. cit., 136.

6. ibid., 103.

7. ibid., 103.

8. Edinburgh Annual Reports, op.cit., (1844), 13.

9. Quoted in Fish, op.cit., 38.

10. Glasgow Annual Reports, op.cit., No. 47 (1861), 23.

11. Fish, op. cit., 38.

12. ibid., 39.

13. See Appendix XVII.

14. G.G.H.B. Glasgow Royal Asylum Patient Case Notes, H.B. 13/5/11, (1838), 63.

15. ibid., HB 13/5/12, (1839), 45.

16. ibid., HB 13/5/14 (1841), 21.

17. Glasgow Annual Reports, op.cit., No.20 (1834), 5.

18. Edinburgh Annual Reports, op.cit., (1841), 1.

19. Glasgow Case Notes, op.cit., HB 13/5/10 (1830-36), 11.

20. ibid., 30.

21. E.R.H. Patient Case Notes, Vol. V (1846-1854),13.

22. ibid., Vol. X (1855-59), 238.

23. Glasgow Case Notes, op.cit., HB 13/5/10 (1830-36), 29.

24. ibid., 44.

25. ibid., HB 13/5/90 (1862-65), 204.

26. ibid., 208.

27. ibid., 232.

28. ibid., HB 13/5/12 (1839),29.

29. ibid., HB 13/5/43 (1846-48), 47.

30. Edinburgh Case Notes, op.cit., Vol.V (1846-54), 259.

31. Glasgow Annual Reports, op. cit., No.48 (1862), 28-29.

32. ibid., 28-29.

33. Edinburgh Case Notes, op.cit., Vol.V., (1846-1854), 20.

34. ibid., 259.

35. ibid., 259.

36. See Appendices XX and XXI.

37. Glasgow Case Notes, op.cit., HB 13/5/11 (1838), 63.

38. ibid., HB 13/5/15 (1842), 35.

39. ibid., HB 13/5/43 (184 -48), 56.

40. ibid., 56.

41. ibid., 60.

42. ibid., 97.

43. Edinburgh Case Notes, op.cit., Vol. X (1855-59), 13.

44. ibid., 14.

45. ibid., 242.

46. ibid., 558.

47. ibid., 379.

48. ibid., Vol. 1 (1840-42) 183.

49. Glasgow Case Notes, op.cit., HB 13/5/43 (1846-48), 41.

50. ibid., 41.

51. E.R.H. Patient Case Notes, op. cit., Vol. X (1855-59), 11.

52. Glasgow Case Notes, op.cit., HB 13/5/11 (1838), 25.

53. ibid., HB 13/5/12 (1839), 45.

54. ibid., 65.

55. ibid., HB 13/5/13 (1840), 63.

56. ibid., HB 13/5/14 (1841), 21.

57. Edinburgh Case Notes, op.cit., Vol. X (1855-59), 8.

58. ibid., Vol. X, (1855-59), 585.

59. Glasgow Annual Reports, op.cit., No. 22 (1836), 4.

60. Fish, op. cit., 52 and see Appendices XVIII & XIX.

61. ibid., 39.

62. ibid., 39.

63. ibid., 39.

64. ibid., 40.

65. ibid., 40.

66. Skultans, op. cit., 136.

67. ibid., 137.

68. Edinburgh Case Notes, op.cit., Vol. X, (1856-59), 54.

69. ibid., 54.

70. ibid., 54.

71. ibid., 54.

72. ibid., 54.

73. ibid., 54.

74. Glasgow Annual Reports, op.cit., No. 28 (1842), 41-43.

75. Edinburgh Case Notes, op.cit., Vol. 1 (1840-42), 134.

76. ibid., 183.

77. ibid., 229.

78. Glasgow Case Notes., op.cit., HB 13/5/13, (1840),7.

79. ibid., HB 13/5/14 (1841), 27.

80. Edinburgh Case Notes, op.cit., Vol. 1 (1840-42), 4.

81. ibid., 130.

82. ibid., 206.

83. ibid., Vol. X (1855-59), 66, 72.

84. ibid., Vol. I (1840-1842), 183.

85. ibid., Vol. V., (1846-1854), 161.

86. ibid . Vol. X (1855-59), 8.

87. Glasgow Case Notes, op.cit., HB 13/5/11 (1838), 25.

88. ibid., HB 13/5/10 (1830-36), 19.

89. ibid., 22.

90. ibid., 29.

91. ibid., 44.

92. ibid., HB 13/5/43 (1846-48), 37.

93. ibid., HB 13/5/51 (1851-52), 12.

94. ibid., 17.

95. ibid., HB 13/5/52 (1852-54), 62.

96. ibid., HB 13/5/10 (1830-36), 8.

97. ibid., 11.

98. ibid., 30.

99. ibid., 44.

100. ibid., 84.

101. ibid., HB 13/5/11 (1838) 25.

102. ibid., 27.

103. ibid., 63.

104. ibid., HB 13/5/13 (1840), 35.

105. Edinburgh Case Notes, Vol. 10 (1855-59), 238.

106. ibid., 242.

107. ibid., Vol. XVI (1862-66), 109.

108. Glasgow Case Notes, op.cit., HB 13/5/10, (1830-35), 44.

109. Edinburgh Case Notes, op.cit., Vol. X, (1855-59), 14.

110. ibid., 739.

111. Glasgow Case Notes, op.cit., HB 13/5/51, (1851-52), 19.

112. ibid., 140.

113. ibid., HB 13/5/55 (1858-62), 364.

114. Edinburgh Case Notes, op.cit., Vol. X, (1855-59), 238.

115. ibid., Vol. XVI (1862-66), 267.

116. Glasgow Case Notes, op.cit., HB -3/5/11 (1838), 21.

117. ibid., HB 13/5/43 (1846-48), 56.

118. ibid., 67.

119. ibid., HB 13/5/51 (1851-1852), 19.

120. Glasgow Annual Reports, op.cit., No. 6 (1820), 10.

121. Royal Commission Report, op.cit., 84.

122. Glasgow Annual Reports, op.cit., No. 28 (1842), 39.

123. ibid., 39.

124. Glasgow Case Notes, op.cit., HB 13/5/55, (1858-62), 356.

125. See p. 496.

126. E.R.H. Patient Case Notes, op. cit., Vol X (1855-59), 739.

127. Royal Commission Report, op.cit., 143.

128. ibid., 143.

129. ibid., 110.

130. ibid., 111.

131. ibid., 111.

132. ibid., 84.

133. ibid., 85.

134. ibid., 85.

135. ibid., 143.

136. Glasgow Case Notes, op.cit., HB 13/5/43, (1846-48), 38.

137. ibid., 41.

138. ibid., 97.

139. ibid., 60.

140. ibid., 64.

141. ibid., 46.

142. Edinburgh Case Notes, op.cit., Vol. X (1855-59), 558.

143. Royal Commission Report, op.cit., 143.

144. ibid., 111.

CONCLUSION

During the years 1830-70, at a time when Scotland was undergoing extensive social and economic change, the statistical evidence suggests that the prevalence of mental illness was less significant than qualitative accounts would lead us to believe. Although there was a clear increase in annual admission figures during the period studied, which became more pronounced in the later decades of the century, nevertheless, when these data are expressed as a percentage of the population, a different perspective is obtained. Moreover, it should be stressed that the greater numbers known to be insane to the authorities at this time is partly an expression of the expanded institutional provision being made.

But the statistics only reveal part of the true dimensions of insanity in Victorian Scotland. It must be understood that the data only referred to those known by the officials to be so afflicted. As the administrators themselves acknowledged, these figures represented perhaps only a half of the 'true' insane population. The remainder were not counted either because they lived alone or with their families or friends, or because their 'condition' was not so serious as to require incarceration.

To the asylum administrators of the time, however, the continuous increases in those seeking

admission, and the often long duration of their stay, posed severe problems of planning, manpower, finance and treatment. The evidence suggests that the Scots, like their English counterparts, were as much at a loss as to how to 'cope' with insanity at the end of Victoria's reign as they were at the beginning.

In looking at the Scottish 'response' to the 'problem' of insanity, it should be recalled that there were a number of significant differences between Scotland and England. Pre-eminent among them was the rise, in the early decades of the nineteenth century, of the seven Royal or Chartered Asylums. These were public charitable institutions, whose roots go back to 1782, ten years before the model retreat was established at York and Pinel's reforms in Paris. Their original role was to cater for the indigent middle-class and labouring insane, but force of circumstances quickly induced the administrators to take in both wealthy and pauper lunatics. As the experience of Edinburgh's Royal Asylum shows, however, this latter patient was a burden most administrators wished quickly to be rid of. By 1840 then, all five Scottish cities and two important towns had equipped themselves with relatively well-endowed Royal Asylums in which a positive medical policy began to be practised.

