

Department of History

MADNESS AND GENDER IN THE NINETEENTH CENTURY:  
A CASE STUDY OF A SCOTTISH ASYLUM

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**ABSTRACT**

Gender and the role it has played in the world of mental illness have been subjects for historians ever since the "second wave" of feminism in the 1970s, when women especially began to study what it meant to be female and insane. Studies of women and mental illness in the present led to studies of women and mental illness in the past, and in the 1970s and 1980s historians began to analyse the role of gender in nineteenth-century mental illness. In an attempt to continue this tradition, and to add needed data to the field of women and mental illness in the nineteenth century, this thesis discusses such literature and background history and analyses a heretofore unstudied population of patients from the Glasgow Royal Asylum in Gartnavel, Scotland.

Using data collected from the admissions registers of two years, 1870 and 1880, I have described and attempted a statistical analysis of the patient population, especially with regards to gender. What were the characteristics of patients in the asylum? What was the typical age, occupation, level of education? What were the major causes of insanity, and what were the relationships between them and variables such as age, occupation, type

of insanity, recovery rates, and gender? Did women and men differ from each other in terms of length of stay, death rate, and cause, and if so, why? How significant are these differences? In the end, I hope I have achieved a fairly thorough description and analysis of the patients, both male and female, at Gartnavel in these two years, and that I have successfully placed them within the larger framework of the 19th-century world.

## INTRODUCTION

The study of insanity has a long and complex history, no less problematic in its discovery and interpretation than any other type of history; in fact, it may be more so, since insanity itself treads the fine line between mind and body, a relationship still under heated discussion today.

(1) However, according to one scholar in the field, because "the meanings of madness were matters for continuous renegotiation" such an inherent problem makes "the history of insanity...more difficult (but also richer) than...that of smallpox or witchcraft." (2) In studying the history of insanity, especially the history of gender and insanity, I have found both the complexity and the richness to exist, and they are equally exasperating and satisfying.

The study of insanity has also enjoyed much popularity in the last twenty years due in large part to work done by Michel Foucault (in his *Madness and Civilization*) and to an accompanying growth of interest in social history. In the past ten years especially the study of insanity has also involved many feminist historians, in British history, perhaps most notably Elaine Showalter with her *The Female Malady*. Important in both these and indeed in any social history of the insane has been the recognition of society's

attitudes toward the insane themselves. Questions that often arise include, for example, in what social and mental health context did the insane find themselves? How was such behavior defined? In studies focusing on women the questions become, was the social and mental health context in which insane women found themselves the same as that of insane men? Was the definition of madness different for women as opposed to men?

In studying a Scottish asylum population of the 19th century I have set myself several tasks. First, I wanted to quantitatively collect, describe and analyze a given population, both as an exercise in a particular research method, and to collect data of possible interest to other scholars in the field. From this description, it will be possible to answer certain questions often raised in the study of the history of insanity: What kind of people were in the asylum? What were the causes of their illness? How long did they stay, and in what condition were they discharged?

Second, by studying this data--collected from the administration records of the Royal Glasgow Asylum at Gartnavel (outside Glasgow) for the years 1870 and 1880--and integrating them with secondary sources I hoped to contribute to the scholarship surrounding one question which several historians have asked concerning gender and the asylum in particular--that is, how did men and women compare to each other? Or, more specifically, were women

worse off in the asylum than men? A good amount of literature on Victorian women and mental illness maintains that women were more likely than Victorian men to be labeled mad, that insanity--and therefore the asylum--was increasingly connected with things female, and that women's experiences inside the asylum was worse than that of the men's. (3 While this paper does not study attitudes which could have led to such unfair asylum admissions and treatment, (4) it does study women already in the asylum in the hopes of discovering any discrepancies--or lack of them--between the sexes that might shed some light on the experience of insane Victorian women. Did insane women and men differ in areas such as marital status, age, education, length of stay, cause, and death rate, and if so, how?

Although the majority of information in this study comes from this data set and is quantitative in nature, there is another, smaller source I looked at nonmathematically that is of potential interest in terms of treatment, since the data themselves do not include methods of treatment. This source consists of notes taken by the asylum doctors on their rounds, and although it is not by any means a comprehensive sampling, these reports give an idea of the treatment administered at Gartnavel. These cases suggest to what extent moral management was practiced in a state asylum of the 1870s.

There has, of course, been a great deal of excellent work done in the field of the history of British insanity.

One need only look to such scholars as T. M. Brown, William Bynum, Michael Clark, Anne Digby, Kathleen Jones, Michael MacDonald, Charlotte Mackenzie, William Parry-Jones, Roy Porter, Andrew Scull, Michael Shepherd, Elaine Showalter, and Vieda Skultans, not to mention a host of their colleagues studying American insanity (see, for example, Ellen Dwyer, Gerald Grob, David Rothman, and Nancy Tomes) to realize how much work has already appeared on the subject (refer to Bibliography). However, in a field rich in theory, contributions still remain to be made.

Roy Porter, W.F. Bynum, and Michael Shepherd, in the introduction to a collection of essays on the history of insanity called *The Anatomy of Madness* (vol. 1), point to the "slim foundations" on which the "sweeping generalizations" made in the history of insanity rest. After reviewing historiographical trends in the field, the editors write: "The work of criticism has thus been launched. What hasn't, to anything like the same degree, is the labour of actually *finding out*...it is important that this research agenda should not be thought of as just a routine filling-in job...rather there must be energetic dialogue between research...and conceptual renewal." (5)

In addition, although there is scholarship on the history of women and mental illness, of the studies whose aim is "the labour of actually finding out" there are relatively few, especially of those which focus on gender differences and similarities. Anne Digby, Ellen Dwyer,

Charlotte Mackenzie, Elaine Showalter and Nancy Tomes are all leading scholars of insanity who have dealt to some degree with women; Digby, Dwyer and Mackenzie have all used quantitative methods in varying degrees. Showalter has focused more exclusively on women than the others, although women are also factors in the others' works. Quantitative studies focusing exclusively on gender and the asylum, however, have been rare.

Except for Francis J. Rice's 1981 doctoral thesis from the University of Strathclyde and two subsequent articles, (6) there is not much that has been concerned directly with insanity in Scotland: in fact, there are no articles in the *Scottish Historical Review* from 1982 to 1990 that deal with insanity. In these, more specific, ways, this study aims to contribute something to the study of the role of gender in the asylum, and to Scottish medical history by providing some needed data and analysis.

In the spirit, therefore, of "actually finding out," I have tried to make some connection between the two methods, by merging empirical data with theory, although the strength of this work ultimately lies in the data themselves. As imperfect and limited as such an undertaking is bound to be, I hope not only that the synthesis is reasonably logical, but also that the simple collection of data itself will help shed some light onto the not-always-so-accessible past. It has, at any rate, proved to be a very exciting glimpse into the lives of

people long dead, who were, in many cases, not so different from us.

Before beginning, however, we must return briefly to the theme mentioned in the first paragraph of dealing with so nebulous a subject as insanity. Although insanity is behavior considered irrational, or deviant from that considered normal, the definition of what exactly normal is varies from time to time, from place to place. The history of insanity is one fraught with perils concerning the very nature of the beast itself: What is madness? What are its causes? Because these questions have never been answered satisfactorily, the study of madness becomes then not a problem of defining it absolutely, but of recognizing a given society's definition of it and observing that society's response to its presence. Or, as Andrew Scull has phrased it, "...we can choose to focus, not on whether certain persons are mentally sick or not, but on how their life is reorganized because they are called mentally sick." (7) This is where societal influences and Roy Porter's "complexity and richness" make their entrance.

Views of insanity in 19th-century Britain were to a certain extent products of the past, a past which included many and varied definitions of insanity, its causes, and its place and level of acceptance. Take, for example, the causes of mental illness. Two streams of thought have been largely responsible for our views of madness and its causes, namely the physical and the spiritual/religious.

(8) These two interpretations can be traced back to ancient Palestine, through the Greeks, into the Middle Ages and Renaissance, and right through most of the 19th century itself (there is a notable gap in the Roman and early Christian era when medical knowledge concerning irrational behavior seems to have stagnated, becoming mired in the accepted general medical dogma of the times). That is, insanity was caused by physical influences--a view that Hippocrates championed with his *On The Sacred Disease*--and is therefore amenable to cures involving medicine, diet, or bodily functions (bleeding and purging were the most popular); by outside, religious forces (found almost exclusively as causes by the ancient Jews and Greeks in Homeric times), which later in the course of the 19th century developed into psychological forces; and in particularly stubborn or unclear cases, madness was attributed to both.

However, different societies at different times in their history placed emphasis more strongly on one explanation than the other; further complicating the picture is the fact that intellectuals and philosophers often thought one thing while the masses thought another. And defining what madness was itself introduces yet more problems, for acceptable behavior changed from era to era and society to society. To the ancient Jews of Palestine madness came from God (an outside, spiritual force), either as a blessing or as a punishment of sins. However, noting

that the verb "to behave like a prophet" also meant "to rave" or "to act like one beside himself" (9) one scholar uncovers the familiar problem of choosing criteria to define insanity, for while to be a prophet was sometimes accepted, to be insane was not. (10) But while "insanity caused by religion" was indeed listed as a cause in the 19th-century admissions books, by that time being a prophet had lost its societal role, and instead the fervor and strong emotion behind such behavior was seen as the driving force leading to insanity.

For this study, then, it is important to remember that while some of the defining factors of madness in the 19th century could be traced far back throughout history, they were also dependent upon 19th-century society itself, and it is to this world that we now turn.

**Chapter One:**  
**INSANITY, REFORM, AND WOMEN**

The eighteenth century is known in the history of madness as the starting point of a reform movement that attempted to improve conditions for the insane through institutionalized care and non-medical treatment. (11) Probably the most famous example of this "moral management" of the insane took place

at the York Retreat (established 1792), founded by William Tuke. (12) It became famous the world over for its moral treatment, a treatment that relied on kindness and patience on the part of the staff in order to encourage patients in self-restraint and the "will" to recover; environment was also considered a great influence and asylum architecture and grounds landscaping assumed increased importance. Spacious buildings with beautiful lawns and gardens were set up to provide as "homey" an atmosphere as possible, thought to be conducive to recovery, and patients were assigned tasks such as gardening and weaving. Samuel Tuke, son of the founder, stated in an article of 1813 that "neither chains nor corporal punishments are tolerated, on any pretext, in this establishment...If it be true, that oppression makes a wise man mad, is it to be supposed that stripes, and insults, and injuries,...are calculated to

make a *madman* wise?" (13)

What motivated the reformers is still debated today. Michel Foucault, in *Madness and Civilization*, saw a dangerous mix of "morality and medicine" at the beginning of the eighteenth century that motivated society to continue to incarcerate its undesirables (such as criminals, the ill, and the insane) and in fact to remove them as far as possible from the rest of the population, in the hopes of avoiding contagion itself. He viewed the reform movement that began in the second half of the eighteenth century as a result of this fear of contracting a kind of moral/physical disease; that the hospitals and penal institutions were cleaned up not due to any altruistic humanitarian impulses but because of purely selfish ones. (14) In his influential *Museums of Madness*, Andrew Scull also sees a scarcity of humanitarian impulses leading to reform, arguing instead that it was a combination of industrialization, an increasing sense of responsibility for the insane by the state, the new asylum, and "the developing link between medicine and insanity" that relegated the insane from a vague and indefinable background to a more controllable foreground. (15)

Other scholars, notably Roy Porter and Michael MacDonald, have argued that there was no clean break at the end of the eighteenth century/beginning of the nineteenth in the treatment of the insane, but that this "reform" followed logically from practices that had gone before

(16). While it may be, perhaps, an exaggeration to see a sudden change occurring in mental health organization and treatment at this time from chains, whippings, water torture and whirling chairs (17) to a sudden benevolent concern for the emotional and physical well-being of the mad patient, it would seem to be equal folly to assert the opposite. There may have been indeed a "grey area" of overlap, or even a generous sprinkling of pre-moral managers in previous centuries, (18) but I think it must be admitted that, at the very least, moral management practices and theory received a great deal of attention at the century's turn, and this vigorous interest and recognition alone must be given its due as an influential force in propelling moral management into the heart of mental health management. Moral treatment of the insane, which attempted to cure madness "through the moderate management and re-education of the patient...[that] aimed to build up their self-esteem and self-restraint" was, by the end of the 18th century, "not a novel phenomenon" (or perhaps in light of the controversy, not just a vague, undefined, and *unlabeled* means of care) but an accepted method of treatment. (19)

More than this, however, moral management reflected change in the (mad) medical profession itself, and reflected the increasingly popular view of insanity as something that could be managed, controlled, and cured, a view that remained until the second part of the nineteenth

century. This change was a result partly of the increasing numbers of mad doctors (thereby legitimizing their profession as one that was necessary and could obtain results, that is, cures), but also a result of the social values of the day. Madness was seen increasingly as a moral defect or lack of restraint, qualities that a mad patient could be ostensibly "re-trained" in. Vieda Skultans, in *Madness and Morals*, explains that "moral" meant the same thing in the nineteenth century as "psychological" means to us today, "[while] at the same time retain[ing] certain ethical implications." (20) Kathleen Jones, in *A History of the Mental Health Services*, also equates the word "moral" with a view of insanity that involves the emotions, both with the causes of madness and its treatment. (21) In the early part of the 19th century moral causes of insanity gained favor in the growing "mad" profession as opposed to physical causes, in that they implied a certain lack of self-governance or will. (22)

As the nineteenth century wore on, and numbers in the asylums continued to swell, the atmosphere of reform and optimism began to wane. The Lunatics Act of 1845 (which provided for a Lunacy Commission in Great Britain set up to inspect asylums) and the Asylums Act (also of 1845, mandating the construction of county asylums for paupers) did not create the Utopia the reformers had hoped for: costs of building and maintaining asylums had proved to be huge financial burdens, and no one had expected them to be

filled--and by the end of the century, over-filled--as fast as they were. (23) At the same time, neurological experiments were being performed in Germany by such early psychiatrists as Griesinger, Meynert and Wernicke, who were establishing a much more rigorously scientific connection between the body and mind than had ever been done before.

(24) Along with other social change, (25) the latter part of the century saw an increasing belief in the physical causes of madness, and a turning away from the moral/emotional explanations that had so influenced the early part of the century.

Some scholars, for example Foucault, see the insane's condition worsening as a result of these changes. Some see women in particular, especially those in asylums, suffering from these reforms. (26) The major goal of this paper is to dispute this second assertion and to present some quantitative evidence that points not to a disproportionate number of women who suffered in the 19th-century asylum in comparison to men, but to a population of asylum patients which suffered fairly equally under ill physical health, dubious mental health, and sometimes an unfortunate mixture of both, and which for a multitude of reasons was set apart from the rest of society. In order to understand this group of insane patients we have to look at the position of women in the Victorian world, and how this was connected to madness.

The Victorian view of women and femininity is a

subject that has been dealt with extensively. In the classic *Clio's Consciousness Raised: New Perspectives on the History of Women*, historians deal with various aspects of what it meant to be a woman in the Victorian age, as well as at different times throughout history. Elizabeth Fee describes the justification of sex roles through 19th-century anthropological science, when evolutionary research was transformed into a "Victorian morality drama" which "brilliantly confirmed [the Victorian] social order by constructing an appropriate past"; Daniel Scott Smith traces the woman's role in the American family from pre-industrial times to the present, and suggests that the Victorian woman gained status within the family that acted as a springboard for her entrance in politics; Barbara Welter studies "The Feminization of American Religion" from 1800 to 1860, concluding that organizational talents learned in the context of church groups, and the introspective nature of religion, assisted women in other areas of the women's movement by training their political ability and giving them an inner strength which "reinforced [a woman's] own belief in her power to overcome obstacles...". (27) In *The Nineteenth-Century Woman: Her Cultural and Physical World*, topics such as evolutionary theory, education, and exercise are explored within an anthropological framework in an effort to show "Victorian society as a culture 'at war with itself,' and the consequences of that conflict." (28) Martha Vicinus'

*Suffer and Be Still: Women in the Victorian Age*, consists of essays which "analyze the changes in the behavior and beliefs of Victorian women and men in regard to a model of femininity, the 'perfect lady,'" and which underline change and conflict in women's role during the late 19th century. (29) In addition, there are studies on class and gender, on growing up as a girl, and gender roles. (30)

In light of all this, it can probably be said that the Victorian era is acknowledged generally as one of emotional and physical restraint, for men as well as women, though definitions of "restraint" run the gamut from "oppression" to simply "reserve," and though this probably meant more restraint for women than men, who had fewer outlets for their mental and physical energy. Kate Millett, in an article about Ruskin and Mill, presents perhaps the most insightful description of the social world in which the Victorian woman found herself. (31) She describes the two views most representative of those found in the 19th century as alternatively "rational and chivalrous." (32) Whereas Mill exemplifies the enlightened thinker who believes in the equal rights of women, Ruskin's opinions are those of the traditional conservative who maintains that "women are loved and honored, have nothing to complain of and are even treated as royalty, so long as they stay at home." (33) However, in a subtle twist, Millett argues that counter to what we may think about the Victorian era, Mill's thinking as well as Ruskin's is representative of

the times, and that Victorian ideas on women and their role did not consist only of a "Victorian chivalry" that represented a "transition phase" between the female chauvinism of previous times and the feminist era which followed. (34) Millett's argument that both these views existed at the same time allows a more complex picture of women in Victorian society in that it includes both extremes (and supposedly everything in the middle).

It is when one delves further into the realm of health and madness and the Victorian woman that one discovers an even wider range of views, ranging from the passionate polemic of the radical feminists to the conservative rhetoric of the female chauvinist, again with numerous examples from the 19th century itself. Women were often viewed as being more susceptible to mental distress because of the influence of the uterus and ovaries, beginning in puberty and ending only after menopause. John Millar's opinion that "mental derangement frequently occurs in young females from Amenorrhoea [absence of the menses], especially in those who have any strong hereditary predisposition to insanity," is not uncommon, and one held by numerous contemporaries, among them Henry Maudsley and George Man Burrows, both leading men in the field of mental health medicine. (35) Other 19th-century sources are quoted by Smith-Rosenberg in an article entitled "Puberty to Menopause," in which she cites such figures as Edward Tilt, Edward Dixon, and Charles Meigs, as well as a number

of others. (36) Lorna Duffin, in "The Conspicuous Consumptive," quotes the *Anthropological Review* of 1869 as maintaining that during the menses, "women are unfit for any great mental or physical labour. They suffer under a languor and depression which disqualify them for thought or action, and render it extremely doubtful how far they can be considered responsible beings while the crisis lasts."

(37) Elaine Showalter states simply that "...women were more vulnerable to insanity than men because the instability of their reproductive systems interfered with their sexual, emotional, and rational control." (38) Though there were also those who saw the male reproductive system as influential in cases of insanity, it does not seem to be a viewpoint representative of the majority, or one emphasized at all by the doctor who expressed it; and indeed, this same author believed education increased the likelihood of a woman going mad, an observation that doesn't exactly lend him credibility. (39)

That there was a belief in the 19th century in the connection between the female reproductive system and health cannot be disputed, given the ample evidence; women were seen as the physically weaker sex and prone to all sorts of ailments. This of course was influenced by and an influence on other factors concerning woman's societal role, and the 19th-century woman was in many ways decidedly not equal to her male counterpart. What can be disputed, however, is the influence this had on the treatment of ill

and insane women, described as some scholars as being full of horrors inflicted on women simply because they were women.

For example, three of the articles in *Clio's Consciousness Raised*, from Ann Douglas Wood, Carroll Smith-Rosenberg, and Regina Morantz, deal directly with women and illness in 19th-century America and Britain, each scholar reaching different conclusions on to what extent women were victims of societal roles and values, and each thereby representing different positions of the feminist scholar. Wood is of the opinion, stated above, that (neurologically) sick women were subjected to painful and unnecessary medical treatment that was related to an "element of distrust, even of condemnation" of women by male doctors, this distrust a result of "a threatening and culpable shirking of [women's] duties as wives and mothers." (40) She paints the picture of the relationship between the neurologically ill woman and her doctor as one of extreme hostility on the part of the doctor resulting in danger to the woman's physical and emotional health, a picture reached by conveniently utilizing some sources, ignoring others, and picking out select quotes and opinions from one doctor especially--S. Weir Mitchell, a famous American medical man of the day--thereby offering a misleading description of women and medicine in 19th-century America.

Carroll Smith-Rosenberg, on the other hand, presents a more even-handed exploration of the relationship between

women and physicians, noting an "ambiguity toward woman's sexual and social nature" on the part of Victorian doctors, although she goes a step further in suggesting a 20th-century psychological theory to explain 19th-century gynecology, (41) which Regina Morantz takes issue with in her essay, "The Lady and Her Physician." Morantz points out that to apply 20th-century psychological theory to beliefs a century before is not sound historical method. She also stresses the fact that medical practice tread equally unsure ground as far as men were concerned, with equally painful treatments administered (also to the reproductive organs), a point often neglected in medical history dealing with gender. (42)

There is less literature that deals directly with women in the asylum. In the introduction several scholars who have dealt with women and madness to different extents are given, namely Anne Digby, Ellen Dwyer, Charlotte Mackenzie, Elaine Showalter, and Nancy Tomes. Digby, Dwyer, Mackenzie and Tomes, as noted above, have all contributed exhaustive studies of different asylums, in which some comparisons are made between the female and male populations. One article in particular by Mackenzie concerns women and madness, although she looks at female professionals and not patients. (43)

While it would seem to be too easy an explanation and, from a historical methodological viewpoint, overly simplistic to assert that there were no differences between

women and men throughout the history of the asylum, it would be equally unimaginative, and just as ideologically suspect, to claim the opposite, that is, that women were mistreated and experienced horrors on a much greater level and at a much higher frequency than men. Such extreme interpretations of women in the 19th-century asylum do exist, however, and find their most recent and influential spokesperson in Elaine Showalter.

Showalter discusses, in *The Female Malady: Women, Madness and English Culture, 1830-1980*, the influence of moral management on the "domestication of insanity," a result of asylums being run as families, with the superintendent as the father and the patients his children. This in itself is not a radical assessment of the situation and is also found in an earlier work by Andrew Scull. (44) However, Showalter takes this idea a step further in asserting that not only were the insane relegated to the foreground as a result of reform, (as does Scull, see above), but that only the *female* insane assumed this position, primarily due to a feminization of insanity occurring at the same time. (45) According to Showalter, whereas madness in the previous century had been personified by the violent male lunatic foaming at the mouth, it became in the 19th century personified by the madwoman, a tragic, even "poetic" figure with, additionally, a decidedly sexual component. (46) As a result of this feminization, and the (supposed) increasing

numbers of women in asylums, the asylum became the place to "house feminine irrationality...[and]...to cure it through paternalistic therapeutic and administrative techniques."  
(47)

Showalter's contribution to the study of women in history and literature cannot and should not be underestimated. She is both thorough in her research and an intelligent and imaginative analyst with the information she uncovers. However, the fault I find with her is the same weakness the editors of *The Anatomy of Madness* find in the scholarship of insanity in general, mentioned already in the introduction: there is simply a paucity of tangible, empirical information in her work to justify such radical conclusions. Some could question this criticism as that of methodological disagreement. I find it very difficult, however, to accept such an argument when no presentation of actual asylum patients is given from which then to draw conclusions. Her very strong assertion of "madwomen...[freed] from the chains of their confinement to obtuse and misogynistic medical practice," should be backed up not only by literary examples and trends but also by direct, hard evidence, in the form of actual asylum data.  
(48)

Although the the majority of the Glasgow Royal Asylum data presented here do not deal directly with treatment (one indicator of conditions within the asylum), some information about the status of women in the asylum and how

it compared to that of men can be ascertained. It may be true, as a few scholars have maintained, that women represented a larger proportion of those treated for mental health reasons *outside* the asylum; that would be a logical result of the inequality found between the sexes as far as emotional and physical health were concerned in the Victorian age. (49) However, at least at the Gartnavel asylum, although there were differences in certain "fringe" groups within the general population, such gaping differences were not found in the population as a whole, and leads me to conclude that women's experience, at least in the asylum, was not one of misogyny and unequal, brutal treatment, but probably one of hopelessness and despair similar to that of the men. (50)

Dywer's *Homes for the Mad*, an overwhelmingly quantitative study of two American asylums in the 19th century, while not a study of women per se, does report some interesting findings on women and men that are similar to mine. Regarding causes of insanity, she notes that, early in Utica Asylum's history, while more men were admitted because of madness caused by "economic stress," "more striking than such differences between the sexes was the overall drop, almost as soon as John Gray became superintendent of the Utica Asylum in 1854, in the number of patients with mental problems attributable to economic causes. Their percentage...did not rise again...until after Gray's death in 1886, a fact clearly more reflective

of his opinions that of any real change in patients' preinstitutional problems." Although this study does not attempt to trace the history of Gartnavel's superintendents (and therefore does not have this perspective), the data themselves are enough to show the overwhelming majority of patients, both female and male, as being admitted for the same, rather vague reasons. And again, "Although more women were reported to suffer the ravages of emotional stress, the long-term variations in male and female susceptibility were quite similar." (51) Even as regards the treatment of sexual disorders, Dwyer observes little recognition of patients suffering from such illness, male or female, and notes that neither asylum she studied performed clitoridectomies. Though medical opinion still maintained a connection between the female reproductive system and a woman's tendency to go insane, and though the asylum's doctor--a woman--gave many gynecological examinations, little treatment was given these women other than "painting cervixes with iodine and soothing irritated areas with glycerin pads." (52) In fact, nothing in Dwyer's findings points to meaningful differences between the sexes and their asylum experiences in terms of undue treatment towards the women, a conclusion that data from the Glasgow Royal Asylum also suggests.

Finally, before presenting the data from Gartnavel, a look at the Scottish approach to the insane and the history of the Glasgow Royal Asylum itself is necessary. I am

indebted to Mr. Francis J. Rice for much of the following information, whose doctoral thesis from the University of Strathclyde pulls together many and varied sources in giving a much-needed history of the organization of insanity in nineteenth-century Scotland.

One of the most important things that Rice notes is that the Scottish approach to the care of the insane was fundamentally different from that of England and Wales. Whereas in England, private "madhouses" and poorhouses housed a substantial number of the insane population, in Scotland, a large philanthropic base allowed the Royal asylums to be constructed relatively early, and there were relatively fewer patients in private madhouses and poorhouses. (53) Consequently, Scotland didn't have much to build when the national organization for the construction and maintenance of asylums was set up in 1845 for Britain (see above), as they already had seven chartered public asylums to their credit: Aberdeen (which opened in 1800), Dufries (1839), Dundee (1820), Edinburgh (1813), Glasgow (1814), Montrose (1781) and Perth (1827). (54) There were other choices, of course, that had existed before the asylums, including poorhouses, private institutions, prisons, and schools for "idiots;" and before the Report of the Royal Commission in 1857, which was the first official tally of the number of insane in Scotland, most of the insane were cared for at home. (55)

Glasgow itself had the Royal Asylum, three poorhouses,

and three private madhouses (56); and, along with the rest of Scotland, a fairly low rate of insanity. Figures for Scotland in 1871 show a population of 3,360,018, with 7,729 insane, or .23%; in 1881 that percentage had not changed much and was only .28% (57) Another finding of Rice's is that rates of insanity were lowest in counties with high concentrations of urban areas, and highest in rural counties (58).

Construction of the original Glasgow Royal was finished in 1814, and moved to its present location in Gartnavel in 1843. It was, as seen above, one of seven Scottish royal asylums that were run from private philanthropic funds, although legally they were considered public institutions. (59) Its clientele were from parishes near and far, including patients from Ayr, Greenoch, Lanark, Monkton, Prestwick, Renfrew, and Campbeltown. Not everyone was given equal consideration, however: People from the Glasgow city parish were admitted first, followed by those from "contributing" and "non-contributing" parishes (defined by their contributions to the asylum itself). (60)

By all accounts, the Glasgow Royal Asylum didn't differ markedly from the other six "royals" in its corporate, financial and medical structure in that all of the public chartered Royal asylums in Scotland were run on local, privately contributed funds (Edinburgh was the only exception) and were staffed in much the same way. (61) The

results of this analysis will be, most likely, fairly representative of the majority of the insane population in Scotland, especially since the majority of the institutionalized insane were in the "royals," as opposed to private "madhouses" or public poorhouses, which held relatively higher populations of the insane in England and Wales. (62)

**Chapter Two:**  
**DESCRIPTION AND ANALYSIS OF DATA**

My data consists of information on 431 patients in the Gartnavel Asylum in Glasgow, Scotland, from the years 1870 and 1880. I chose this time period because the record books were particularly thorough and consistent with their information in these years. I chose two separate years, and didn't sample, for instance, a ten-year period, out of a purely personal preference to the continuity that working with two complete years brings, as opposed to the more generalized method of sampling. Nonetheless, it is a method that I hope will represent the asylum population accurately and fairly.