It was principally because of their exist-

ence that another comparison can be validly made with England. Although certain of the English subscription hospitals, which were the nearest equivalent to the 'Royals', clearly distinguished themselves, such as at Manchester, nevertheless, their number and geographical spread did not meet the needs of the English insane as sufficiently as the Royals originally did in Scotland. Hence the English, during the early decades of the nineteenth century, bearing in mind the slow growth of the county asylums, had to rely on a far more extensive private 'trade in lunacy' than the Scots. The evidence suggests that although the existence of private mad-houses clearly worried the Scottish authorities, they remained small in number essentially because of the more effective competition offered by the 'Royals'.

Furthermore, the existence of the 'Chartered Asylums' was the major reason behind the later entry of the state into lunacy care in Scotland than in England. The English process had begun tentatively in 1808, and had been consolidated in 1845, whereas the major Scottish reform in this area did not come until 1857. However, it should be added that both the part played by the Sheriff in lunacy care and the minimal role of the poorhouses in lunacy organisation prior to 1857 are indicators of a trend.

That trend reached its fulfilment in 1857. By the middle decades of the nineteenth century, it was clear to administrators that, despite the quality

of 'service' offered by the 'Royals', this essentially 'laissez-faire' system was not coping with the problem of insanity. Reforms not dissimilar to those taking place in England at the time were needed. Hence a Royal Commission was appointed in 1855, the result of which was the one major legislative enactment covering insanity in Scotland during the Victorian era, the Lunacy (Scotland) Act of 1857. In consequence, a General Board of Commissioners in Lunacy, staffed by civil servants was appointed to superintend the organisation of insanity on a national basis. Scotland was divided into twenty one 'lunacy districts' through which this objective was to be achieved locally and 'district asylums' were to be built. The Royal Asylums were to be integrated into the organisation and it was the intention of the legislation that both the poor-houses and the private madhouses be 'phased out' of lunacy care. Moreover, a reading of the Report of the Royal Commission suggests that what was being proposed was a 'dual mandate' in the new regime. District asylums for pauper lunatics, creating a depository 'psychiatry for the poor' were envisaged, ostensibly leaving the 'Royals' free to pursue their medically positive, curative role for the fee-paying patient.

The practical working out of the legislation was somewhat different. Six of the new District Boards merely availed themselves of powers written into the Act, and 'acquired' Royal Asylums existing

within their geographical area of jurisdiction for their own use. The remaining boards without a Royal Asylum in their midst went about their statutory tasks of building a district institution very slowly. As a result, by 1870, only ten such institutions had been built.

Hence, although by the end of the nineteenth century, District Asylums did proliferate, the immediate consequences of District Boards merely making use of existing Royal Asylums or building District Asylums only slowly, meant that the radical change in the organisation of insanity envisaged by the Royal Commission was lost. Specifically, although the private madhouses were virtually 'rooted out', poorhouses continued to house insane paupers until the end of the nineteenth century. Moreover, it was partly because of this want of accommodation that Scotland practised the 'boarding out' concept more extensively than England. Finally in contrast to the intentions of most of their founders, the Royal Asylums with one single exception, despite the 1857 changes, remained as firmly wedded to the needs of the pauper insane in the early twentieth century as they were in the early nineteenth.

However, despite these administrative problems, the Lunacy (Scotland) Act of 1857 did fulfil the expectations of Victorian reformers in the sense that the legal defence of individual liberty was upheld. As we have seen, the medical profession was

anxious that admissions be expedited as effectively as possible so that a cure might be achieved. But the legal profession was concerned that incarceration might take place without due cause, and hence built many assurances into legislation to avoid such a contingency. These safeguards were maintained in the 1857 code. Although the Sheriff's previously dominant role in lunacy care was reduced, he still retained the power to sign admission warrants and, in this respect, the Scottish reforms can be seen as similar to the English. Although the Scottish reforms were not perhaps the 'triumph of legalism', jurisprudental interests were preserved.

We can, perhaps, appreciate the anxiety of the lawyers in this area when we come to look at conditions within the asylums. As we have seen, the Royal Asylums offered both a private and a 'pauper' service, and the quality of that provision differed radically. Any analysis of conditions in Scottish asylums during the Victorian era points conclusively to the fact that this was a class demarcated service. The quality of environment, accommodation, diet, occupation and exercise was clearly distinguished between those paying for such amenities, and those who were supported by parochial authorities.

But the class distinction so evident in the organisation of insanity in Scotland merely reflected prevailing views in the society of the time. What is

remarkable is that certain of these caring procedures, should be of such a high quality. The therapeutic milieu created particularly for the fee-paying patient in the Royal Asylums during the early decades of the nineteenth century clearly places these institutions within the 'moral management' movement. It should be recalled that part of this argument was devoted to the need to establish a pleasant, therapeutic environment for the patient. As practised particularly at the York Retreat, the patient was to be treated humanely and given every opportunity to develop his resources through occupation, exercise and recreation. There is unimpeachable evidence that this objective was achieved at least for the fee-paying patient in the Royal Asylums. Indeed, when aspects of this service for the seven institutions are taken together, the collective reputation of the Royal Asylums becomes enviable.

However, there was a limit to the 'Royals' moral management pedigree. In addition to the factors mentioned above, it was axiomatic to the reformers that the eighteenth century medicinal remedies be reduced to a minimum. Purgings, blood-letting, counter-initiations, restraint and seclusion were regarded as, at best, an unfortunate necessity. But the evidence from the Case Notes of the Glasgow and Edinburgh Royal Asylums suggests that old methods of inducing vomits and bleedings, and the use of

blisters, leeches and narcotics were used in these two institutions at least, until the 1850s. Moreover, although Dr. Hutcheson of Glasgow claimed to have abolished all restraint in 1841, thus putting Glasgow ostensibly at the forefront of the non-restraint movement, nevertheless, as the Case Notes suggest, this claim must be regarded with caution. Moreover, seclusion was quite widely practiced in both institutions, and while evidence on this particular matter was gathered from only two Royal Asylums, it would not be impossible to infer that similar practices were being utilized in the other Chartered Asylums.

But however bizarre such practices may appear to the modern eye, it is essential not to adopt too censorious a tone in discussing them. Instead, in the age before the advent of psychodropic drugs, they were the only options open to a doctor in his attempt to control the more violent patient. However, despite the continuation of these practices far into the Victorian era, it should be noted that most of the Royal Asylums were, during the nineteenth century, to emerge as teaching hospitals for psychiatry. The contrast, with the poorhouses and private madhouses, was stark indeed, for in the latter institutions little medicine and extensive restraint were practised. But these comments notwithstanding, it is true that

the evidence from the Case Notes proves that the writ of moral management ran only so far in Scotland. The medical managers of the Royal Asylums apparently opted for a judicious synthesis of moral management where therapy was concerned and medicinal remedies for treatment.

Moreover, it is only when we come to study these conditions within the asylums that we begin to appreciate the true nature of the problem facing Victorian 'mad doctors'. The contemporary statistical analysis notwithstanding, the nineteenth century lunacy managers were clearly burdened by numbers, and this pressure made it increasingly difficult for 'enlightened' medicine to be practised within the institutions. Moreover, evidence from the penultimate years of the Victorian era suggests that the problem only increased as research indicated an increasingly pessimistic prognosis for insanity, with long term incarcerations inevitable.

But in interpreting the rise of an organisation of insanity in Scotland, it is clear that Scull's theses for the English experience can have only limited application. It should be recalled that Scull rejected the correlation between the building of asylums and urbanisation. Instead, he saw the coming of the asylum as a national, Benthamite solution to one of the 'problem populations' which had to be solved to allow 'market capitalism' its

head. Three important distinctions can be made to Scull's argument where Scotland is concerned. In the first place, the majority of asylums were built in urban settings. Moreover, although the 1857 reforms can be seen as a utilitarian, Benthamite exercise in a country which, by that time, as Lenman put it, had become an 'industrial society based on market forces',[1] nevertheless, the spirit of philanthropy was closely associated with that initiative, as witnessed by Lord Shaftesbury's concern. Finally, and crucially, the 1857 Act was by no means the beginnings of the organisation of insanity in Scotland. Attempts at finding a solution to this social problem, albeit unco-ordinated, can be traced as far back as 1769, when the Montrose project was first mooted, and gathered strength in the late eighteenth and early nineteenth centuries with the rise of the Royal Asylums. This was at a time when Scotland was only really beginning its industrialisation process. Not surprisingly, the spur to action here was not the desire for some national panacea, but parochial philanthropic concern. The Royal Asylums were founded on local medical, civic and mercantile vision and capital.

One final comment is called for. In the writing of a thesis on essentially a national theme, time and space inevitably dictated economies. Generalisations were unavoidably made, and 'labels', particularly in Chapter Ten, regrettably used. A

picture of a national organisation has been painted, and such an endeavour remains the basis of this work. But the author tried not to forget the human element involved. For that reason, Chapter Nine and, in particular, the use of Case Notes in Chapter Ten, were essentially an attempt to evoke what life was actually like for those unfortunate enough to lose their reason in Victorian times. Whereas the evidence suggests that those with means lived, in some cases, very well in the Royal Asylums, the experience of the pauper insane was quite different. They were indeed 'the wretched of the earth'.