In order to be able to deal with such a large group of people, variables, and possible statistical analyses, it will be necessary to narrow the field a bit by posing several key questions. First, did women and men differ in their asylum experiences, and if so, how? Second, what was the relationship between class and factors like cause of insanity, mental disorder, and death rate? Third, what were the factors related to the high death rate? And fourth, what was the typical Gartnavel patient in 1870 and 1880? The resulting picture of this asylum's population, in addition to placing it in the context of the 19th

century, hopefully will help connect data and theory in the study of gender and insanity.

The data are taken from the asylum admission book, which listed 23 pieces of information for each patient: previous asylum admission record, patient admission number, admission date, name, sex, asylum class of patient (that is, whether they were admitted as pauper or private patients), age, marital status, occupation, bodily condition upon admission, diagnosed mental disorder, supposed cause, duration of the attack that led to admission (and also telling us how soon after the onset of the "attack" it was deemed necessary to admit the person to an asylum), duration of stay, exit date, exit reason, education level, religion, epileptic history, presence of suicidal or violent tendencies, medical category of mental disorder, whether there was a history of insanity in the family, and whether the patient had living relatives. I will be working with all but the admission number, admission date, name, and exit date (the variable "Duration of Stay" was computed by me from both the admission and exit dates). It is also important to note that percentages will not always add up to 100% due to random missing cases.

There are shortcomings inherent in the database, of course. For instance, it isn't possible to ascertain directly from the data how women and men were treated differently by the asylum staff, because such day-to-day events that may have dealt with such behavior are not

included in them: The data are taken directly from the admissions register, and include no doctors' notes or comments. Medical and/or "moral management" treatments are also not given, and it is for this reason that I have not included them in this study, except for a brief discussion of various treatments (from another source) in the last section. Information on who entered the data into the register or even who provided the facts about a patient in the first place are not known--information about a patient was sometimes provided by a relative, sometimes the Sheriff, at other times by a caretaker or parish official. It is difficult for this reason to ascertain any kind of judgments that may have been made on the part of the asylum staff upon admission. These are, indeed, some unfortunate weaknesses of the data.

However, at least in my opinion, the strengths outweigh the weaknesses. From these data it is possible to gather certain important pieces of information crucial in constructing a description and carrying out an analysis of any population, such as age, marital status, occupation, and education. Even without descriptions of treatment or behavior, much can be learned from such a source. For example, what was the dominant social class within the asylum? How old were the patients, and what age was represented most frequently? Were most people married, single, or widowed? What kind of educational level did they have? And how did the patients compare to one

another--how did the men and women differ from each other, in terms of education, social class, cause of insanity, length of stay, and death rate? Also, the data themselves are very consistently kept for these two years--compilation of them was not erratic but very constant, and there is not that much that is missing (again, as stated above, there are only a few bits of information missing at random). With this wealth of consistent, numerous data, it would simply be a shame *not* to study such a source rich in potential information.

### **The General Population**

It will be necessary from the outset to get a general overview of the asylum population, and from table 1 several things are already apparent. Of 431 people, it was pretty evenly divided between the sexes: 212 were women and 219 were men, ranging in age from 14 to 80; just under 75% were between 20 and 50 years old. Most patients, over 330 of them, or 77.3%, had never been in an asylum before. Over 60% were admitted within one month of their "attack" of insanity. Almost 64% of the population were registered in the pauper class, which meant the state paid for their hospital fees; this makes sense, given that 60% of the population came from the working class. Occupations ranged from the unemployed; to students; to unskilled workers such

as lodging house keepers, domestics, dockers, bottlers, hawkers, housekeepers, and those employed in casual or seasonal work; to skilled craftsmen such as tailors, joiners, shoemakers, cotton spinners, engineers, shipwrights, seamstresses, builders, masons, bakers, patternmakers, ship caulkers and riveters; to lower-middle-class retailers, shopkeepers, clerks, and schoolteachers; to middle-class housewives, doctors, lawyers, merchants, farmers, clergy, and military officers.

It is important to note that the terms used to describe occupations--"Unskilled," "Skilled," "Middle class," etc.--were not given by the asylum but were given by me (working with an advisor who is familiar with and knowledgeable about occupations and social class in 19th-century Glasgow). This method, of course, has its pitfalls, since listed occupations could have been jobs held long before the person fell ill, and subsequently "slid down the occupational ladder;" or they could represent the most recent or the most "prestigious" job (63). However, in order to work with this variable at all, some judgement had to be exercised; as long as the variable is used with caution and as a general indicator of class, and not as an absolute definition in comparing specific cases, I feel such judgement is justified and reliable.

Around 50% were single, 40% were married, and 10% were widowed. Physical condition upon admission was evenly divided between weak and ordinary or good. Over 75% were

admitted because of mania ("extreme mental or physical excitement") or dementia ("temporary or permanent intellectual debility"), with mania far outnumbering dementia by two to one; only 11% were considered melancholic (what we today would call depressed), and 10% monomaniac (an extreme form of mania). (64) Perhaps surprisingly, it was on the whole an intelligent group: only 13% could neither read nor write (65). Almost 70% could both read and write, or had what was considered by the hospital administration to be a "good education." Patients were overwhelmingly Protestant (81.9%).

According to the admissions register, almost none of the patients were epileptic, an important note, considering that the "sacred disease" of epilepsy had been considered in the past an indication of madness, holiness, or prophecy, and sometimes a combination of all three. (66) Another variable is whether the patient was thought to be suicidal or dangerous: Of almost 45% either nothing about it was known or they were considered neither suicidal nor dangerous; 30% were considered dangerous (to others); just under 13% were considered suicidal; eleven percent were considered both. How this opinion was arrived at is not always known. Sometimes it was based on the doctors' observations of the patient previous to admission, but there are also some cases in which family members bringing in a patient would provide such information.

The variable "Category" refers to the type of mentally

disturbed person that the doctors considered the patient to be. According to the Madhouse Act of 1828 two doctors had to examine a prospective patient before that person could be admitted to the asylum. They then wrote their impressions and opinions on the admission form, and categorized the patient under one of four categories: idiot, person of unsound mind, insane person, or lunatic; or three combinations of these, representing two doctors with opinions differing from each other: Lunatic/person of unsound mind, insane person/person of unsound mind, and insane person/lunatic. (67) Over 61% came under the category "person of unsound mind," a category I assume to be milder than that of "lunatic" or "insane person;" the next highest percentage is 14% under "lunatic/person of unsound mind." Also recorded was any family history of insanity, and the majority--83%--either had no history of insanity in the family, or didn't know. Information on which patients actually had family (often they were admitted by family members) was also kept, and over 84% of them did, implying some kind of tie to kin.

The length of each patient's stay was listed in the register in days, from which I made seven categories: 1) 1 to 14 days; 2) 15 to 30 days; 3) 31 to 90 days (one to three months); 4) 92 to 365 days (three months to a year); 5) 366 to 1095 days (one to three years); 6) 1096 to 3650 days (three to ten years); and 7) 3651 days and up (ten years and over). Almost 60% of the population were out

within a year of their admission; 75% were out within three years. This high turnover rate was common for state asylums of the time. The death rate, 22.5%, was also remarkably high when compared with the general population, and jumped dramatically within the male population (see table).

The supposed causes of insanity are perhaps some of the most interesting information (please refer to tables 17 and 18 for a complete list of causes; otherwise refer to table 1). Almost 60% of the causes were fairly vague--either unknown (35.7%), due to a predisposition from previous attacks (12.1%) or due to heredity (8.1%). General paralysis was next with 6.3% (27 people) of the population, and intemperance was all the way in fifth place with 6% of the total. After intemperance came epilepsy with 3.9%, illness (2.8%), and childbirth (2.3%, or ten cases). Each of the remaining 41 causes accounted for under 2% (or fewer than 10 people) of the population, and in fact 26 of these represent only 2 patients or less. However, these remaining causes are fascinating not for the number of cases they explained but for showing the wide range of explanations for mental illness that existed at the time, including physical injury, emotional reasons, overwork, menstruation, irregular habits, fatigue, disappointment, and religion.

From this information a picture emerges, a vague sense of someone, equally likely to be male or female, in the

supposed prime of life, entering an asylum for the first time most likely because of mania, most likely from the working class. A direct cause of this illness is not known, although it may be attributed to a "predisposition" to insanity or to a past history of insanity, either in the person or in the family background. The patient is decently educated and Protestant, with family members living, and is slightly more likely to be single than married, slightly more likely to be in a weakened physical condition upon admission.

Margaret M., admitted into Gartnavel Royal Asylum on 3 February, 1870, is a good example of an average patient. She had never been admitted to an asylum before. She was admitted as a pauper, in "spare" condition, was single, and 23 years old. Her occupation was listed as "weaver." She had mania caused by religion, and had been admitted after an "attack" of two days. She could read only, was Protestant, non-epileptic, considered neither suicidal nor dangerous, and was categorized by the admitting doctors as being a "person of unsound mind." Margaret was discharged recovered on 26 March, 1870, after 53 days in the asylum.

### Comparing Women and Men

To understand more about the asylum patients let us compare two easily distinguishable groups within the asylum

population--women and men--looking at frequency and crosstabulation tables for each of the eighteen variables. Whenever a significant difference between women and men is found, it will be explored further by comparing that variable with those of the "top fourteen" variables, or variables that I consider to be the most important: admission history, duration of attack before admission, age, asylum class, marital status, occupation, bodily condition upon admission, mental disorder, cause, education, whether suicidal or dangerous, doctors' category, duration of stay, and exit reason. Religion, epilepsy, insanity in family, and family members living are all variables that contain fairly constant numbers no matter what the case (the majority of the population were Protestant, not epileptic, had no insanity in the family, and had family members living); and because of the nature of the inquiry, comparing as it does men and women, they seem to me the most expendable.

Table 1 is a comprehensive view of the total population and of both the female and male populations, figured in percentages, with the corresponding number of patients in brackets. For example, reading across, 77.3% of the total population, or 333 people, had never been admitted to an asylum before. 77.4% of women (164 women) fell into this category, as did 77.2% (169) of men. From this it is evident that neither women's nor men's rates differed significantly from that of the total population.

Reading all the figures under the variable "Patient admission" we can see that those people that had previously been in an asylum represented roughly 20% of either sex, and that the biggest difference was the number of male patients coming from "the other side of the law": they outnumbered female lawbreakers more than two to one. (68) There are no significant differences in "Duration of attack before admission": Most people were admitted after a brief attack, and the numbers decrease from there. This follows the received wisdom of the day, which dictated that people suffering from an "attack" of insanity be institutionalized as soon as possible in order to better the chances of a speedy and thorough recovery.

Moving to the variable "Age", a trend in the general population can be observed. There are very few patients in the first age group. The majority of patients--321, or 74.5%--are between 20 and 50 years old, after which the numbers decrease in each successive age group. This pattern is true for both women and men: 152 women (71.7%) and 169 men (77.2%) are between 20 and 50 (see table 2), with only about a quarter of each population in the other groups. The greatest differences between the sexes are in the under-20 age group, where there are 18 women to only 8 men, and in the 50-year-old group, where women make up almost 63% of the group as opposed to the men's close 38%. Why did both these groups have more women and fewer men?

### Young Patients

Looking closer at patients under 20 years old (see table 3), it can be seen that there are more differences between the sexes in this age group than there are between the sexes in the total population. To begin, four women--over 20%--had either been previously admitted at Gartnavel or were transfers from another asylum. This is a rate similar to that of men aged 50-59, which is quite high. The pattern of duration of attack before admission for the population as a whole, as well as for both men and women when calculated separately, shows a rough 46% of patients suffering a brief attack before they were admitted, a figure which decreases as the length of attacks increase. But patients under 20 differ from this trend: women from this group have the highest rate of admission after a brief attack, and the men have the lowest.

Almost a quarter of the women were private patients, in comparison with no private male patients in this group, although the group together had a higher percentage of paupers than the population as a whole. All under-20 patients were single. Under "Occupation," over 70% of the under-20 women held unskilled or semi-skilled jobs, whereas over 85% of the under-20 men held semi-skilled or skilled jobs. The women tended to be in slightly better physical condition upon admission than the men. All the men were considered manics, whereas just under 70% of the women

were--the remaining six female patients included three dementia cases and one imbecile, one melancholic, and one patient with amentia.

In terms of causes, 75% of the men were listed as unknown, in addition to one case caused by fright and one caused by masturbation. In comparison, 33% of the women were listed as unknown--their insanity was more likely to be explained by a predisposition from previous attacks or from hereditary or congenital factors (44%). The remaining 22% were single cases of fright, menstruation, puberty, and childbirth.

Three-quarters of the men could read and write or were described as having a good education, in comparison with just over 40% of the women.

Striking is the suicidal/dangerous category, where the percentages of both sexes considered dangerous nearly double from those of the general populations (although more men than women are still considered dangerous). In fact, both groups consisted of patients considered for the most part either dangerous or neither/unknown--no men are considered suicidal or both, and there is only one woman in each of these categories.

Whereas, in the general population, roughly 70% of both men and women are categorized as persons of unsound mind under the doctors' category, except for a slight tendency toward using "lunatic" when describing men and "insane" when describing women, women under 20 are far less

likely than their male counterparts to be persons of unsound mind (probably the mildest of the lot) and far more likely to be described as lunatic, in complete disagreement with the tendency in the general population just mentioned. Not only this, but seventeen percent are also considered insane, compared to none amongst the men--an *exaggeration* of the tendency just mentioned to label women insane and men lunatic. In other words, none of the trends found in this category in the general population apply in this age group.