REFERENCES

1. Lenman, op. cit., 101.

APPENDICES

APPENDICES

I. Total number of patients remaining at the end of each year and total number of annual admissions, Edinburgh.

II. Total number of patients remaining at the end of each year and total number of annual admissions, Glasgow.

III. Edinburgh total annual revenue.

IV. Edinburgh total annual expenditure.

V. Edinburgh patient board.

VI. Edinburgh independent contributions.

VII. Edinburgh additional revenue.

VIII. Edinburgh expenditure (itemized).

IX. Glasgow total annual revenue.

X. Glasgow total annual expenditure.

XI. Glasgow patient board.

XII. Glasgow independent contributions.

XIII. Glasgow additional revenue.

XIV. Glasgow expenditure (itemized).

XV. Physicians Superintendent, Edinburgh.

XVI. Physicians Superintendent, Glasgow.

XVII. Some examples of the 'Supposed causes of insanity' cited by Edinburgh and Glasgow physicians.

XVIII. Dr.Skae's classification of insanity.

XIX Dr. Balmanno's nomenclature and classification of the various forms of insanity.

XX. Classification of admissions according to type, Edinburgh.

XXI. Classification of admissions according to type, Glasgow.

XXII. Dietary of the Dumfries Royal Asylum.

XXIII. Trades, Occupations and Professions of patients, Glasgow, 1850-1900.

APPENDIX I

	Total number of patients remaining, at end of year. Edinburgh.	Total number of annual admissions
1840	39	12
1841	59	Not recorded
1842	162	154
1843	276	212
1844	303	162
1845	405	253
1846	418	197
1847	456	251
1848	473	246
1849	476	265
1850	498	253
1851	516	248
1852	543	247
1853	545	236
1854	539	212
1855	519	223
1856	550	258
1857	639	308
1858	642	235
1859	673	216
1860	668	258
1861	679	241
1862	687	246
1863	672	220
1864	644	224
1865	616	226
1866	673	330
1867	716	275
1868	730	284
1869	739	302
1870	720	280

L.R.H.B. Annual Reports of the Managers of the Edinburgh Royal Asylum (1841-71), pp. 2-3.

APPENDIX II

	Total number of patients remaining at end of the year. Glasgow.	Total number of annual admissions
1830	123	89
1831	137	96
1832	139	99
1833	139	89
1834	140	85
1835	137	96
1836	149	122
1837	146	114
1838	157	117
1839	155	131
1840	183	149
1841	170	157
1842	202	199
1843	344	327
1844	405	290
1845	464	364
1846	539	414
1847	552	365
1848	518	366
1849	487	378
1850	425	393
1851	428	259
1852	420	266
1853	473	319
1854	424	240
1855	412	201
1856	420	217
1857	470	287
1858	504	267
1859	500	204
1860	502	204
1861	488	211
1862	498	196
1863	484	225
1864	497	224
1865	502	238
1866	525	339
1867	561	334
1868	589	313
1869	545	320
1870	561	326

M.L. Annual Reports of the Directors of the Glasgow Royal Asylum Nos. 17 (1831)- 57 (1871), pp.2-3.

APPENDIX III

Edinburgh Total Annual Revenue

1837	2,583.3.4½
1838	2,736.9.9
1839	2,561.14.1½
1840	3,324.4.7
1841	17,838.8.11
1842	13,855.4.0
1843	15,499.16.0
1844	13,953.11.2½
1845	13,909.11.9½
1846	17,333.2.3
1847	12,127.2.9½
1848	14,816.11.6
1849	13,583.10.6½
1850	19,834.1.5½
1851	14,407.0.0
1852	18,281.0.7¾
1853	15,897.16.2¾
1854	17,251.14.5½
1855	35,998.18.9
1856	27,588.6.3½
1857	Not recorded
1858	22,510.13.10½
1859	27,594.0.5½
1860	27,444.15.3½
1861	27,010.3.4
1862	26,392.6.3
1863	25,100.11.2
1864	24,549.6.10½
1865	23,517.13.5
1866	26,813.10.10
1867	29,650.7.8
1868	32,712.15.8½
1869	29,501.14.4½
1870	30,264.9.10

Edinburgh Annual Reports, *op. cit.*, (1838-71), statements of accounts.

APPENDIX IV

Edinburgh Total Annual Expenditure

1837	2,267.8.9
1838	1,969.8.9
1839	2,459.9.0½
1840	2,154.7.11½
1841	3,819.18.4
1842	3,595.5.4½
1843	10,123.2.10
1844	12,881.15.11
1845	17,338.11.11½
1846	13,993.6.7
1847	26,338.17.2
1848	12,322.4.8
1849	14,706.13.7¼
1850	17,093.6.2½
1851	14,298.15.8
1852	17,558.8.8½
1853	15,240.6.3¼
1854	17,634.1.5
1855	26,603.5.11
1856	24,682.12.6
1857	Not recorded
1858	22,510.13.10½
1859	27,594.0.5½
1860	27,444.15.3½
1861	27,016.3.4
1862	26,392.6.3
1863	25,100.11.2
1864	24,549.6.10½
1865	23,517.13.5
1866	26,813.10.10
1867	29,650.7.8
1868	32,712.15.8½
1869	29,501.14.4½
1870	30,264.9.10

ibid.

APPENDIX V

Edinburgh Patient Board

1837	2,098.0.11½
1838	2,326.2.2
1839	2,117.7.2½
1840	1,868.5.7
1841	2,105.15.4
1842	3,312.18.2
1843	5,831.19.5
1844	6,811.8.9½
1845	8,261.6.2½
1846	8,754.14.6
1847	10,305.2.3½
1848	12,316.8.10
1849	12,416.0.4½
1850	13,351.5.1½
1851	13,388.18.4½
1852	13,129.7.2
1853	13,690.15.1½
1854	15,270.17.0
1855	16,051.18.6
1856	16,228.5.10
1857	Not recorded
1858	18,977.9.10
1859	19,358.18.9
1860	20,579.9.2
1861	21,732.4.1
1862	22,059.9.5
1863	21,874.0.9
1864	21,078.16.9
1865	20,773.6.5
1866	21,701.19.5
1867	22,799.10.7
1868	23,215.4.10
1869	23,516.5.11
1870	22,289.17.10

ibid.

APPENDIX VI

Edinburgh Independent Contributions

1837	102.11.9
1838	6.1.0
1839	51.1.0
1840	863.3.10
1841	6,552.12.10
1842	3,078.11.11
1843	876.5.7
1844	471.16.1
1845	518.16.0
1846	8,092.4.0
1847	256.0.0
1848	474.0.0
1849	645.0.0
1850	5,670.1.6
1851	116.10.0
1852	2,150.0.0
1853	750.0.0
1854	400.0.0
1855	19,228.0.11
1856	900.18.0
1857	Not recorded
1858	3,740.0.0
1859	3,263.9.0
1860	1,600.0.0
1861	2,400.0.0

ibid.

APPENDIX VII

Edinburgh Additional Revenues

Dividend from Stock

1837-44	2,528.14.7

Interest on sum in Bank

1837-39	89.11.4

Produce Marketed

1837-70	10,367.1.8

Sundries

1838-70	50,698.12.3½

ibid.

APPENDIX VIII

Edinburgh Expenditure (itemized)

Establishments

1837-50	78,192.10.11½
1851-60	116,717.4.1¾
1861-70	192,448.7.3½
	387,358.2.4¾

Salaries & Wages

1837-50	15,377.10.7¼
1851-60	28,483.5.0¾
1861-70	22,273.5.6½
	66,134.1.2½

Extra

1837-50	42,594.16.3
1851-60	42,464.17.10
1861-70	40,956.16.13½
	126,016.11.2½

Expenditure on grounds for and building of West House

1840-42	29,173.2.7½

ibid.

APPENDIX IX

Glasgow Total Annual Revenue

1830	4,582.16.6
1831	4,439.0.8
1832	Not recorded
1833	5,766.3.5½
1834	4,772.18.3
1835	4,775.6.8½
1836	5,194.14.1½
1837	6,145.6.11
1838	5,908.9.4
1839	7,171.1.2½
1840	7,590.0.8½
1841	7,010.4.5
1842	33,000.8.1½
1843	38,026.4.11½
1844	54,995.7.2½
1845	15,064.11.0
1846	17,894.0.5
1847	20,224.9.5
1848	19,438.0.0
1849	21,062.8.10
1850	30,776.7.2
1851	14,445.7.0
1852	13,954.15.2
1853	14,109.18.0
1854	15,366.6.7
1855	14,274.3.2
1856	16,248.4.6
1857	19,488.14.8
1858	18,717.2.3
1859	18,707.11.6
1860	17,745.18.3
1861	21,662.19.9
1862	19,543.18.0
1863	19,787.5.0
1864	18,636.7.9
1865	19,961.14.7
1866	20,262.8.5½
1867	52,495.5.10
1868	25,090.4.10
1869	25,677.19.8
1870	25,639.9.10

Glasgow Annual Reports, op. cit., Nos. 17 (1831) - 57 (1871) statements of accounts.