In terms of duration of stay, over 70% of the women were out in a year or less, compared with over 85% of the men. This also contrasts with the comparison of the general population of men and women, as just over 74% of women and 68% of men were released in a year or less. This reversal of the general population's trend is also true for the exit reasons: A smaller percentage of women under 20 were considered relieved or recovered in comparison with the men, and they had a death rate of almost 17%, compared with no deaths in the men's group, although this is lower than the death rates in both the female and male general populations.

Rose Ann K. was 19 when she was admitted 11 June, 1870. She had previously been in Gartnavel a year before (19 July, 1869), and was admitted this time after an "attack" that lasted a few days. She was single, a pauper patient, and worked as a millworker in Govan. She was in

ordinary condition upon admission, labeled as "manic," and the cause was listed as "predisposition from previous attacks." She could read only. She was categorized as a "person of unsound mind" but was considered dangerous; and was discharged 15 October, 1870--roughly four months later--as "recovered." James G., an 18-year-old admitted after a longer attack on 31 March, 1870 from Carluke, was also a pauper patient and single, but held a skilled job as an apprentice baker. His condition upon entrance was "spare,", and he was considered manic due to unknown reasons. He could both read and write, and was considered neither dangerous nor suicidal. He was discharged within a year as recovered.

From this information we see that the biggest differences between the sexes in this age group involve duration of attack before admission, asylum class, occupation (with an overlap under "semi-skilled"), bodily condition, mental disorder, cause, education, suicidal/dangerous, doctors' category, duration of stay, and exit reason. When the differences in this group are compared with the general population we can see that some of them can be explained by similar differences between the sexes in the population as a whole. For example, this is true for asylum class (more male paupers, more female privates), occupation (more unskilled women, more skilled men), and education (women with less education than the men). There are more female private patients than male in

the under-20 group, but that holds true for the general population as well (there were, in fact, even more private patients in the total population). The discrepancy in occupations--most of the under-20 women are unskilled or semi-skilled workers, whereas the under-20 men are mostly semi-skilled or skilled--can be found when comparing men and women in the general population, except there are more wives and fewer semi-skilled women, and more men who are skilled workers, lower- and middle-class. Whatever differences there are, however, between jobs held by patients under 20 and those of the population as a whole can be explained by the larger number of paupers in the under-20 group, in that more people with higher skills on the occupation ladder generally meant an increase of private patients (see table 4). Education also mirrors the differences in figures of the general population--men were simply better educated as a whole.

But what explains the other differences? These women were considered more dangerous than other women in the asylum. They were admitted after a briefer attack than the men in this age group, were more likely to be insane because of a predisposition to insanity or because of heredity, were discharged later than the men, and had a higher death rate. The only explanation seems to be that these women, by and large, were considered "crazier" than the men in their group, particularly when one looks at the high number of those categorized as "lunatic" and "insane"

by the doctors in comparison with their male counterparts.

### Older Patients

Patients between the ages of 50-59 present a slightly different picture, both from the under-20 group and from the population as a whole. The majority had never been admitted into an asylum before, similar to the general population. The percentage of people who had been previously admitted to an asylum or who were transfers was higher than the general population, however; that is, the gap between those with previous asylum experience and those with none had narrowed.

There is also a difference between the sexes in the duration of attacks before admission. Contrary to accepted theory, few women were admitted after brief attacks (12%, compared with 46% in the general female population)--their bouts of insanity lasted quite a while before they were brought to the asylum. In marked contrast to this were the men, over 73% (also 46% in the general male population) of whom were admitted after only brief attacks. There is also a big difference in asylum class. Admittedly, in the general population itself, there were more women than men in the private class and more men than women in the pauper class, and this 5% difference is noticeable. However, it is easy to see which group this 5% represents, when one

notes that a full 68% of women aged 50-59 were private patients, and 32% were paupers, and that the picture is turned upside down for men 50-59: almost 27% were private patients compared with 73% pauper.

This age group also differed from the general population in terms of marital status. Differences between the sexes when the population is taken as a whole are very slight: around half are single, just under 40% are married, around 10% are widowed. But in this age group there are two noticeable changes: one, the greatest concentration of people in both sexes are found under "widowed"; and two, more women than men are single, and more men than women are married. That more people are found widowed at this age is no great surprise; and that women have greater longevity than men probably also pertains here.

The percentage of women aged 50-59 who held unskilled jobs is roughly equal to that of the general population, as is the percentage of wives. Among the 50-59 age group, however, there were far fewer semi-skilled workers and almost twice as many listed as having no occupation at all. The highest concentration of men in the general population, 58%, held skilled, semi-skilled and unskilled jobs (of these three the greatest percentage--25%--were skilled workers). Men aged 50-59 were also concentrated in the unskilled/semi-skilled/skilled area but at a much higher percentage of 80% (due to higher numbers of unskilled and

semi-skilled workers), and with only half as many from the lower middle class. In essence, then, there were more lower working-class men in this group than in the general male population, and fewer lower working-class women than in the general female population (and double as many women listed as living at home or having no occupation).

Bodily conditions upon entering the asylum were very similar for the women; the men, however, were much worse off than the general population, with 67% of them entering in a spare/reduced condition (compared with 50% of the total male population) and only a fifth of them in an ordinary condition. Women's rates also didn't differ as much as far as diagnosed mental disorder was concerned (except for a slightly higher rate of monomania, which, in this population at least, includes more men than women)--the highest concentration was still under mania, with almost one-quarter under dementia and the rest considered monomaniacs or melancholics, similar to the general female population. But the men were another story: only one-quarter of them were considered manic, compared with 55% in the general male population. More were diagnosed as having dementia, monomania (20%) and melancholia (20%). Significant is the rate of melancholia, which is more than double that of the general male population, and higher than that of both the women's general population and the women in the same age group. This contrasts with the general population, where there is a general trend involving

slightly more men suffering from monomania than women, and slightly more women suffering from melancholia than men (see page 43 for a similar pattern in "Doctors' category").

As far as causes were concerned in both general populations, the highest percentage in both sexes came under the "Unknown" category, with well over a third in both. Women were over twice as likely to be considered insane from a predisposition from previous attacks than men, and slightly more likely to have heredity count as a factor. Men, on the other hand, had a higher percentage of insanity due to general paralysis, intemperance or epilepsy. In the 50-59 age group, "Unknown" still had the highest concentration of cases for both sexes, but the next highest concentration for women, 12%, was under "Intemperance" (followed by "Predisposition" and "Heredity"), with a rate higher than that of the general male population and roughly equal to that of the males in their age group. The next highest concentration of men is under "Predisposition from previous attacks," with a full 20%--much higher than the women's 8% in this group. The men's rates of general paralysis and intemperance are higher than the rates in the general male population as well.

In education, women in the 50-59 group are better educated than the general female population, with 68% of them able to read and write or possessing a good education, and the percentage of those with a good education almost

doubles. They are also better educated when compared to the men. Men's percentages drop from 75% reading and writing or having a good education to 60%, and their illiteracy rate rises.

In terms of patients being suicidal and/or dangerous, these patients differ markedly from the general populations in several ways. First, the rate of women considered neither dangerous nor suicidal, or it is unknown if they are either, rises. However, the rate of those considered suicidal and both suicidal and dangerous rises as well. The real difference lies with the percentage of those considered dangerous alone, which drops to almost a third of that of the general female population. It is just the opposite with the men, where over half are considered dangerous, and the number of men considered neither or unknown drops considerably; in addition, the percentage of those considered suicidal doubles. There are also no men considered to be both suicidal and dangerous.

There are some changes in the percentages under the variable "Doctors' category" as well. Most people--around 70% of both sexes--are still considered persons of unsound mind (compared with roughly 60% for the both general populations); but the interesting thing is that the percentage of men considered insane doubles, the corresponding percentage for women is roughly the same as before and there are no women described as lunatic. There are still more women considered insane than men, but the

men's rate is double that of the general male population. Again, as seen under the variable mental disorder (page 41), this represents a change from the general population's trend as far as men are concerned, in this case, where more men than women are described as lunatic, and more women than men are described as insane. It is difficult to know what these doctors meant exactly by these terms, but I suspect that "lunatic", while referring to someone believed to be "crazy," also had a connotation of physical unruliness or lack of physical control; whereas "insane" was a term applied to someone whose main problem was thought to involve mostly the mind. Table 5 gives some support to this theory, especially if the figures under "Dangerous" for "Lunatic" and "Lunatic/person of unsound mind" are added together, giving 32 people labeled "Lunatic" as being dangerous compared with 12 people labeled either "Insane" or "Insane person/person of unsound mind." However, those categorized as "Person of unsound mind" still have the highest amount considered dangerous. Men might have been viewed as more of a physical threat than women, and because of this more likely to be labeled as lunatic. Still, the change exists and would seem to indicate a tendency for the mad behavior of men in this age group to be evaluated as more similar to that exhibited by a large number of women.

In the general male and female populations, just under 70% of the men are in the asylum for a year or less,

compared with 74% of the women--in other words, the duration of stay for both sexes is pretty much equal. In the 50-59 age group, though, 80% of the men are out within a year compared with 64% of the women. Reasons for leaving the asylum change as well: fewer 50-59-year-olds are relieved compared to the general population, slightly more recover, and the death rate for both is around 25%, with the women's death rate rising more dramatically.

Having looked at these two age groups in detail, I now want to take a broader look at the women in both, comparing and contrasting them to the men and to the general populations. What made them different? Were these differences related to the higher numbers of women in these groups?

More women than men under 20 had previous asylum experience (that is, they had been in an asylum before or were being transferred), most were admitted into the asylum after a brief attack of insanity, all were single, and the greatest concentration held unskilled jobs. Most were considered manic, and their madness was attributed to a predisposition from previous attacks, heredity, fright, menstruation, puberty, and childbirth. They were less educated than their male counterparts, considered more dangerous than the women in general, and over half were labeled as either lunatic or insane--much more than the under-20 men or either the general male or female population. They stayed in the asylum longer and had a

higher death rate than the men in their group, although a lower one than men and women in general. Three of these characteristics are similar to the men in the group, who were also single, manic, and considered more dangerous than the rest of the population. However, it appears that these women, by and large, were considered "crazier" than the men in their group, when one looks at the higher numbers of those categorized as "Lunatic" and "Insane" by the doctors, and by the extraordinary number--when compared with the general female population--considered dangerous (certainly "Suicidal" was a more common condition for the women in Gartnavel; it should be remembered, though, that more men in the group were considered dangerous than women).

Something that could help explain this view of these women as more dangerous and insane than much of the general population could be the fact that three cases--that is, 17%--were thought to be caused by menstruation, puberty, and childbirth, that is, "female" causes (I include puberty because no males were listed as insane because of it). That is the highest percentage of female causes in any group, and one would expect there to be some connection. However, when these three cases are explored further, only one (caused by childbirth) is listed as dangerous--the other two are considered neither suicidal nor dangerous; and the same patient is considered a person of unsound mind/lunatic, while the others are listed simply as persons

of unsound mind (as mentioned before, probably the mildest category). The results, then, are these: one, only one-sixth of these cases were explained by female causes, which is not only relatively low but is at the same time the highest in any group; and two, even when explored further there seems to be no connection between these female causes and the "dangerousness" of the patients. Not only were there very few cases of insanity caused by "female" causes in both this group *and the female population as a whole*, but that, in this age group at least, there is no connection between those cases that were and the perception that the women in this group are more dangerous, lunatic and insane than other groups. This lack of a connection is not too surprising, since it was not unusual for madness to be attributed to sex-related causes (see also masturbation). What is surprising is the low number of women in *all* age groups who were diagnosed as being mad from female causes.

In comparison with both sexes in the under-20 group, and both general populations, very few women aged 50-59 were admitted to the asylum after a brief attack of insanity; in fact, over half--52%--were admitted after a lengthy or longstanding attack. When compared to the men in their group, more women were single, far many more were private patients, fewer were working class, and they were in much better physical condition. There was a slight rise in those considered monomaniac, but otherwise the numbers

under "Mental disorder" didn't change much (unlike the men, whose percentage of melancholics was more than double that of the general male population). Causes for both sexes remained mostly unknown, although the rate of intemperance among the women more than tripled from that of the general female population, and the percentage of those insane from previous attacks was halved (rates of intemperance among the men increased too, and, interestingly enough, the percentage of men thought insane from a predisposition from previous attacks almost tripled from that of the general population). These women were much better educated than the men in their group and the general female population, and were almost as well educated as the general male population. They were less dangerous but more suicidal, whereas the men were more dangerous *and* more suicidal. Their rates under "Doctors' category" didn't change much from that of the general female population, except there were none categorized as "Lunatic"; the men's rates also held, except there were more categorized as "Insane." Women in this group stayed in longer than the men, and had a higher death rate--close to that of the general male population--than the general female population, although still not as high as men aged 50-59.

It is more difficult with this group to imagine why there would be so many more women than men. Unlike their fellow female patients under 20 they were not considered more dangerous than other patients, nor were they

considered more "lunatic." Instead, the clue lies not with a marked change from that of the general population, but rather with the fact that 68% of 50-59-year-old women were private patients, and that over 73% of 50-59-year-old men were pauper patients. Indeed, a crosstabulation run on this group comparing the asylum class with duration of attack shows a direct relationship: In table 6 one can see that even though there were more women in this age group than men, there were eleven male pauper patients to four female, and only three male private patients to seventeen female private patients. The overwhelming number of men in this age group were pauper patients who were admitted after an attack that had lasted about a week or less. Over half of the women admitted as private patients were admitted after an attack of about a month or more. An obvious explanation of this would be that working-class men were valuable sources of income, and that they were packed off to the asylum for a cure the instant they showed signs of insanity, whereas the economic role of their female counterparts (both pauper and private) was not so large.

Looking at the figures under "Occupation" in table 3, we can see that 80% of the men aged 50-59 indeed held unskilled, semi-skilled or skilled jobs, compared to the women's 44%. Of that 80% male working class, however, only three of twelve men were married. Most were single or widowed. Of the 44% female working class, two of eleven women were married. Most were also single or widowed.

Looking at the rest (56%) of the women aged 50-59 we see that ten of the fourteen, or just over 70%, were single or widowed, and that only four were married. Taking the age group as a whole, then (see table 3 under "Marital status") we can see that people aged 50-59 were less likely to be married, and more likely to be widowed, than the general population, and ostensibly had no dependents to support. For the women (who were mostly private patients not employed) this meant being cared for at home for a longer time. For the men (who were mostly pauper patients and employed) this meant a complete loss of any functioning role in society and subsequent removal to an asylum. But why would single or widowed women from strong economic backgrounds outnumber poor single or widowed men who have supposedly lost their role in society, and why in this particular age group? One answer could lie with the fact that the men in this age group--mostly working-class--could be "cured" and sent back to work, whereas the women--mostly private patients--had no work to be sent back to, and were too old to fulfill the other female role, that of mother. This theory is supported by the figures under "Duration of stay," which show that the percentage of women in this age group who stayed in the asylum over a year (36%) is greater than that of their male counterparts (20%), and that they were less likely to be released in a year or less (64%) than the men (80%).

### Differences in Asylum Class

The next variable where a noticeable difference is found between women and men is asylum class, where over half of the private patients were women, and over half the paupers were men (see table 2). Why was this?

At first glance, we see that the number of women and the number of men who worked was equal--it was around 60% for both groups (see table 1, "Unskilled" through "Middle class" percentages). The women held more unskilled jobs than the men, who held more skilled jobs than the women. It seems more likely that a skilled worker would be able to afford private fees, and hence that the number of private patients of both sexes would be equal (most women who were registered as private patients were listed as "Female, no occupation." This category did not include wives, which was a separate group, and it is impossible to know exactly what was meant by this term. Since they were private patients, however, it can be safely assumed that they were women who were in some way being taken care of by a family or friend of some means).

But this is not the case. In fact, the highest concentration of male *paupers*--over a third of them--were skilled workers, not unskilled, as one might expect. With women, comparisons between occupations and asylum class show that roughly half the pauper women--49%--held unskilled jobs. Underlining this tendency for female

paupers to be unskilled workers and male paupers to be skilled are other figures: that is, most skilled women (64%) are private patients, yet most skilled men (87%) are paupers. Why the difference?

Before going further, it should be pointed out that there were five times as many skilled men as skilled women--as we have already seen from table 1, the highest concentration of women under the variable "Occupation" is under "Unskilled" (over a third of them), whereas that of men is "Skilled" (one-quarter of them). This small group of women, while perhaps in and of itself not so significant, will mainly serve as comparison against that of the men; because while it is not surprising that paupers would be unskilled laborers who couldn't afford to pay private fees--as is the case with the women--it is noteworthy that so many male paupers were skilled workers, especially when compared with the large percentage of female skilled workers who were paying private fees.

The biggest reason for the imbalance was that most women who worked were single (see table 8) and paupers (except for those who were skilled, many of whom were private patients), whereas there were more working men who were married, with wives and perhaps children to support. The results of a crosstabulation run on both women and men comparing occupation and marital status show that almost three-quarters (73%) of skilled women were single; assuming they had savings, or the support of another, presumably

parental, income, this would suggest an ability to pay higher (private) fees. In contrast, just under half (48%) of the men were single, with the same amount married. It would have been difficult to pay private fees with more than one person living off these wages, assuming there was money the family had saved; without the prime breadwinner it would have been a difficult task for his wife to pay asylum fees in addition to supporting herself, and children, if there were any.

We can see, then, that even though there were more men who held highly skilled jobs than women (and who were subsequently paid better) more of them were married and had families to support; in contrast, those women who were private patients were not from the working classes but were wives or listed as having no occupation, and ostensibly supported by their own funds or those of someone else. There is also a second reason for the imbalance, and that is that there were slightly more female non-working class private patients (19% of the total asylum population, or 83 people) than male non-working class private patients (17%, or 74 people). These two factors together add up to more female private patients than male.

## Men, Women, and Suicide

Further differences between the sexes involved the percentages of men and women under "Mental disorder" and "Suicidal/dangerous": 60% of melancholics were women, 60% of monomaniacs were men, 60% of suicidal patients were women, and 60% of dangerous patients were men (see table 2). Because these disorders tend to be associated with these tendencies--at least that of melancholia with that of suicidal tendencies--they will be looked at together.

Two explanations of these differences that come to mind immediately are that either women in general were more depressed and suicidal than men, or that depressed and suicidal women were more apt to be admitted into an asylum than depressed and suicidal men. Similarly, perhaps men in general were more monomaniac and dangerous than women, or more likely than women of being admitted into an asylum because of it. Unfortunately, neither of these hypotheses can be tested by these data; what can be explored, however, are the characteristics of the disorders and tendencies in the hopes of understanding what being melancholic or monomaniac really meant. What are the connections among the four, and what can we conclude from them?

To begin, let us take a closer look at monomaniac patients, and determine whether they are linked to suicidal and/or dangerous behavior. Figures in table 2 show that men were more likely than women to be described as

dangerous: 60% of dangerous patients were men, 40% were women; and we have seen already that men were more likely to be monomaniac than women. But this does not mean that monomaniacs tended to be dangerous as well; in fact, half of all monomaniacs--whether taken from the general population or from either sex--are considered neither suicidal nor dangerous/unknown (see table 9). What seems to determine whether or not a monomaniac is dangerous is sex: one-quarter of female monomaniacs (the next highest concentration after neither/unknown) are considered suicidal; one-third of male monomaniacs, on the other hand, are considered dangerous. This is not surprising, since men tended to be considered dangerous more often than women anyway. There is more of a connection between dangerousness and mania than dangerousness and monomania: 75% of dangerous women and over 65% of dangerous men were manics (many men suffering from dementia were dangerous, hence the difference). It seems, then, that there was a connection between monomania and dangerousness if a patient was male; but dangerous behavior in both women and men was tied more strongly to mania.

There is a much stronger connection between melancholia and suicide than that between monomania and dangerousness--half of all melancholics were suicidal, and the greatest concentration of patients with suicidal tendencies were melancholics (table 9). Given that the majority of melancholics were women, and the majority of

suicidal patients were women, it might be natural to assume that melancholic women were also suicidal, and that suicidal women would more likely be diagnosed with melancholia; and both these assumptions turn out to be true. What is surprising, however, is that when these numbers are compared with the men, something unexpected turns up: male melancholics were actually *more* likely to be suicidal (55%) than female (45%), and more suicidal men (48%) than women (39%) were diagnosed as melancholic. So while melancholia and suicidal tendencies are connected absolutely, much more so than monomania and dangerousness, and women account for the largest population in both variables, it does not follow that suicidal women were more likely than men to be diagnosed as melancholic, or that melancholic women were more likely than men to be considered suicidal. In fact, suicidal *men* were more likely than women to be diagnosed as melancholic, and melancholic *men* were more likely than women to be considered suicidal. Suicidal women are more likely than the men to be diagnosed as manic, cases which are not found under melancholia at all, which accounts for the first difference; and melancholic women are more apt to be diagnosed as neither suicidal nor dangerous/unknown, which accounts for the second. It is interesting to see that suicide and melancholia were more likely to go hand in hand as far as men were concerned, and that suicidal women were more apt to be considered manic and not melancholic, mainly

because it is a common assumption, because of the greater number of females with melancholia and suicidal tendencies, that it would be the other way around.

### **Causes of Insanity**

We come next to the variable "Cause." Over a third of Gartnavel's population were listed as insane from unknown causes, and it is by far the cause with the greatest concentration of patients included in it (see table 1). This also holds true for both the female and male populations when looked at separately. After "Cause unknown," however, the sexes differ in their causes of insanity. Moving down the line, we see that over twice as many women than men were diagnosed as being mad because of a "predisposition from previous attacks," and that in fact this cause for the women has the highest concentration of patients next to "Cause unknown." This is interesting, given that roughly the same number of women and men had similar previous asylum experience--that is, roughly the same number of each sex had been previously admitted to an asylum, either to Gartnavel or to another. Why then were there more women in this category?

Both sexes share many characteristics: most were paupers, single, unskilled or semi-skilled in the case of the women, unskilled or skilled in the case of the men,

most were in a weakened or ordinary physical condition, most were manic, decently educated, over a third of each group were considered dangerous, most stayed one month to a year, and most recovered. It could be that many of these patients had had previous attacks of insanity but had never been admitted into an asylum because of them; in this case the previous admission history would be of little significance. Another variable that could be related is "Duratack," or duration of the attack that preceded the patient's admission into the asylum. If women suffering from "bouts of insanity" were kept at home for a longer period of time before being admitted to an asylum, then the cause for admission, by the time they were admitted, would be attributed more likely than not to a predisposition from previous attacks. Conversely, if men were admitted after only brief attacks, a predisposition would be a less likely cause. And this seems to be the case. In table 10 we see that women were more likely than men to be admitted after a longer "bout," and that the majority of patients suffering from a moderate, lengthy, or longstanding attack prior to admission were women. There is also another factor to influence these figures: there are more female private patients under this category than male, 73% of which had moderate or longer "bouts" prior to admission (all male private patients had been admitted after only a brief attack, see table 11). Another significant difference in this category is that over half the women

(54%) were in their 30s and 40s, and half of these were married (only 40% were single); well over half the men (62%) were in their 20s and 30s, and 80% of them (twice the women's rate) were single (table 12). Again, we see a tendency, similar to that among the 50-59-year-olds, for men to be admitted to the asylum sooner after an attack than women (see page 47); unlike that age group, although men and women who were admitted due to a predisposition were more likely to be single than married--in keeping with the figures for the population as a whole--when broken down into the predominant age groups, the women are over twice as likely to be married than the men, and half as likely to be single. The fact that they were married could also help explain why they were not admitted immediately after an attack--a spouse at home could care for them until time, energy, money or experience ran out.

After "Predisposition from previous attacks," the biggest differences between the sexes in terms of causes are found under "General paralysis," "Intemperance," and "Epilepsy" (men were more likely to be insane from work anxiety and masturbation, and women by emotional stress and of course childbirth, but these causes represented very small percentages of the population. However, they were listed as legitimate causes, and are important for that reason). General paralysis, the "terminal form of syphilis", affected many more men in asylums than women (69), and will be discussed with the death rate at the end

of this section.

There are over twice as many men as women listed as insane due to "intemperance" (table 13). Alcohol was for the nineteenth-century "mad" doctor a very real cause: "The repeated use of liquids containing alcohol cannot...leave the brain of any undisturbed...Inebriation is temporary madness. If often repeated it may become permanent madness." (70) Intemperate males were likely to be in their 20s, 30s or 40s, married (with almost a third single), and holding either skilled or lower middle class jobs. Almost 70% had never been admitted to an asylum before; but a full third either had been in an asylum or were transfers from the Sheriff's office or prison. Most were paupers, manic, and were well educated (83% could read and write or were considered having a "good education"); half of them were considered dangerous, and one quarter were considered both suicidal and dangerous. It is interesting to note that only one patient was out within two weeks, implying the asylum was not functioning as simply a "drying out" place for drunks: over half--56%--were out in under three months, 78% were out in a year or less, and 22% stayed between one and three years. Fourteen out of the eighteen were considered recovered, three were relieved, and one died (the dementia patient, after three to five years). Female intemperates tended to be in their 40s and 50s, married (with well over a third--38%--widowed), and holding unskilled or semi-skilled jobs. All

but two (representing 25%) had never been institutionalized before. Most were paupers, although there was a higher percentage of private patients than among the men; most had a good education, but differed from the men's by twenty percentage points (63%); half were considered both suicidal and dangerous, and one quarter were considered suicidal. Sixty-three percent were out within three months, 76% within a year, and 25% stayed between three to ten years. Seven out of the eight recovered, and one was considered relieved. None died.

Either there were simply more men than women in the general population of Scotland who were drunkards, or there were more drunk men than drunk women who were considered insane. The first hypothesis cannot be tested by these data, of course; as for the second, an argument can be made that the data show intemperate men as being more insane than intemperate women, if "person of unsound mind" can be thought of as milder than either "lunatic" or "insane person." In table 13 we see that whereas seven out of the eight, or 88%, intemperate women were considered to be "persons of unsound mind," only nine (57%) of the men came under that category: the remaining seven were described as "lunatic/person of unsound mind" (both doctors categorizing them differently), "insane person," or "lunatic." Half of the men were also described as being dangerous, and a quarter as both dangerous and suicidal; it was turned the other way around with the women, half of

whom were considered both and a quarter of whom were considered dangerous. It is my guess that "dangerous" described a person that threatened greater physical danger than a person described as "both suicidal and dangerous"; if this were true, intemperate males were definitely seen as an unruly bunch, especially given that the percentage of the general male population considered dangerous was only 32% (see table 1).

There were also 16 male patients who were listed as being insane due to epilepsy as opposed to one female patient, even though under the category "Epileptic" 14 men and eight women were listed as suffering from the disease. Of these 14 men and eight women, differences between them included the usual differences between men and women in the general population, i.e., more private female patients than private male, a tendency for women to be unskilled laborers and the men to be semi-skilled or skilled, a tendency for the men to be better educated than the women, more suicidal women and more dangerous men, and a higher death rate among the men (see table 14). Unusual differences include a higher rate among the men for previous admission to an asylum: six out of the 14, or 43%, had already had asylum experience upon entrance to Gartnavel, whereas there were no women with previous asylum experience--there was only one transfer from prison or Sheriff's custody. Also, women tended to be slightly older--87% were in their 20s, 30s or 40s--whereas 86% of the men were in their 20s and 30s.

Whereas the majority of the epileptic patients were married, more women (62%) tended to be married than men (57%), and, conversely, more men (43%) were single than women (38%), although this probably has more to do with the women being older and the men younger than anything else. And even though both groups had high rates of dementia--half of all epileptic men and 38% of epileptic women were suffering from it (the rest suffering mostly from mania)--the 12% difference between them is fairly significant. Epilepsy was often linked to dementia, since both involved loss of memory to varying degrees; but epilepsy could also be linked to mania (as the above figures show), and wild, unruly behavior. (71) It would seem that the men were more likely to be diagnosed as suffering from loss of memory and the women from physical unruliness.