APPENDIX X

Glasgow Total Annual Expenditure

1830	4,656.10.2½
1831	4,435.15.9
1832	4,666.19.5½
1833	5,755.16.5½
1834	4,746.7.4
1835	4,766.11.10½
1836	5,195.13.1
1837	6,208.13.8
1838	6,018.17.4½
1839	7,170.15.11
1840	7,523.19.7½
1841	6,936.0.3
1842	32,904.14.9
1843	38,002.14.9
1844	54,979.9.6½
1845	15,043.8.2
1846	18,425.7.1
1847	20,172.13.4
1848	19,529.14.9
1849	21,037.11.9
1850	30,792.12.3
1851	14,440.5.10
1852	13,950.6.0
1853	14,252.12.11
1854	15,358.2.8
1855	14,318.15.9
1856	15,620.3.8
1857	19,506.8.0
1858	19.001.14.1
1859	18,819.2.6
1860	17,747.12.11
1861	21,760.8.4
1862	19,538.12.0
1863	19,781.14.6
1864	18,635.13.5
1865	19,646.14.3½
1866	20,262.8.5½
1867	52,495.5.10
1868	25,090.4.10
1869	25,677.19.8
1870	25,639.9.10

ibid.

APPENDIX XI

Glasgow Patient Board

1830	3,787.11.2
1831	4,186.7.11
1832	4,410.7.1
1833	4,533.6.5
1834	4,086.13.6
1835	4,271.17.7
1836	4,825.12.11½
1837	5,264.10.10
1838	5,100.5.0
1839	5,326.9.5½
1840	5,754.19.0
1841	6,072.4.3
1842	6,788.7.9
1843	8,511.18.8
1844	10,935.16.10
1845	12,876.15.9
1846	17,167.3.3
1847	19,764.18.2
1848	18,873.4.2
1849	16,043.18.3
1850	14,403.2.4
1851	13,138.14.8
1852	12,258.14.2
1853	13,223.12.1
1854	14,183.8.6
1855	13,103.19.7
1856	14,857.16.6
1857	15,703.5.8
1858	17,273.19.7
1859	16,999.17.8
1860	15,597.8.10
1861	19.386.15.9
1862	17,633.5.3
1863	17,930.19.7
1864	17,005.14.11
1865	17,954.12.12
1866	18,883.14.11
1867	21,359.15.1
1868	23,967.14.4
1869	24,118.6.3
1870	23,592.12.10

ibid.

APPENDIX XII

Glasgow Independent Contributions

1830	769.19.0
1831	229.9.4
1832	234.18.3
1833	1,182.8.4
1834	595.5.5
1835	292.8.3½
1836	263.18.6
1837	579.10.4
1838	117.12.0
1839	65.12.0
1840	361.16.7
1841	64.10.10
1842	2,008.11.0
1843	1,336.16.9
1844	148.6.0
1845	762.3.7
1846	337.18.10
1847	67.19.0
1848	58.10.0
1849	1,063.3.0
1850	778.3.10
1851	828.11.7
1852	337.6.6
1853	110.7.6
1854	303.14.10
1855	25.0.0
1856	145.7.6
1857	2,500.0.0
1858	225.10.0
1859	358.19.0
1860	591.9.2
1861	410.17.7
1862	449.17.11
1863	726.9.9
1864	9.7.0
1865	501.1.0
1866	2.2.0
1867	277.17.0
1868	248.1.0
1869	226.10.5
1870	41.10.0

ibid.

APPENDIX XIII

Glasgow Additional Revenue

Amount realized from sale of stock

1842 585.12.4

Charity Box Income

1830-33 23.9.3½

Compensation from Edinburgh and Glasgow Railway Tunnel passing through Asylum property

1840 1,194.10.6

Dividend from Stock

1834-44 179.5.4

Interest on Deposit Account with Royal Bank

1831-43 1,039.9.4

Price of Buildings and Ground of Former Asylum

1843 17,732.10.0

Produce Marketed

1830-70 10,936.16.8

Road Trustees, a Sum for Damages

1835 30.0.0

ibid.

APPENDIX XIV

Glasgow Expenditure (itemized)

Establishments

1830-43	34,712.6.3½
1844-50	47,435.13.4
1851-60	74,748.19.11
1861-70	103,953.14.4½
	260,850.13.11

Salaries & Wages

1830-43	14,507.12.7
1844-50	18,125.3.6
1851-60	31,368.18.3
1861-70	33,397.5.4
	97,398.19.8

Extra

1830-43	42,091.18.5½
1844-50	11,907.16.11½
1851-60	36,169.7.10
1861-70	22,938.6.10
	113,107.10.1

ibid.

APPENDIX XV

Physicians Superintendent of the Edinburgh Royal Asylum (later Hospital).

Dr. W.McKinnon	1839-46
Dr. D.Skae	1846-73
Dr. T.Clouston	1873-1907
Prof. G.M. Robertson	1907-1932
Dr.Sir David Henderson	1932-1955
Dr. T.Munro	1955-1966
Dr. J.W. Affleck	1966-1980
Dr. W. Boyd	1980-

Edinburgh Annual Reports.
op.cit., passim.

APPENDIX XVI

Physicians Superintendent of the Glasgow Royal Asylum (later Gartnavel Royal Hospital)

Dr. W. Hutcheson	1841-49
Dr.A. McIntosh	1849-74
Dr.D. Yellowlees	1874-1901
Dr. R. R. Oswald	1901-21
Dr. Sir D. Henderson	1921-32
Dr. A. McNiven	1932-65
Dr. G. Timbury	1965-80
Dr. W. Kiernan	1980-

Glasgow Annual Reports, op. cit., passim.

APPENDIX XVII

Some Examples of the 'Supposed Causes of Insanity' cited by Edinburgh and Glasgow Physicians

Abortion
Anger
Business Failure
Cancer
Census, Taking of
Cold, Exposure to
Congenital
Constipation
Debilitating Evacuations
Deaths
Debts
Defamation of Character
Epilepsy
Excitement after attending Great Exhibition
Excitement after attending theatre
Excitement after attending a wedding
Fatigue
Fall of House in High Street
Friend , Suicide of
Gastric Irritation
General Hysteria
General Paralysis
Haemorrage
Hard Labour
Head, Injury to
Hearing a Lecture
Hereditary Predisposition
Hydrocephalus
Hysteria
Idiocy
Imbecility
Indulgence in opiates
Influenza
Intemperance
Jealousy
Love Disappointed
Massacre of Relatives at Cawnpore
Masturbation
Meningitis
Menstruation
Mental Exhaustion
Mesmerism
Miscarriage
Ovarian Disease
Papal Aggression
Paralysis
Political Excitement
Poverty
Pregnancy
Pride
Prostitution
Puerperal Disorders
Queen's Visit to Scotland
Rheumatism
Rupture of Blood Vessel
Railway Travelling
Religion
Remorse
Revival Meeting
Scarlatina
Secret Vice
Seduction
Senile Decay
Sexual Excess
Shipwreck of Husband
Smallpox
Softening of Brain
Spinal Disease
Strike of Miners
Sunstroke
Syphilis
Tobacco
Typhus
Ulcers
Unknown or Gradual Approach
Uterine Difficulties
Venereal Disease
Visiting Mother in Asylum
Vice
Want of Employment

Edinburgh Annual Reports, op. cit., Appendix, passim.

Glasgow Annual Reports, op. cit., Appendix, passim.

APPENDIX XVII

Dr Skae's Classification of Insanity

Idiocy
Imbecility
Insanity with Epilepsy
Insanity of Masturbation
Insanity of Pubescence
Satyriasis
Nymphomania
Hysterical Mania
Amenorrheal Mania
Post-Connubial Mania
Puerperal Mania
Mania of Pregnancy
Mania of Lactation
Climacteric Mania
Ovario-Mania
(Uterio-Mania)
Senile Mania
Phthisical Mania
Metastatic Mania
Traumatic Mania
Syphilitic Mania
Delirium Tremens
Dipsomania
Mania of Alcoholism
Post-Febrile Mania
Mania of Oxaluria
and Phosphaturia
General Paralysis
with Insanity
Epidemic Mania
Idiopathic Mania
Sthenic
Asthenic

Moral and
Intellectual

F. Fish, David Skae, M.D., F.R.C.S. Founder of the Edinburgh School of Psychiatry, in Med. Hist. Vol. IX, No.1. (1965), 52.

APPENDIX XIX

Dr Balmanno's nomenclature and classification of the various forms of insanity

Insania	Mania	Monomania	Mitis Estatica
		Polymania	Iracunda Furibunda
		Pantomania	Mitis Iracunda Furibunda
		Tranquilla	
	Melancholia	Agitata	
		Tremebunda	
		Iracunda	
	Dementia	Imbecilitas	Tranquila Iracunda
		Stupor	
		Fatuitas	
	Amentia	Transiens	
		Chronica	
		Congenita	

Glasgow Annual Reports, op. cit.

No.26, (1840) Appendix 23.

APPENDIX XX

Classification of admissions according to type, Edinburgh, in years in which 'type' figures, correlated absolutely with 'admission' figures, 1845, 1852, 1862.