Patients whose insanity was thought to be caused by epilepsy were, as stated above, all men but one. Half of these men were considered manic, and another 44% demented, similar to women with epilepsy. In all other respects they were similar to the men listed as epileptics, except that they were much more likely to be considered insane and/or lunatic than either male or female epileptics, over 70% of whom were considered "persons of unsound mind." On the other hand, they had a lower death rate than those men described as epileptic (40%), although all death rates for people associated with epilepsy were extraordinarily high.

**Death in the Asylum**

And this brings us to the last variable, that of "Exit reason." Here there are two differences between men and women: whereas both sexes had the same recovery rate (about 42%), more women than men were considered "relieved", and they also had a lower death rate--20%, as compared with the men's almost 25%. What were people dying of?

Most women who died (84%) had never been in an asylum before (table 15). Most (68%) had had brief to moderate attacks of insanity before being admitted to Gartnavel. In terms of age, over half (53%) were in their thirties and forties, and most were paupers (70%). Whereas 57% of the women who were discharged as relieved and 54% of those discharged recovered were single, only 37% of those women who died were single: 44% were married, and 19% were widows. Forty-four percent of the women who died were unskilled laborers, which was the highest percentage of unskilled workers in the whole female population as well as the highest concentration among dead women; and they were also more likely to be in poor physical condition upon admittance in comparison with their fellow female patients who survived. Almost half of those who died (49%) were admitted with dementia, whereas those relieved were mostly manic or monomaniac (58%), and those considered recovered were mostly manic (72%). The highest concentration of

women who died were insane from unknown causes (40%); the next highest concentrations were insane from general paralysis (16%), hereditary factors (12%) and childbirth (also 12%). Over half could read and write or had good educations (although more of those who survived were well educated); and well over half--63%--were considered neither suicidal nor dangerous (one-fourth of those who survived were considered dangerous). Most who died were considered persons of unsound mind. Interestingly, both women who died and those who recovered had more history of insanity in their families than women considered relieved, who had the lowest percentage of insanity in the family. And perhaps the strongest correlation of all is that between duration of stay in the asylum and exit reason: those women who died had the highest number of patients staying over a year (47%), and the lowest number staying under a year (53%). Those who recovered had the lowest number staying over a year (only 6%) and the highest staying under (94%); those who were relieved were in the middle (37% and 63% respectively).

Men who died were also more likely than not to have been in an asylum for the first time. They were also much more likely to have been admitted sooner after an attack than the dead women (57% as compared to the women's 35%). Even more dead men than women were in their thirties and forties (63%). Interestingly, there were also more private patients among those men who died (37%) than among the

women (30%), and many more were married--over half, in fact (52%). One-fourth of the men who died were also middle class (almost a third were skilled). Most of them, like the women, were also in poor bodily condition upon admission in comparison with the men who survived; and also similar to the women, dementia accounted for over half (55%) the male patients who died. These men were better educated than the women, which was true in the general population as well; and, like the women, were mostly considered neither dangerous nor suicidal. Most were also considered "Persons of unsound mind," and had the same patterns of insanity in the family as the women. And there was a decided correlation between the duration of stay and the exit reason, similar to the women, although it was not as strong--54% of the men who died stayed under a year, 46% over; 56% of those relieved stayed under a year, 44% over; and 88% of those who recovered stayed under a year, 12% over.

Along with differences in occupations, it is with "Cause" that we see a big difference between men and women, because the highest concentration of men who died died of general paralysis, with "Unknown" a close second and "Epilepsy" a distant third. This meant almost a third of the men who died (31%) died from general paralysis, a big contrast to the dead women's 16%.

When "Cause" and "Occupation" are compared (table 16), we see that even though most men who died were skilled and

middle class, the highest concentration of men who died of general paralysis--41%--were unskilled or semi-skilled laborers, but that close to a quarter (24%) were middle class and another quarter (also 24%) were skilled (12% had no occupation). With women, five out of the seven who died from general paralysis (71%) were unskilled or semiskilled; one woman (14%) was middle class (holding a middle class job), and one (14%) was a wife. From these figures we can see that women who died of general paralysis were more likely than men to be unskilled or semiskilled laborers, and that their male counterparts were more likely to be skilled or middle class.

We see, then, that reasons of death among the women were vaguer ("Unknown") than those of the men, who were most likely to die of general paralysis. Those women who *did* die of general paralysis tended to be unskilled or semiskilled laborers. Those men who died of general paralysis also tended to hold unskilled or semiskilled jobs, but a significant number of them were skilled and middle class.

### Chapter Three:

#### FINAL DISCUSSION AND CONCLUSION: GENDER AND MADNESS IN THE NINETEENTH CENTURY

From the data certain things have been discovered about this asylum population. For example, the number of men and women in Gartnavel was roughly equal. Three-quarters of the population were between the ages of 20 and 50, and over three-quarters of the patients had never been in an asylum before. Just over 60% were listed as pauper patients, and roughly the same amount were from the working classes. The highest concentrations of patients were listed as insane for unknown reasons, although there were a multitude of causes possible. Half were single, 40% were married. Most suffered from mania. Most patients could read and write or had "good educations." The highest concentration of patients was considered neither dangerous nor suicidal (although just under a third were labeled as dangerous). Over 60% were considered "Persons of unsound mind," in all probability the mildest description of mental disorder of those possible. About 60% were discharged (for whatever reason) within a year of being admitted. And the death rate was high--overall, 22.5%

In the course of some basic analysis (crosstabulations and frequencies) other characteristics--dealing with women and men as compared and contrasted with each other--have

come out which were not apparent at first glance. Although the number of men and women in the asylum was basically the same, certain age groups (those under 20 and between 50 and 59) contained many more women than men. Women under 20 seemed to be viewed as both "crazier" and more dangerous than their male counterparts; and women between the ages of 50 and 59 stayed in the asylum much longer than the men in this group, ostensibly because their societal role at that age was less important than a man's, and there was less to return to. However, as we have seen, these populations represented a statistically small portion of the overall population, and as such do not represent gaping differences between women and men.

More women were private patients than were men, perhaps due to the fact that men who might have otherwise been able to afford private fees had families to support, while the private women were not from the working class and probably had no dependents. Although most patients of both sexes were listed as suffering from mania, those patients with melancholia were mostly women, and those with monomania mostly men; most suicidal patients were women, most dangerous patients men.

Although the highest percentage of patients of both sexes had "Unknown" listed as the cause of insanity, those causes taking second and third place differed for men and women. Women were much more likely to have "Predisposition from previous attacks" listed as a cause, probably due to

the fact that they tended to be admitted after longer "bouts" of insanity, thereby making "Predisposition" a logical choice. It also suggests that these women were admitted to the asylum only when it was deemed a last resort (in contrast to others' findings; see discussion of Dwyer's book below). Men, on the other hand, had higher rates of general paralysis, intemperance (a full half of the intemperate men were considered dangerous), and epilepsy. This tendency was also found by Dwyer in the Utica asylum, also among the upper classes. (72) The fact remains, however, that the majority of both sexes was still considered insane for reasons unknown, pointing to an inability or unwillingness on the part of doctors to make judgements in the case of either sex.

Finally, men had a higher death rate than the women, due to more cases of general paralysis, which, because no one knew what it was (syphilis) or how it should be dealt with, was left untreated, inevitably leading to death.

Still, the overall impression of the sexes in this particular asylum is that they were very similar in most ways. While there were differences between men and women in two age groups, these groups themselves were relatively small within the population when compared with the largest groups, where trends were the same between the sexes. There was a difference also in terms of asylum class, but again, the majority in both sexes was the same. Women tended to hold more unskilled jobs and the men more

skilled, but this was true of the general population as a whole. (73) The majority of men and women were categorized very similarly by the doctors--differences, again, were between smaller groups. And most people of both sexes were diagnosed as having mania stemming from unknown causes.

In other words, there were differences between women and men in this population, but they were numerically not as significant as the similarities. This is not to say that women were not victims in some ways of Victorian life (and in the area of mental health); as suggested in the introduction, women did seem to represent a substantial percentage of psychiatric out-patients, and were restrained in their societal role arguably more than men. But as far as the asylum was concerned, the fact that most patients of both sexes were admitted with mania caused by unknown factors suggests that a similar definition of madness applied to both women and men, that attitudes toward the insane of both sexes did not differ greatly, and that indeed, women's and men's experiences within such institutions may not have been very different at all. It is an accepted fact that economic standing was an influential factor in asylum populations: that is, the majority of state asylum patients were from the lower classes. In the case of the Royal Glasgow Asylum, economic class, and not gender, proved to be more of a separating factor between those in and not in the asylum. In this asylum, at least, women appeared to be no worse off than

their male counterparts, and it probably can be assumed quite safely that it was a fairly miserable experience for all.

The entire population of these two years consists of 431 patients, not a huge number but still enough to lend resulting information credibility and be of relevance to other insane populations. While it may not be representative of state asylums everywhere during this time, it is a group that has provided some very real and tangible clues to who was actually in a 19th-century Scottish asylum. Although there is no similar Scottish study, there are several histories of individual English and American asylums, mentioned in the introduction, among them Ellen Dwyer's book *Homes for the Mad*, which deals with two American institutions in the same time period. The underlying (and stated) purpose of Dwyer's book is not to theorize in a general way on the rise and influence of the asylum and its relation to its societal context, but to actually do some of the sweaty work of trying to "find out": "...While doctors' policies and the growth of their institutions may well have been an important expression of nascent capitalism and industrialization in nineteenth-century America, it is not easy to uncover the connections between macro-level economic change and internal institutional developments," and her study goes a long way, along with Digby, Mackenzie and Tomes and their equally thorough works on individual asylums, in discovering what

life in the asylum was really like, and what forces, internal as well as external, personal as well as political, influenced it. (74)

Dwyer does make some comparisons between the sexes. For example, she found no meaningful discrepancies in admission causes. While the above-mentioned Utica superintendent Gray was apt to view women as more likely to suffer from physical disease, and concurred with the accepted argument that women's mental health was connected to their reproductive system, Dwyer still notes a rise in madness due to physical causes in *both* sexes and attributes much of this rise to Gray's own theoretical beliefs concerning insanity and not to some sinister, vague, external societal force trying to oppress women. (75)

However, other than admission cause, Dwyer does find "considerable difference" between the sexes in the asylum as far as three factors are concerned: church membership (more women members), age differential (women younger than men upon admission), and duration of insanity (shorter for women, indicating that "women were institutionalized more quickly than men"). Again, the data from Glasgow differ from that of Utica in that they show a similarity in age upon admission, with actually slightly more younger men (although this difference is very slight, please refer to Table 1). Duration of insanity is also very similar between the sexes at Glasgow.

This paper does not look at church membership, and

Dwyer's study does not analyze it either. The difference in findings on age are difficult to explain, but could have more to do with local demographical factors than anything else. Also, as the Gartnavel numbers show, the youngest patients were mostly female. Wild behavior from very young women could have been seen as more threatening as from that of very young men. Duration of insanity, while an interesting variable, must, as Dwyer stresses, "be treated with care," for such information could be unreliable. As she states, "Because counties were supposed to send to Utica only recently ill indigent patients, Utica's doctors suspected that local superintendents of the poor sometimes misrepresented the length of time particular troublesome paupers had been ill." (76) While this still leaves the question of why women would outnumber men in one case but not another, it points out the caution needed in dealing with certain variables, and duration of insanity (before admission) is certainly a variable from which conclusions should only very cautiously be made. I have included the figures for duration of insanity (duration of attack) in the tables, but have used them for analysis only in connection with another variable, that of cause, in which I felt such figures could help as an explanation of a certain trend. Generally speaking, however, using this variable *on its own* to draw general conclusions is, I agree with Dwyer, probably less reliable than using other, more clearly defined, variables such as type of insanity and

cause.

Dwyer mentions two additional points to explain the differences she found that also speak against the oppressed woman theory, namely that violent men would more likely be sent to jail than to an asylum, and that the majority of working class women found in asylums were domestics and therefore more prone than male unskilled workers to be under the watchful eye of an employer, increasing their chances of having their behavior noticed and labeled insane. (77) Again, I find both these explanations plausible.

Finally, however, I must defend my own findings and stress that though the Gartnavel data also include various differences between the sexes none of these differences were judged by me to be numerically significant. Those differences that do exist could be construed as being representative of unfair attitudes toward women, and in fact I believe that to be true in a general sense--that is, wild and/or inexplicable behavior was less tolerated in women than in men. However, since these differences concern such a small portion of the overall asylum population, I disagree with scholars such as Showalter, who see female oppression as the guiding force behind the asylum experience.

## Changes in the Asylum: Moral Management at Gartnavel

Causes for insanity ranged throughout history from whims of the gods (or devils) to a more medical framework, to a model that emphasized the continuous battle between reason and unreason; it could be argued that all these views coexisted at the same time, with varying emphases put on any one of them, to a certain extent throughout history. (78) The insane, considered vagrants by the state when roaming the streets (79), were institutionalized in some cases--in such "grab bags" as state hospitals that also contained criminals and the physically handicapped--left to roam in others, or taken care of by friends and/or family. Causes could reflect outside forces or an inner conflict, a physical illness or a tendency to "unreason." For these reasons those concerned with the insane continued to have difficulty defining madness: when did illness lead to insanity? How "unreasonable" did a person have to be to be labeled mad? What caused seemingly mad, irrational behavior--disease, loss of reason, the Devil? As discussed, beginning at the end of the eighteenth century, insanity was viewed increasingly as a condition of immorality. At the same time, proponents of the new "moral management" began to exert an influence on the care of the insane: the insane, in an odd paradox, were at the same time being judged from a seemingly harsh moral standpoint, yet cared for perhaps better than at any other time in

history.

A little later than the mid-nineteenth century, as seen in the first chapter, attitudes toward what caused insanity and how best to treat it again began to change. Within Gartnavel itself, the explaining causes of predisposition to madness and heredity exemplify the moral/emotional and physical arguments of the time. Predisposition was more likely to be given as a cause in roughly the first half of the century, while heredity became more popular as an explaining factor towards the end. Predisposition was a cause strongly tinged with morality--that is, a person disposed to vice and unrestrained living was "predisposed" to madness; once there, these patients could, in effect, cure themselves by a strong will to rebuild their character and change whatever damaging behavior had gotten them there in the first place. (80) Only the madman himself was responsible for his condition and his cure. This was the underlying belief behind the concept of moral management. Then, as discussed earlier, a constellation of events and developments led slowly toward a more physical explanation of insanity, which would lead eventually toward an emphasis on neurological and medical treatments.

The data from Gartnavel certainly reflect these trends, at least in terms of what caused madness. As late in the century as 1870 there is a marked prevalence of such predispositional causes such as general paralysis and

predisposition itself (see table 17), while "heredity" places a measly fifth. In 1880, however (table 18), only ten years later, the percentage of cases due to predisposition and general paralysis drops significantly, and the percentage of cases attributed to heredity increases significantly, second only to unknown causes. Interesting also is the prevalence in 1870 of "Unknown" as a cause; in 1880, the percentage of cases attributed to unknown causes drops dramatically, and there is all of a sudden a much greater number of causes (some a mix of "Predisposition" and "Heredity" with other causes; this could represent a transitional stage from a "moral" to a "physical" framework).

These figures indicate a common trend in the changing ideas concerning what caused insanity found within the 19th century. To explore treatment and to what extent moral management was practiced at Gartnavel another source can be drawn on, namely, the doctors' rounds notes taken from some of the first patients of 1870. These notes were kept by the overseeing physician when he made his rounds, which, according to the notes themselves, were infrequent. Although the subject of symptoms has so far been left out (this information was not included in the admissions register), at this point it may prove interesting to provide them along with the treatments prescribed in order to "flesh out" the picture of the asylum patients already drawn by the admissions data. As mentioned in the

introduction, these cases are in no way definitive because so few are presented. In order to construct an accurate picture more cases would have to be read, and unfortunately, it was not within the realm of this study to do so. Still, they are in many ways representative of many of the patients and do not (upon a brief reading of them) seem to differ substantially from the rest of the asylum population.

Peter O., a 71-year-old widowed dealer suffering from dementia due to "senile decay," was admitted the first of the year as a transfer from the city parish poorhouse in Glasgow. The notes say: "Prior to admission he was in a confused state of mind and unfit to give any rational account of himself. Suddenly became violent and dangerous in the Town's Hospital, assaulting the inmates...On admission he appears to labour under senile dementia--being confused and forgetful, displaying considerable weakness of mind with loss of memory...Feb. 7: Exhibits the same weakness of the mental faculties. Says his memory is too bad to enable him to give much of his past history. Has threatened to strike his neighbors, thinking that they were taking advantage of him." There is no treatment mentioned. He was discharged "Recovered" almost six months later.

Rodger R., admitted two days later, was a 30-year-old laborer, single, suffering from mania. The notes regarding him are as follows: "Prior to admission the symptoms were--staring eyes, flushed face, ceaseless talking of nonsense,

was incoherent and restless. Also had broken windows, and at times struck at any person near him. Had been apprehended by the Police.

"On admission he labours under acute mania, is noisy, incoherent and violent. Bodily health indifferent; tongue furred, eyes suffused. Treatment: rhubarb and Hdg. with creta. Readmitted 18 Jan. Labouring under an attack of acute mania. Treatment same. Discharged cured again."

Rhubarb had been used for centuries in cases of insanity. "Hdg." could stand for mercury, which was widely used for many disorders and later for treating syphilis. (81) "Cret." most likely stands for chalk, in this case a prepared form of chalk, a source of calcium carbonate and used as an antacid and as a treatment for diarrhea. (82) Whatever the concoction was, it was most likely a very traditional treatment designed to purge the body of whatever ailed it (a common method from time immemorial), and did not necessarily represent any kind of "moral treatment." (83)

Isabella M., a 53-year-old domestic servant, was admitted for dementia, cause unknown. "Prior to admission she laboured under peculiar delusions about property. The Inspector of Poor stated that she was subject to periodic attacks of excitement.

"On admission she was free from excitement...Jan. 15: She is very quiet and orderly...Feb. 14: She is very industrious and quiet...appears to be quite happy."

Treatment: None mentioned, except her working in the galleries and foundry, which is much more along the lines of moral treatment. However, she died six years later.

Andrew K. was a 27-year-old clerk suffering from mania from unknown causes. His case: "Prior to admission he was in abject terror of being lost, sent to Hell; protested that he would do anything to be saved; pointed a neighbour as being Satan. Was afraid his wife was going to do him harm, that she was tempting him--was very troublesome and had to be watched.

"On admission he is in great distress and in constant fear of being killed--believed he is lost and delivered up to the 'devil'; is very restless and incessantly asking what is to be done with him. Bodily health very indifferent; tongue furred." Treatment: Blistering of the neck. "Seldom is prevailed upon to take medicine," and what this may be is not given. Blistering was also a traditional treatment and certainly did not constitute moral treatment. He was discharged a year later as "Relieved."

Robert P. was a 42-year-old single bottler suffering from mania due to sunstroke. "Wild maniacal look, incoherent, people conspiring against him to take his life, could not sleep for fear of these persons, very violent, assaulted his sister in a savage manner; excited, irritable, morbidly suspicious, confused, tongue much furred; much quieter, more coherent, dreads being poisoned

or killed, treacherous; tongue cleaner, has had repeated doses of rhubarb and Hdg. with cret.; sleeps generally well but occasionally is noisy; confused and inclined to ramble in conversation, his mind is weak with a much impaired memory, mistakes the identity of others. Relieved (removed to his settlement in England)."

Again, a traditional medicinal treatment is given. There also seems to be no correlation between violent behavior and seemingly harsh treatment (even though such treatment was not seen as harsh): Andrew K., whose neck was blistered, was not violent but suffered from great fear; while Robert P., who was "very violent" and "assaulted his sister in a savage manner" was given medicine. Very often in these cases no treatment at all is mentioned. (84)

It is difficult to determine from these accounts to what extent the Royal Glasgow Asylum practiced moral management. They do suggest, however, a mixture of treatments, from the very traditional preparations of rhubarb and the practice of blistering, to moral management techniques introduced earlier in the century. A continuing reliance on traditional methods also suggests that moral management, in this particular asylum by 1870, had lost much of its charm. Practitioners either went back to using old methods or had never abandoned them in the first place.

In conclusion, the Royal Glasgow Asylum at Gartnavel became home for a wide variety of people in 1870 and 1880,

people who did not fit into the "outside" world mostly because of inexplicable behavior ranging from hallucinations to violence. The definitions of what was acceptable behavior were of course influenced by society, medical developments, the rise of an industrial marketplace, the prevailing philosophies of the day, the attitudes towards women and men and the roles they were supposed to fulfill, and so on. However, at the end of the day, as had been true throughout history, what defined them as mad was in itself indefinable. The concept of insanity, once nebulous, was just so in the 19th century and is so today. Over one hundred years later, psychiatric specialists and scholars alike are still wondering what makes mental illness--an illness that goes beyond the mere physical and "reaches down to the core of the personality"--so elusive a problem to solve. (85) And the insistence of scholars such as Ingleby, Bynum, Scull, Shepherd and Porter that the importance of understanding madness is not always understanding what it is but rather understanding how we react to it, socially and politically, should be heeded, for if the mad will always be with us, we should be prepared to make room at the table for them.

## NOTES

1. See, for example, David Ingleby, ed., *Critical Psychiatry: The Politics of Mental Health* (New York: Pantheon, 1980), 7-8; and L.J. Rather, *Mind and Body in Eighteenth Century Medicine* (Berkeley and Los Angeles: University of California Press, 1965), 1.
2. Roy Porter, *Mind-forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Athlone Press, 1987), 17.
3. Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London: Virago Press, 1987); Ann Douglas Wood, "'The fashionable diseases': Women's complaints and their treatment in nineteenth-century America," in Lois Banner and Mary S. Hartman, eds., *Clio's Consciousness Raised: New Perspectives on the History of Woman* (New York: Harper & Row, 1974), pp. 1-22.
4. See Showalter's book.
5. W.F. Bynum, Roy Porter, and Michael Shepherd, eds., *The Anatomy of Madness: Essays in the History of Psychiatry*, vol. 1 (London: Tavistock, 1985), 4.
6. Francis J. Rice, "Madness and industrial society: A study of the origins and early growth of the organisation of insanity in 19th-century Scotland c. 1830-1870," PhD diss., University of Strathclyde, 1981.

7. Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (London: Routledge, 1989), 123.

8. The history of madness previous to the eighteenth and nineteenth centuries is extremely interesting. Some books pertaining to the subject include: Basil Clarke, *Mental Disorder in Earlier Britain* (Cardiff: University of Wales Press, 1975); George Rosen, *Madness in Society: Chapters in the Historical Sociology of Mental Illness* (Chicago: University of Chicago Press 1968); E.R. Dodds, *The Greeks and the Irrational* (Berkeley and Los Angeles: University of California Press 1951); Bennett Simon, *Mind and Madness in Ancient Greece: The Classical Roots of Modern Psychiatry* (Ithaca and London: Cornell University Press, 1978); T.M. Brown, "Descartes, dualism, and psychosomatic medicine." M.A. Screech, "Good madness in Christendom," and Roy Porter, "'The Hunger of Imagination': Approaching Samuel Johnson's melancholy," in Bynum, Porter, and Shepherd, *Anatomy*; Robert Burton, *The Anatomy of Melancholy*, ed. Joan K. Peters (New York: Frederick Ungar, 1979); and Klaus Doerner, *Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry* (Oxford: Basil Blackwell, 1981).

9. Rosen, *Madness*, 42.

10. *Ibid.*, 63.

11. Standard works that include discussion of reform include Anne Digby, *Madness, Morality, and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge

University Press, 1985); Kathleen Jones, *A History of the Mental Health Services* (London: Routledge & Kegan Paul, 1972); Roy Porter, *Mind-Forg'd Manacles*; Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane; New York: St. Martin's Press, 1979).

12. Refer to Digby's *Madness, Morality, and Medicine* for more on this particular asylum.

13. Samuel Tuke, *A Description of the Retreat* (York: W. Alexander, 1813), 141-4; in Skultans, *Madness and Morals*, 136-38. Italics the author's.

14. Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (New York: Vintage Books, 1988), 206-207.

15. Scull, *Museums of Madness*, 14.

16. See Porter, *Mind-Forg'd Manacles*; Michael MacDonald, *Mystical Bedlam: Madness, Anxiety, and Healing in Seventeenth-Century England* (Cambridge: Cambridge University Press, 1981).

17. See William F. Bynum, Jr., "Rationales for therapy in British psychiatry, 1780-1835," in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981); and Andrew Scull's essay "Dazeland," in *Social Order/Mental Disorder*.

18. Please refer to Porter's and MacDonald's works mentioned above. Charlotte Mackenzie's article, "Women and

psychiatric professionalization, 1780-1914," in The London Feminist History Group, *The Sexual Dynamics of History* (London: Pluto Press, 1983), pp. 107-119, on women running private madhouses concerns this period of "overlap", as does Elaine Showalter's "Victorian Women and Insanity," in Scull, *Madhouses*.

19. Anne Digby, "Moral treatment at the Retreat, 1796-1846," 53.

20. Vieda Skultans, *Madness and Morals: Ideas on Insanity in the Nineteenth Century* (London: Routledge & Kegan Paul, 1975), 2.

21. Jones, *History of the Mental Health Services*, 100.

22. Skultans, *Madness and Morals*, 10. Physical explanations again took precedence over moral/emotional ones in the second part of the century (see page 2). See especially selections under "Causes and Prevalence," where both sides of the argument are presented by practitioners of the time. For more discussion, see also Michael J. Clark, "The rejection of psychological approaches to mental disorder in late nineteenth-century British psychiatry," in Scull, *Madhouses*, 271-312.

23. Scull, *Museums of Madness*, 113-114.

24. Doerner, *Madmen and the Bourgeoisie*, 273-291; Bynum, "Rationales for therapy in British psychiatry, 1780-1835," 35.

25. See Skultans' criticism of Scull's economic model and her own proposition of the influence of the "emerging

- middle classes," in *English Madness: Ideas on Insanity, 1580-1890* (London: Routledge & Kegan Paul, 1979), 10-11.
26. Showalter, *The Female Malady*, 250.
27. Elizabeth Fee, "The sexual politics of Victorian social anthropology," pp. 86-102; Daniel Scott Smith, "Family limitation, sexual control, and domestic feminism in Victorian America," pp. 119-136; Barbara Welter, "The feminization of American religion: 1800-1860," pp. 137-157; in *Clio's Consciousness Raised*.
28. Sara Delamont and Lorna Duffin, eds., *The Nineteenth-Century Woman: Her Cultural and Physical World* (London: Croom Helm, 1978).
29. Martha Vicinus, ed., *Suffer and Be Still: Women in the Victorian Age* (Bloomington, IN: Indiana University Press, 1972).
30. See in particular Leonore Davidoff, "Class and Gender in Victorian England," *Feminist Studies* 5 (1979): 87-141; Carol Dyhouse, *Girls Growing Up in Late Victorian and Edwardian England* (London: Routledge & Kegan Paul, 1981); Deborah Gorham, *The Victorian Girl and the Feminine Ideal* (London: Croom Helm, 1982); and Carroll Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America* (New York: Alfred A. Knopf, 1985).
31. Kate Millett, "The debate over women: Ruskin vs. Mill," in Vicinus, *Suffer and Be Still*, pp. 121-139.
32. *Ibid.*, p. 121.
33. *Ibid.*, p. 123.

34. Ibid., p. 122.
35. See selections from George Man Burrows, John Haslam, John Millar, and Henry Maudsley, in Skultans, *Madness and Morals*, 230-233.
36. Carroll Smith-Rosenberg, "Puberty to menopause: The cycle of femininity in nineteenth-century America," 23-37.
37. J. McGrigor Allan, "On the real differences in the minds of men and women," *Anthropological Review* 7 (1869), p. cscviii; in Delamont and Duffin, *The Nineteenth-Century Woman*, 32.
38. Showalter, *The Female Malady*, 55. For more on women and health, past and present, see Sandra M. Gilbert and Susan Gubar, *The Madwoman in the Attic: The Woman Writer and the Nineteenth-Century Literary Imagination* (New Haven, CN: Yale University Press, 1978); Judith Walzer Leavitt, ed., *Women and Health in America* (Madison and London: University of Wisconsin Press, 1984).
39. Alfred Beaumont Maddock, "The education of women," from *On Mental and Nervous Disorders* (London: Simpkin, Marshall & Co., 1854), 16-17; in Skultans, *Madness and Morals*, 227-230.
40. Wood, "'The fashionable diseases'," 6-7.
41. Smith-Rosenberg, "Puberty to menopause," 33-34.
42. See Regina Morantz, "The lady and her physician," in Banner and Hartman, *Clio's Consciousness Raised*, 38-53, for cases of cauterization of male genitalia; and Scull's discussion of medical practice in "Dazeland," in *Social*

*Order/Mental Disorder*, pp. 267-279.