	M	F	T	%
Mania	113	166	279	37.40
Dementia	108	98	206	27.61
Melancholia	47	50	97	13.00
Monomania	38	33	71	9.52
General Paralysis of the Insane	37	1	38	5.09
Moral Insanity	14	13	27	3.61
Idiocy/Imbecility	9	7	16	2.14
Delerium Tremens	8		8	1.07
Dipsomania	2	0	2	0.26
Demonomania	1	0	1	0.13
Epilepsy	0	1	1	0.13

Total number of admissions of 3 years 746

Edinburgh Annual Reports, op. cit. 1846, 1853, 1863, Appendices.

APPENDIX XXI

Classification of admissions according to type, Glasgow, 1850-70

	M	F	T	%
Mania	1,551	1,404	2,955	52.93
Monomania	607	573	1,180	21.13
Dementia	537	384	921	16.50
Melancholia	204	256	460	8.24
Idiocy/Imbecility	26	23	49	0.88

The remainder was make up of isolated references to epilepsy, fatuity, general paralysis and nymphomania (total number of admissions 5583)

Glasgow Annual reports, Op. cit., Nos.37 (1851)-57 (1871), Appendices.

APPENDIX XXII

Dietary of the Dumfries Royal Asylum

Crichton Institution

1 Class

Breakfast - Tea, 16ozs; Bread, 8ozs; Coffee; an egg; fish; cold meat.
Dinner - Soup, 10 ozs; meat; 8ozs; Bread, 4ozs; vegetable 6ozs; pudding, 6ozs; beer, 10ozs; Dessert and wine, 4ozs, every day. Game given in season.
To have a remove.
Tea - Tea, 12ozs; Bread, 4ozs.
Supper - An egg, or breadburry, gruel or sago, 8ozs.

II Class

The same as class 1, but without game and without a remove.

III Class

The same as class II, but with dessert and wine only three times a week.

IV Class

The same as class III, but with plainer breadfast, and without dessert and wine.

Low Diet

Breakfast - Tea, 8ozs; Bread, 2ozs.
Dinner - Sowens, Breadburry or tapioca, 8ozs.
Supper - Tea or gruel, 8 ozs.

Southern Counties Asylum

Males

Breakfast - Porridge, 2lbs; Milk, 10ozs; or tea, 16ozs; Bread, 8ozs; Butter, ½ozs.

APPENDIX XXII (cont.)

Southern Counties Asylum (cont.)

The same evening meal is given every day.

Supper - Porridge, 2lbs; Milk, 10 ozs; or tea, 16 ozs; Bread, 8ozs; Butter, ½ ozs. The same evening meal is given every day.

Dinner - Monday and Friday, Broth, 24oz; Meat, 8ozs; Potatoes, 16ozs; Bread, 4ozs; Beet, 10 ozs.

Tuesday, Broth, 24ozs; Potatoes, 16ozs; Bread, 4ozs; Beer, 10 ozs.

Wednesday - Pease soup, 24 ozs; meat, 8ozs; Potatoes, 16ozs; Bread, 4ozs; Beer, 10 ozs.

Thursday - Broth, 24ozs; Potatoes, 16ozs; Bread, 4 ozs; Beer, 10 ozs.

There is no record for Saturday & Sunday's fare.

Females

Breakfast - Porridge, 1½lb; Milk, 10 ozs; or Tea, 16ozs; Bread, 8ozs; Butter, ½ozs.
The same breakfast is given every day.

Supper or evening meal - Porridge, 1½lbs; Milk, 10ozs; or Tea, 16ozs; Bread, 8ozs; Butter, ½ozs.
The same supper is given every day.

Dinner - Monday and Friday - Broth, 16ozs; Potatoes, 16 ozs; Bread, 4ozs.

Tuesday - Broth, 16ozs; Meat, 8ozs; Potatoes, 16ozs; Bread, 4ozs.

Wednesday - Pease soup, 16ozs; Potatoes, 10ozs; Bread, 4ozs.

Thursday - Broth, 16ozs; Meat, 8ozs; Potatoes, 10ozs; Bread, 4ozs.

There is no record for Saturday or Sunday's fare.

Report by Her Majesty's Commissioners appointed to inquire into the state of Lunatic Asylums in Scotland, Appendix, 1857 (1) (2148-1), Vol.5,293. (E, No. 11, 187).

APPENDIX XXIII

Trades, Occupations & Profession of Patients

1850-1900

Males

Accountant	7
Actor	4
Advocate	2
Agent	24
Agricultural Servant	1
Apothecary	2
Architect	6
Army Surgeon	1
Artist	11
Assayer	1
Author	1
	60
Baker	58
Banker	8
Banker's Clerk	4
Barber	2
Barrister	2
Basketmaker	7
Beadle	1
Beamer	1
Bill-poster	1
Blacksmiths	63
Bleacher	7
Blockmaker	12
Boatmen	1
Bobbin-turner	1
Boilermaker	15
Bookbinder	6
Bookseller	5
Bootmaker	12
Bottle-blower	6
Boxmaker	1
Brassfounder	20
Brewer	6
Bricklayer	14
Brokers	3
Brushmaker	3
Buffer merchant	2
Builder	2

Butcher	16	
Butler	8	
Buyers	1	
		288
Cab-driver	8	
Cabinetmaker	13	
Calenderer	6	
Calico-printer	10	
Card Dealer (Grinder)	2	
Carpet weaver	3	
Carpenter	48	
Carrier	8	
Carter	21	
Cartwright	2	
Cashier	9	
Catechist	1	
Cattle-dealer	9	
Caulker	7	
Chain-tester	4	
Chairmaker	1	
Chemical Mft.	1	
Chemist	10	
Chimney-sweep	2	
Church officer	1	
Clergymen	46	
Clerk	460	
Clothier	7	
Clothlapper	9	
Clock-agent/maker	3	
Coachmen	22	
Coal agent	53	
Collector	1	
Colour mixer	1	
Combmakers	1	
Commission Agent	1	
Compositor	7	
Confectioner	2	
Constable	3	
Contractor	4	
Cook	2	
Cooper	20	
Coppersmith	3	
Cork Cutter	3	
Cotton-broker	1	
Cotton-spinner	3	
Cowfeeder	3	
Customhouse Officer	5	
		826
Dealer	20	
Dealer in curios	1	
Dentist	3	
Designer	12	

Detective	1	
Discharged Soldier	1	
Dispenser	1	
Distiller	2	
Die-stamp cutter	3	
Doctor of Medicine	26	
Draper	54	
Draughtsmen	8	
Drayman	2	
Drill sergeant	1	
Druggist	1	
Drysalter	3	
Dyer	13	
		152
Editor	1	
Electrician	4	
Electro-plater	1	
Enameler	1	
Engineer	142	
Engraver	20	
Engine-Keeper	20	
Excise Officer	3	
Ex-Bank Teller	1	
Ex-Inland Revenue Officer	1	
Ex W. India Merchant	2	
Equestrians	2	
		198
Factor	1	
Farm Servant	57	
Farmers	158	
Fancy Dressmaker	1	
Fencing Master	2	
Fiddler	1	
Fireclay Mft.	1	
Firemen	12	
Fishermen	16	
Fish Lock Maker	2	
Fish Merchant	4	
Flax-dresser	1	
Flax-spinner	2	
Flesher	37	
Florist	2	
Flour-miller	1	
Foot attendant	1	
Forester	3	
Founder	2	
Forgeman	1	
Fortman	4	
French Polisher	1	
Furnace Fitter	1	
		311

Gamekeeper	4	
Gardiner	22	
Gas-fitter	7	
Gatekeeper	3	
Gentlemen	108	
Gentlemen's servant	2	
Glass Beveller	1	
Glass Cutter	3	
Glazier	5	
Gilder	1	
Grocer	77	
Grain merchant	3	
Groom	6	
Gutta worker	1	
		243
Hair-dresser	2	
Ham Curer	5	
Hammerer	21	
Hatmaker	13	
Hawker	42	
Hecklemaker	2	
Horse-dealer	4	
Hostler	2	
Hot-presser	2	
Hotelkeeper	9	
House-dealer	9	
House-painter	1	
Hutchrunner	1	
		113
Ice dealer	1	
Inland Revenue Officer	3	
Innkeeper	3	
Insurance-broker	3	
Inspector	2	
Ironmonger	13	
Iron worker	58	
		.83
Janitor	1	
Japanner	3	
Jeweller	9	
Joiner	103	
		116
Labourers	722	
Lamplighter	1	
Land agent	6	
Lathsplitter	1	
Laundryman	1	
Lawyer	9	

Law Student	11	
Leather Cutter	5	
Letter deliverer	3	
Linen merchant	5	
Lithographer	6	
Lieutenant (navy)	1	
(army)	1	
Lodging House Keeper	2	
		774
Machinist	3	
Major	1	
Malster	2	
Manufacturer	22	
Manager	3	
Marble-cutter	3	
Marine	1	
Marine engineer	1	
Masons	83	
Master Mariner	1	
Master of Work	1	
Master Joner	1	
Measurer	3	
Mechanic	13	
Medical Student	7	
Merchants	192	
Messenger-at-Arms	2	
Message Boy	5	
Miller	8	
Mill-weaver	1	
Millwright	7	
Military Officer	1	
Miners	184	
Minister	24	
Missionary	3	
Moulder	32	
Mole catcher	1	
Museum Keeper	1	
Muslin Printer	1	
Music Hall Propr.	1	
Music seller	2	
Music teacher	1	
Musical Instrument maker	1	
Musician	4	
		616
Nailer	3	
Newsvendor	2	
Night watchman	3	
No occupation	175	
		183
Officer-in-the-Army	2	

Omnibus Driver	4	
Optician	2	
Ostler	1	
Overseer	1	
		10
Packer	22	
Painter	36	
Paper maker	9	
Pattern designer	15	
Pawnbroker's asst.	3	
Pavior	2	
Physician	16	
Pianoforte maker	2	
Pilot	4	
Piper	1	
Pipemaker	7	
Plainer	1	
Plasterer	13	
Platelayer	1	
Plumber	33	
Ploughman	7	
Policeman	10	
Polisher	2	
Porter	28	
Portioner	4	
Portmanteau-maker	2	
Post officer servant	5	
Potter	9	
Potato merchant	2	
Power loom mft.	1	
Preacher	6	
Press-printer	2	
Priest	1	
Prison warder	2	
Provision merchant	1	
Printer	21	
Purser	3	
Puddler	11	
Pensioner	7	
Publican	5	
		294
Rabbit catcher	1	
Reporter	1	
Retired steamship officer	2	
Retired surveyor	2	
Restaurateur	3	
Rigger	1	
Rubber worker	1	
		11

Sailor	49
Saddler	7
Salesman	42
Sausagemaker	1
Sawyer	4
Sailmaker	1
Sawmaker	1
Saltmaker	1
Sawyer	2
Sea Captain	12
Seamen	6
Seedsmen	3
Servant	1
Shawl mft.	1
Sheep farmer	5
Shepherd	11
Sheriff clerk depute	1
Sheriff officer	6
Shiner	4
Shingler	2
Shipbuilder	2
Shipowner	4
Ships broker	4
Ships captain	2
Ships carpenter	7
Ships steward	9
Shipwright	2
Shoemaker	147
Shopkeeper	34
Silvermaker	1
Slater	7
Slowmen	2
Slopine	2
Soldier	52
Spindlemaker	1
Spirit dealer	43
Speechmaker	1
Stationer	2
Station master	2
Stableman	1
Steelworker	1
Stetch maker	1
Stockbroker	1
Stoker	3
Strolling fiddler	2
Student	25
Student of law	28
Student of divinity	10
Storebreaker	9
Storeman	1
Sugar broker	4
Sugar planter	1
Sugar sampler	1
Superintendant of police	1
Supervisor	2
Supply agent	1

Surfaceman	1	
Surveyor	5	
Surgeon	5	
Sweep	1	
Scavenger	1	
Sculptor	1	
Schoolboy	2	
Schoolmaster	5	
Speechmaker	1	
Sheep driver	1	
Sergeant	1	
		600
Tanner	2	
Tailor	61	
Teacher	45	
Tea dealer	2	
Tenter	4	
Telegraphist	2	
Thread-finisher	1	
Threadlapper	1	
Theatrical manager	1	
Tide waiter	1	
Timber merchant	2	
Timekeeper	2	
Tinsmith	17	
Tobacconist	4	
Tobacco-pipe merchant	1	
Tobacco-spinner	7	
Tollkeeper	1	
Tramway-guard	1	
Travellers (comm.)	70	
Tube worker	1	
Tutor	1	
Twine mft.	2	
Twister	4	
Type founder	1	
Tax surveyor	1	
		235
Umbrella maker	3	
Unascertained	26	
Unknown	76	
Undertaker	1	
Upholsterer	13	
		119
Waggon builder	1	
Waiter	8	
Warehousemen	59	
Watchmaker	10	
Watchmen	14	

Warper	13	
Washer	3	
Weaver	184	
Wine-worker	4	
Winder	2	
Wood carver	5	
Wood cutter	2	
Wood turner	4	
Wood merchant	1	
Wood gaveller	2	
		312
Van driver	2	
Vagrant	2	
Victualler	1	
Vocalist	1	
		6
Yarn agent	2	
		2

Females

Annuitant	1	
Asylum attendant	2	
		3
Bag sewer	2	
Bandage maker	1	
Bible woman	1	
Biscuit packer	4	
Bleachers	11	
Bookfolder	6	
Bootcloser	4	
Broker	1	
Brushmaker	1	
		31
Calenderer	1	
Capmaker	2	
Charwoman	2	
Cleaners	2	
Clerkess	2	
Clipper-in-the-mill	4	
Clippers	7	
Coal dealer	1	
Colourer	1	
Confectioner	4	

Cotton spinner	3	
Cook	3	
Crotchet worker	1	
		33
Dairymaid	11	
Darner	3	
Domestic Occupation	855	
Domestic servant	322	
Domestic	187	
Dressmaker	63	
Dyer	2	
		1443
Envelope maker	1	
		1
Factory worker	44	
Farmer	4	
Farmer's daughter	2	
Farm servant	50	
Field worker	2	
Fishdealer/seller	5	
French polisher	5	
Fringer	1	
Fruiterer	1	
Fur cleaner	1	
		115
Governess	21	
Grocer	2	
Grounder	1	
		24
Hair teaser	2	
Hawkers	39	
Horse dealer	1	
Hospital nurse	1	
Hotelkeeper	8	
Housekeeper	91	
Housewife	588	
		730
Innkeeper	1	
Innkeeper's wife	1	
Ironer	1	
		3

Knitter	2	
		2
Ladies	266	
Ladies Maid	2	
Laundress	11	
Landlady	1	
Librarian	1	
Lodging Keeper	14	
		295
Machinist	11	
Machine-worker	21	
Mangle Keeper	2	
Matron	1	
Medical Doctor	1	
Medical Student	1	
Merchant's Wife	3	
Merchant's Widow	4	
Milliner	29	
Midwife	4	
Millworker	93	
Millwright	8	
Missionary	3	
Music Teacher	1	
Muslin Dottar	1	
		183
No occupation	802	
		802
Patternmaker	1	
Paper-maker	2	
Pawnbroker	1	
Physician's wife	2	
Physician's widow	3	
Photographic assistant	2	
Pin filler	2	
Polisher	2	
Pottery worker	1	
Powerloom weaver	4	
Printfield worker	8	
Pupil teacher	1	
Prostitute	3	
		32
Saleswoman	131	
School-girl	1	
Scripture reader	1	
Servant	37	
Sewer	57	

Sewing Machine worker	2	
Seamstress	149	
Shawl finisher	7	
Shoe-binder	2	
Shepherdess	1	
Shopkeeper	37	
Spinster	8	
Spirit dealer	1	
Soda bread maker	1	
Staymaker	4	
Stocking knitter	1	
Stockbinders	1	
Straw-hatmaker	1	
		442
Tambourner	7	
Tavern keeper	7	
Tea dealer	1	
Teachers	101	
Telegraphic clerk	1	
Tight rope dancer	1	
Tobacco-pipe maker	1	
Tract distributor	1	
Tradesmen's wife & daughter	26	
		146
Umbrella maker	1	
Unascertained	15	
Unmarried gentlewoman	33	
Unknown	46	
Upholsterer	1	
		96
Vest maker	2	
Vagrant	4	
		6
Waitress	1	
Warehouse worker	19	
Warper	3	
Washerwoman	36	
Watchman	1	
Weaver	60	
Winder	47	
Workers in Pottery	1	
		168
		10,107

Glasgow Annual Reports, op. cit., Nos.37-87 (1851-1901), Appendices.

BIBLIOGRAPHY

1. MANUSCRIPT SOURCES

EDINBURGH

A. EDINBURGH ROYAL HOSPITAL

Minutes of the Board of Managers of the Royal Asylum
Vol. II, R.A. 1/2 (29 Jan. 1816-24 Oct. 1849).
Vol. III, R.A.1/3 (28 Jan. 1850-2 May, 1856).
Vol. IV, R.A.1/4 (30 May 1856-29 June, 1871).

Patient Case Notes
Vol. I (May 1840-Sept.1842).
Vol. V (Aug. 1846-Dec.1854).
Vol. X (Aug. 1855-Dec.1859).
Vol. XVI (1862-1866).

B. SCOTTISH RECORD OFFICE

General Register of Patients admitted to lunatic asylums
MC.7/1 (1859).

GLASGOW

C. GARTNAVEL ROYAL HOSPITAL

Anon. Historical Outline.
Rev. J. Brodie, History, 1810-1948.
Dr. D. Yellowlees, Glasgow Royal Asylum, Gartnavel; Brief History.

D. GREATER GLASGOW HEALTH BOARD

Glasgow Royal Asylum
Patient Case Notes
H.B. 13/5/10, (1830-36).
H.B. 13/5/11, (1838).
H.B. 13/5/12, (1839).
H.B. 13/5/13, (1840).

H.B. 13/5/14, (1841).
H.B. 13/5/15, (1842).
H.B. 13/5/43, (1846-48).
H.B. 13/5/51, (1851-52).
H.B. 13/5/52, (1852-54).
H.B. 13/5/55, (1858-62).
H.B. 13/5/90, (1862-65).

2. PRINTED ORIGINAL SOURCES

All references to Parliamentary Papers have been made according to the official citation used by the British Library.

A. House of Commons Parliamentary Reports

145; Parliamentary Debates, 3S, Cols. 1025-1045, (29 May, 1857).

B. House of Commons Sessional Papers

Annual Reports of the Board of Supervision for the Relief of the Poor in Scotland

No. 1; 1847 (767), Vol. XXVII, 405.
No. 2; 1847-8 (906), Vol. XXXIII, 113.
No. 3; 1849 (1011), Vol. XXV, 347.
No. 4; 1850 (1151), Vol. XXVII, 597.
No. 5; 1851 (1294), Vol. XXVI, 755.
No. 6; 1852 (1426), Vol. XXI, 383.
No. 7; 1852-3 (1576), Vol. L, 571.
No. 8; 1854 (1710), Vol. XXIX, 641.
No. 9; 1854-5 (1877), Vol. XXIV, 159.
No. 10; 1856 (2019), Vol. XXVIII, 187.
No. 11; 1857(1)(2150), Vol. IV, 375.
No. 12; 1857-58 (2323), Vol. XXVII, 527.

Annual Reports of the General Board of Commissioners in Lunacy for Scotland

No. 1; 1859 (2489), Vol. IX, 81.
No. 2; 1860 (2658), Vol. XXXIV, 1.
No. 3; 1861 (2809), Vol. XXVII, 311.
No. 4; 1862 (2974), Vol. XXIII, 255.
No. 5; 1863 (3140), Vol. XX, 715.
No. 6; 1864 (3344), Vol. XXIII, 457.
No. 7; 1865 (3506), Vol. XXI, 239.
No. 8; 1866 (3659), Vol. XXXII, 213.
No. 9; 1867 (3876), Vol. XVIII, 569.
No. 10; 1867-8 (4038), Vol. XXXI, 433.
No. 11; 1868-9 (4160), Vol. XXVII, 511.
No. 12; 1870 (c.88), Vol. XXXIV, 457.
No. 13; 1871 (c.363), Vol. XXVI, 615.

No. 14; 1872 (c.556), Vol. XXVII, 483.
No. 24; 1882 (c. 3357), Vol. XXXII, 599.
No. 34; 1892 (c.6756), Vol. XL, 549.
No. 43; 1901 (c.755), Vol. XXVIII, 817.

The Census

Census for 1831; 1833 (149), Vols. XXXVI-XXXVIII, 1.
Census for 1841; 1841 (2)(52), Vol. II, 277.
Census for 1851, Vol. II; 1852-53 (1632), Vol. LXXXVI, 1.
Census for Scotland 1861, Vol. II; 1864 (3275), Vol. LI, 49.
Census for Scotland, 1871, Vol. I; 1872 (c.592), Vol. LXVIII, 1.
Vol. II; 1873 (c.841), Vol. LXXIII, 1.

Report by Her Majesty's Commissioners appointed to inquire into the state of Lunatic Asylums in Scotland, and the existing law in reference to Lunatics and Lunatic Asylums in that part of the United Kingdom.

1857 (1)(2148), Vol. V, 1.
Appendix, 1857 (1)(2148-1), Vol. V, 293.

Report from Her Majesty's Commissioners for inquiring into the Administration and Practical Operation of the Poor Laws in Scotland.

1844 (557), Vol. XX, 1.

Second Report of Her Majesty's Commissioners for Inquiring into the Housing of the Working Classes (Scotland)

1884-5 (c.4409), Vol. XXXXI, 1.

C. Lothian Regional Health Board

Annual Reports of the Managers of the Edinburgh Royal Asylum.

(1836-1870)

Report of the Lunatic Asylum at Morningside to

the Managers of that Institution detailing its rise, progress and present condition, with regard to its funds and inmates (W. Scott., 1836).

D. Mitchell Library

Annual Reports of the Directors of the Glasgow Royal Asylum

Nos. 1-8 (1815-22).

Nos. 11-15 (1825-29).

Nos. 16-57 (1830-71).

Report of the General Committee appointed to carry into effect the proposal for a Lunatic Asylum at Glasgow (1814).

E. Newspapers

The Glasgow Herald

The Montrose Standard and Angus and Mearns Register

The Scotsman

The Scots Law Times

The Orcadian

F. Public General Statutes

The 55 George III, Ch. 69.

The 9 George IV, Ch. 34.

The 2 and 3 Victoria, Ch. 42.

The 4 and 5 Victoria, Ch. 60.

The 7 and 8 Victoria, Ch. 34.

The 8 and 9 Victoria, Ch. 83.

The 20 and 21 Victoria, Ch. 71.

The 21 and 22 Victoria, Ch. 89.

The 25 and 26 Victoria, Ch. 54.

The 27 and 28 Victoria, Ch. 59.

The 29 and 30 Victoria, Ch. 51.

The 30 and 31 Victoria, Ch. 55.

G. Writings and Records

J.R. Adam, Gartnavel Minstrel ... consisting of original pieces in rhyme, both comic and sentimental (Glasgow, 1845).

Anon, The Philosophy of Insanity (Glasgow, 1847).

Anon, Voices from Gartnavel Asylum (Glasgow, 1865).

J. Gourlay, A Glasgow Miscellany. (Privately Printed).

The Gartnavel Gazette.

S. Macgill, On Lunatic Asylums ... laying the foundation stone of the Glasgow Lunatic Asylum (Glasgow, 1810).

3. UNPUBLISHED THESES AND DISSERTATIONS

S. Blackden, 'The Development of Public Health Administration in Glasgow, 1842-72', University of Edinburgh, Ph.D. (1976).

S. Laidlaw, 'Glasgow Common Lodging Houses and the People Living in Them', University of Glasgow, Ph.D. (1956).

C. Pennington, 'Mortality, Public Health and Medical Improvements in Glasgow, 1855-1911', University of Stirling, Ph.D. (1977).

F.J. Rice, 'A Study of the Annual Reports of the Glasgow Royal Asylum, 1814-43', University of Strathclyde, Undergraduate Dissertation (1974).

4. SECONDARY SOURCES

(A) ARTICLES

J.Butt, 'Capital and Enterprise in the Scottish Iron Industry, 1780-1840', in J.Ward & J.Butt (eds.), Scottish Themes (Edinburgh, 1976).

J. Butt, 'Working Class Housing in Glasgow; 1851-1914' in S.D. Chapman (ed), History of Working Class Housing (Newton Abbot, 1971).

W. Bynum, 'Rationales for Therapy in British Psychiatry', Medical History, vol. 18 (1974).

D. Carnahan, W. Gove and O. Galle, 'Urbanization, Population Density and Overcrowding', Social Forces, 53(1) (1974).

C.O. Cheney, Dorothea Lynde Dix, American Journal of Psychiatry, 100 (1944).

T.M. Devine, 'The Cromwellian Union and the Scottish Burghs', in J. Ward and J. Butt (eds), Scottish Themes (Edinburgh, 1976).

B.P. Dohrenwend and B.S. Dohrenwend,'Social and Cultural Influences on Psychopathology', American Journal of Psychology, 25 (1974).

J. Donnachie, 'Drink and Society, 1750-1850', Journal of the Scottish Labour History Society, 13 (May, 1979)..

F. Fish, 'David Skae, M.D., F.R.C.S., Founder of the Edinburgh School of Psychiatry', Medical History, Vol. IX, 1 (1965).

T.R. Gourvish, 'The Cost of Living in Glasgow in the Early Nineteenth Century', Economic History Review, 11s, Vol. XXV, (1972).

D. Horrobin, 'A Singular Solution for Schizophrenia', New Scientist, Vol. 87, No. 1988 (1980).

R.E. Kendall, 'The Concept of Disease and its implications for Psychiatry', British Journal of Psychiatry, Vol. 127 (1975).

A. Lewis, 'The Psychoses' in P. Beeson and W. McDermott, (eds),'Cecil Loeb' Textbook of Medicine, Vol. II (Philadelphia and London, 1963).

T. Y. Lin and C.C. Standley, 'Scope of Epidemiology in Psychiatry', Public Health Papers, No. 16, World Health Organisation (1960).

P. McCandless, 'Build! Build! The Controversy over the care of the chronically insane', Bulletin for the History of Medicine, Vol. 53, No. 4 (1979).

A. MacNiven, 'The First Commissioners; Reform in Scotland in the mid-nineteenth century', Journal of Mental Science, Vol. 106, No. 443 (April, 1960).

R. Mitchison, 'The Making of the Old Scottish Poor Law', Past and Present, 63 (1974).

G.G. Moss, 'The Mortality and Personality of the Judeo-Claudian Emperors', Medical History, Vol. VII (1963).

D.S. Paterson, 'Glasgow and its Buildings', Illustrated Quarterly of the Royal Incorporation of Architects in Scotland, 26 (Spring, 1928).

A.M. Platt and B. Diamond, 'The Origins and Development of the 'Wild Beast' Concept of Mental Illness and its relation to theories of criminal responsibility', History of the Behavioral Sciences, Vol. 1, No. 4 (1965).

D.D. Reid, Epidemiological Methods in the Study of Mental Disorders', Public Health Papers, No. 2 World Health Organisation (1960).

M. Schiller, 'The Psychoses', in John Collins Harvey (ed), Practice of Medicine (Maryland, 1967).

L. Scrole, 'Urbanization and Mental Health; Some Reformulations', American Scientist, Vol. 60, 5 (1972).

N.F. Shead, 'Hospitals in the Twelfth and Thirteenth Centuries', in Macneel and Nicholson (eds), Scottish Medieval Historical Atlas (Edinburgh, 1975).

M. Shepherd, 'Lunacy and Labour', Bulletin for the Study of Labour History, 34 (1977).

M. Siegler, H. Osmund, and H. Mann, 'Laing's Model of Madness', British Journal of Psychiatry, 115 (1969).

J. Talbot, 'Radical Psychiatry', American Journal of Psychiatry, 131, 2 (1974).

J.K. Walton, 'Lunacy in the Industrial Revolution, 1848-50', Journal of Social History (Fall, 1979).

H.G. Wolff, 'Diseases of the Nervous System' in P. Beeson and W. McDermott (eds), 'Cecil Loeb' Textbook of Medicine, Vol. II (Philadelphia and London, 1963).

J.S. Zamaldin and P.L. Taylor, 'Asylum and Society', Journal of Social History (Fall, 1979).

(B) BOOKS

E. Ackernecht, A Short History of Psychiatry (London and New York, 1959).

F. Alexander and S. Selesnick, History of Psychiatry (New York, 1967).

R.J. Arthur, Introduction to Social Psychiatry (Harmondsworth, 1972).

J. Burnett, Plenty and Want (London, 1966).

R.H. Campbell, Scotland since 1707, the rise of an industrial society (Oxford, 1965).

F. Cartwright, Social History of Medicine (London, 1977).

A.K. Chalmers (ed), Public Health Administration in Glasgow (Glasgow, 1905).

O. Checkland, Scottish Philanthropy (Edinburgh, 1980).

J. Cleland, Abridgement of the Annals of Glasgow (Glasgow, 1817).

J.D. Comrie, History of Scottish Medicine, 1st edn. (London,1932).

D. Cooper, The Death of the Family (Harmondsworth, 1971).

D. Cooper, Psychiatry and Anti-Psychiatry (Harmondsworth, 1967).

A. Crowcroft, The Psychotic (London, 1967).

D. Daiches, Edinburgh (London, 1978).

D. Daiches, Glasgow (London, 1976).

J. Dawson, The Abridged Statistical History of Scotland (Edinburgh, 1854).

P. Deane and W. Cole, British Economic Growth, 1688-1959, 2nd edn. (Cambridge, 1967).

T.M. Devine, The Tobacco Lords (Edinburgh, 1975).

B.F. Duckham, A History of the Scottish Coal Industry, Vol. 1 (Newton Abbot, 1970).

C.A. Easterbrook, The Chronicle of Crichton Royal (Dumfries, 1940).

A. Esterson, The Leaves of Spring, 1st edn. (Harmondsworth, 1970).

M. Flinn (ed), Scottish Population History (Cambridge, 1977).

M. Foucault, Madness and Civilization, 3rd edn. (London, 1977).

E. Goffman, Asylums, 2nd edn. (Harmondsworth, 1961).

B.L. Gordon, Medicine Throughout Antiquity (Philadelphia, 1949).

R. Graves, I Claudius (London, 1976).

H. Hamilton, The Industrial Revolution in Scotland (London, 1932).

J. Harris, Unemployment and Politics (Oxford, 1972).

R.M. Hartwell (ed), The Causes of the Industrial Revolution in England (London, 1967).

Sir D. Henderson, The Evolution of Psychiatry in Scotland (Edinburgh and London, 1964).

Sir D. Henderson and R. Gillespie, Textbook of Psychiatry (Oxford, 1969).

D. Hill (ed), The Burden on the Community (Oxford, 1962).

E. Hobsbawm, Industry and Empire, 5th edn. (London, 1973).

E. Hobsbawm, Labouring Men (London, 1964).

B. Hollinshead and F. Redlich, Social Class and Mental Illness (New York, 1958).

J.G. Howells (ed), World History of Psychiatry (London, 1975).

H. Huizinga, The Waning of the Middle Ages (New York, 1954).

C. Humphries, Buddism (Harmondsworth, 1951).

E. Hunt, Regional Wage Variations in Britain, 1850-1914 (Oxford, 1973).

R.A.H. Hunter and I. Macalpine, Psychiatry for the Poor; 1851 Colney Hatch Asylum - Friern Hospital, 1973 (London, 1974).

K. Jones, A history of the Mental Health Services (London, 1972).

J. Kellett, Glasgow (London, 1967).

R.D. Laing, The Divided Self, 7th edn (Hardmonsworth, 1969).

R.D. Laing, H. Phillipson and A.R. Lee, Interpersonal Perception (Harmondsworth, 1970).

R.D. Laing, The Politics of Experience and the Bird of Paradise, 8th edn., (Harmondsworth, 1972).

R.D. Laing and D. Cooper, Reason and Violence (Harmondsworth, 1964).

R.D. Laing, Self and Others, 2nd edn (Harmondsworth, 1969).

R.D. Laing and D. Cooper, Society, Madness and the Family, 5th edn (Harmondsworth, 1972).

P. Laslett, The World we have lost, 2nd edn (Whitstable, 1971).

A. Lee and A.B. Sclare, Psychiatry (London, 1971).

B. Lenman, An Economic History of Modern Scotland (London, 1977).

N. Longmate, Alive and Well (Harmondsworth, 1970).

S.G.E. Lythe and J. Butt, An Economic History of Scotland (Glasgow, 1975).

Sir A. Macgregor, Public Health in Glasgow (Edinburgh and London, 1967).

J. Macleod (ed), 'Davidson's Principles and Practice of Medicine (Edinburgh, London and New York, 1974).

P. Mathias, The First Industrial Nation (London, 1969).

B.R. Mitchell and P. Deane, Abstract of British Historical Statistics (Cambridge, 1962).

B. Murphy, A History of the British Economy, Vol. II (Bristol, 1973).

N. Murray, The Scottish Handloom Weavers (Edinburgh, 1978).

New Statistical Account (Edinburgh, 1842).

R. Nijinsky, Nijinsky, 2nd edn (Glasgow, 1980).

W. Parry-Jones, The Trade in Lunacy (London, 1972).

H. Pelling, Popular Politics and Society in Late Victorian Britain (London, 1968).

H. Perkin, The Origins of Modern English Society (London, 1969).

Pigot and Co's New Commercial Directory of Scotland (London, 1825).

R. Platt and A. Parkes, Social and Genetic Influences on Life and Death (London, 1966).

J.M. Reid, Glasgow (London, 1956).

M. Rose, The Relief of Poverty (London, 1972).

G. Rosen, Madness in Society (London, 1968).

D. Rothman, The Discovery of the Asylum (Boston and Toronto, 1971).

R. Scott (ed), 'Prices' Textbook of the Practice of Medicine (London, 1966).

A. Scull, Museums of Madness (London, 1979).

W. Shakespeare, King Lear (Oxford, 1978).

H. Sigerist, History of Medicine (London, 1951).

Sir J. Sinclair (ed), The Old Statistical Account (Edinburgh, 1791-8).

V. Skultans, English Madness (London, 1979).

A. Slaven, The Development of the West of Scotland (London, 1975).

T.C. Smout, A History of the Scottish People, 1550-1830 (Glasgow,1969).

St. Augustine, Confessions (London, 1978).

W. Stark, Remarks on the Construction of Public Hospitals for the Cure of Mental Derangement (Glasgow, 1810).

T. Szasz, The Myth of Mental Illness (London, 1961).

T. Szasz, The Manufacture of Madness (London, 1971).

E.P. Thompson, The Making of the English Working Class (Harmondsworth, 1968).

F. Tiffany, Dorothea Lynde Dix (Boston, 1890).

J.J. Tobias, Crime and Industrial Society in the Nineteenth Century (Harmondsworth, 1972).

J.H. Treble, Urban Poverty in Britain, 1830-1914 (London, 1979).

H.D. Tuke, Chapters in the History of the Insane of the British Isles (London, 1882).

W.L. Turner, History of a Great Hospital; The Edinburgh Royal Infirmary (London, 1937).

J. Weeks, Coming Out (London, 1977).

J.K. Wing, Reasoning About Madness (Oxford, 1978).

T. Wintrobe, 'Harrison's' Principles of Internal Medicine (New York, 1974).

F. Worsdall, The Tenement (Edinburgh, 1979).

G. Zilboorg and G.W. Henry, A History of Medical Psychology (New York, 1941).