43. See Mackenzie, "Women and psychiatric professionalization, 1780-1914."

44. Showalter, *The Female Malady*, 28. See also Scull, "Dazeland," in *Social Order/Mental Disorder*, for a critique of her book.

45. *Ibid.*, 52.

46. *Ibid.*, Introduction, especially 10-11; 29.

47. *Ibid.*, 17. It has been taken for granted for years that women outnumbered men in asylums. Andrew Scull has argued that the difference amounted to "no more than a few percent." See Scull, "Dazeland," in *Social Order/Mental Disorder*, 270-271. See also the findings of this study.

48. Showalter, *The Female Malady*, 250.

49. Scull, "Dazeland," in *Social Order/Mental Disorder*, 270-271.

50. For more on this tendency for "fringe" groups influencing group differences see chapter 5, "Criminals and victims: The crucial importance of gender," in Eric A. Johnson, *Urbanization and Crime: Germany, 1871-1914* (Cambridge and New York: Cambridge University Press, 1994).

51. Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick: Rutgers University Press, 1987), 98-102.

52. *Ibid.*, 146-147.

53. Rice, "Madness and industrial society," 224-225.

54. *Ibid.*, 239.

55. Ibid., 237-238; see also Mackenzie, "Women and psychiatric professionalization, 1780-1914."
56. Rice, "Madness and industrial society," 241.
57. Ibid., 202.
58. Ibid., 207.
59. Ibid., 246.
60. Ibid., 242.
61. Ibid., 246.
62. Ibid., 224-225, 245-246.
63. Dwyer, *Homes for the Mad*, 105-106.
64. Ibid., 5.
65. See Michael Flinn, ed., *Scottish Population History* (Cambridge: Cambridge University Press, 1977), 356, Table 5.4.6. There are some problems with comparing my illiteracy figures with Flinn's. First, Flinn's figures vary widely from district to district, from 4.75 (male) and 7.54 (female) in Roxburgh, Dumfries, Kirkcudbright, and Wigtown (Southern district) to 31.61 (male) and 49.12 (female) in Ross and Inverness (North-Western district). Second, it's not clear how he defines illiteracy; I have defined it as not being able to read or write. Third, my rate reflects Glasgow and its immediate environs, whereas his rates reflect whole districts. However, it can be stated that the asylum illiteracy rate does not exceed Flinn's rate for Renfrew, Ayr, and Lanark (South-Western district).
66. Simon, *Mind and Madness*, 216, 220.

67. Showalter, *The Female Malady*, 26.
68. See Randolph E. Bergstrom and Eric A. Johnson, "The female victim: Homicide and women in Imperial Germany," in John C. Fout, ed., *German Women in the Nineteenth Century: A Social History* (New York: Holmes & Meier, 1984), 345-367, for findings that suggest men were more likely to be criminals and women victims. This could apply to Scotland as well, although I know of no such similar study.
69. Showalter, *The Female Malady*, 111; Richard Hunter and Ida Macalpine, eds., *Three Hundred Years of Psychiatry, 1535-1860* (London: Oxford University Press, 1963), 1052.
70. William Willis Moseley, "Predisposing and exciting causes of insanity," from *Eleven Chapters on Nervous and Mental Complaints* (London: Simpkin, Marshall & Co., 1838); in Vieda Skultans, *Madness and Morals*, 45-46.
71. See also J.R. Reynolds, "Epilepsy: Its symptoms, treatment, and relation to other chronic convulsive diseases," in Hunter and Macalpine, *Three Hundred Years*, 1044-1048.
72. Dwyer, *Homes for the Mad*, 92, 101, Figure 4.5.
73. Olive and Sydney Checkland, *Industry and Ethos: Scotland, 1832-1914* (Edinburgh: Edinburgh University Press, 1984), 200-205. See J.H. Treble, "The standard of living of the working class," in T.M. Devine and Rosalind Mitchison, eds., *People and Society in Scotland*, vol. 1 (Edinburgh: John Donald Publishers, 1988), for a discussion on the low standard of living in Scotland.

74. Dwyer, *Homes for the Mad*, 6.
75. *Ibid.*, 103-104.
76. *Ibid.*, p. 108.
77. *Ibid.*, 107-108.
78. Refer to footnote 8 for a brief bibliography.
79. William F. Bynum, Jr., "Rationales for therapy in British psychiatry, 1780-1835," 36.
80. Skultans, *Madness and Morals*, 1-28.
81. Hunter and Macalpine, *Three Hundred Years*, 1052; for the fruitlessness of using mercury in cases of hysteria see also Walter Johnson, *An Essay on the Diseases of Young Women* (London: Simpkin, 1849), *ibid.*, 971.
82. *Webster's Medical Desk Dictionary*, 1986 ed., s.v. "creta."
83. Austin, *A Practical Account*, in Hunter and Macalpine, *Three Hundred Years*, 1052; for "moral treatment" as nonmedicinal, see Bynum, "Rationales for therapy in British psychiatry, 1780-1835," 37.
84. Bynum, "Rationales for therapy in British psychiatry, 1780-1835," 38; see Bryan Crowther, "Bleeding," "Purging," and "Vomits," from *Practical Remarks on Insanity* (London: Underwood, 1811); John Haslam, "The therapeutic value of confinement," and "Restraint," from *Considerations on the Moral Management of Insane Persons* (London: R. Hunter, 1817); and George Man Burrows, "Gyration and swinging," "Blistering," and "Separation and seclusion," from *Commentaries on Insanity* (London: Underwood, 1828); in

Skultans, *Madness and Morals*, 98-128. These were all common treatments for insanity, although, increasingly, "indiscriminate" use was to be avoided, as Burrows states in "Blistering" on page 188. These treatments had in the past not been viewed as cruel and inhuman, but as tried and traditional medical practices; a doctor practicing such methods was not necessarily a monster, but a medical man practicing his profession.

85. Ingleby, *Critical Psychiatry*, 7; Bynum, Porter, and Shepherd, *Anatomy*, 1-2.

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TABLE 1  
POPULATION FREQUENCIES  
(Glasgow Royal Asylum, 1870, 1880)

	% of total pop. (#)	% of women (#)	% of men (#)
<b>Patient admission history</b>			
Never admitted	77.3 (333)	77.4 (164)	77.2 (169)
Previously admitted/transfer	19.5 (84)	20.8 (44)	18.3 (40)
Transfer from Sheriff/prison	3.2 (14)	1.9 (4)	4.6 (10)
<b>Age</b>			
14-19	6.0 (26)	8.5 (18)	3.7 (8)
20-29	28.5 (123)	26.4 (56)	30.6 (67)
30-39	26.5 (114)	25.0 (53)	27.9 (61)
40-49	19.5 (84)	20.3 (43)	18.7 (41)
50-59	9.3 (40)	11.8 (25)	6.8 (15)
60-69	3.7 (16)	3.8 (8)	3.7 (8)
70+	1.9 (8)	1.9 (4)	1.8 (4)
<b>Sex</b>			
Female	49.2 (212)		
Male	50.8 (219)		
<b>Asylum class</b>			
Pauper	63.6 (274)	60.8 (129)	66.2 (145)
Private	36.4 (157)	39.2 (83)	33.8 (74)
<b>Marital status</b>			
Single	49.7 (214)	51.4 (109)	47.9 (105)
Married	37.1 (160)	36.8 (78)	37.4 (82)
Widowed	9.7 (42)	10.8 (23)	8.7 (19)
<b>Occupation</b>			
Unskilled	25.8 (111)	35.8 (76)	16.0 (35)
Semi-skilled	16.0 (69)	15.6 (33)	16.4 (36)
Skilled	15.3 (66)	5.2 (11)	25.1 (55)

## (FREQUENCIES CONT'D)

	% of total pop. (#)	% of women (#)	% of men (#)
<b>Occupation (cont'd)</b>			
Lower middle class	8.6 (37)	2.4 (5)	14.6 (32)
Middle class	7.0 (30)	.5 (1)	13.2 (29)
Wives	8.4 (36)	16.5 (36)	
Women at home	1.6 (7)	3.3 (7)	
Female, no occupation	8.4 (36)	17.0 (36)	
Male, no occupation	6.3 (27)		9.1 (20)
Other	.9 (4)	.5 (1)	1.4 (3)
<b>Bodily condition</b>			
Spare/reduced	49.7 (214)	49.1 (104)	50.2 (110)
Ordinary	38.3 (165)	37.7 (80)	38.8 (85)
Good	11.4 (49)	12.3 (26)	10.5 (23)
<b>Mental disorder</b>			
Imbecility	1.2 (5)	1.4 (3)	.9 (2)
Amentia	.5 (2)	.9 (2)	
Dementia	23.7 (102)	22.6 (48)	24.7 (54)
Mania	53.8 (232)	52.8 (112)	54.8 (120)
Monomania	10.0 (43)	8.5 (18)	11.4 (25)
Melancholia	10.9 (47)	13.7 (29)	8.2 (18)
<b>Cause (top eleven)</b>			
Unknown	35.7 (154)	36.8 (78)	34.7 (76)
Predisposition from previous attacks	12.1 (52)	17.0 (36)	7.3 (16)
Hereditary	8.1 (35)	9.4 (20)	6.8 (15)
General paralysis	6.3 (27)	3.3 (7)	9.1 (20)
Intemperance	6.0 (26)	3.8 (8)	8.2 (18)
Epilepsy	3.9 (17)	.5 (1)	7.3 (16)
Illness	2.8 (12)	2.4 (5)	3.2 (7)
Childbirth	2.3 (10)	4.7 (10)	
Work anxiety	1.9 (8)	.9 (2)	2.7 (6)

## (FREQUENCIES CONT'D)

	% of total pop. (#)	% of women (#)	% of men (#)
<b>Cause (cont'd)</b>			
Emotional stress	1.6 (7)	2.4 (5)	.9 (2)
Masturbation	1.6 (7)	.5 (1)	2.7 (6)
<b>Duration of attack before admission</b>			
Brief	45.9 (198)	45.8 (97)	46.1 (101)
Moderate	17.9 (77)	19.8 (42)	16.0 (35)
Lengthy	15.3 (66)	16.5 (35)	14.2 (31)
Longstanding	7.2 (31)	8.5 (18)	5.9 (13)
From birth	.2 (1)	.5 (1)	
<b>Education</b>			
Neither reads nor writes	13.0 (56)	7.5 (16)	18.3 (40)
Reads only	17.2 (74)	28.3 (60)	6.4 (14)
Reads and writes	37.4 (161)	40.1 (85)	34.7 (76)
Good education	30.4 (131)	19.8 (42)	40.6 (89)
<b>Religion</b>			
Protestant	81.9 (353)	88.7 (188)	75.3 (165)
Catholic	11.4 (49)	8.0 (17)	14.6 (32)
Other	1.6 (7)	.9 (2)	2.3 (5)
<b>Epileptic</b>			
No or unknown	91.4 (394)	95.3 (202)	87.7 (192)
Yes	5.1 (22)	3.8 (8)	6.4 (14)
<b>Suicidal and/or dangerous</b>			
Neither or unknown	44.5 (192)	47.2 (100)	42.0 (92)
Suicidal	12.5 (54)	15.6 (33)	9.6 (21)
Dangerous	27.8 (120)	23.1 (49)	32.4 (71)
Both	11.4 (49)	12.3 (26)	10.5 (23)

## (FREQUENCIES CONT'D)

	% of total pop. (#)	% of women (#)	% of men (#)
<b>Doctors' category</b>			
Idiot	.2 (1)	.5 (1)	
Person of unsound mind	61.5 (265)	63.7 (135)	59.4 (130)
Insane person	4.6 (20)	6.1 (13)	3.2 (7)
Lunatic	7.0 (30)	6.6 (14)	7.3 (16)
Lunatic/person of unsound mind	14.4 (62)	10.8 (23)	17.8 (39)
Insane person/person of unsound mind	5.3 (23)	7.5 (16)	3.2 (7)
Insane person/lunatic	.9 (4)	1.9 (4)	
<b>Insanity in family</b>			
No or unknown	83.3 (359)	83.5 (177)	83.1 (182)
Yes	13.2 (57)	15.1 (32)	11.4 (25)
<b>Family members living</b>			
No or unknown	12.1 (52)	9.4 (20)	14.6 (32)
Yes	84.5 (364)	89.2 (189)	79.9 (175)
<b>Duration of stay</b>			
1-14 days	3.5 (15)	2.4 (5)	4.6 (10)
2 weeks-1 month	9.5 (41)	10.4 (22)	8.7 (19)
1-3 months	25.1 (108)	26.4 (56)	23.7 (52)
3 months-1 year	33.2 (143)	34.9 (74)	31.5 (69)
1-3 years	16.7 (72)	16.5 (35)	16.9 (37)
3-10 years	7.2 (31)	5.2 (11)	9.1 (20)
Over 10 years	4.6 (20)	4.2 (9)	5.0 (11)
<b>Exit reason</b>			
Relieved	34.8 (150)	37.3 (79)	32.4 (71)
Recovered	41.8 (180)	42.0 (89)	41.6 (91)
Dead	22.5 (97)	20.3 (43)	24.7 (54)

TABLE 2  
COMPARISON OF WOMEN AND MEN  
(in percentages)

	% of variable was WOMEN (#)	% of variable was MEN (#)
<b>Patient admission history</b>		
Never admitted	49.2 (164)	50.8 (169)
Previously admitted/transfer	52.4 (44)	47.6 (40)
Transfer from Sheriff/prison	28.6 (4)	71.4 (10)
<b>Duration of attack before admission</b>		
Brief	49.0 (97)	51.0 (101)
Moderate	54.5 (42)	45.5 (35)
Lengthy	53.0 (35)	47.0 (31)
Longstanding	58.1 (18)	42.0 (13)
From birth	100.0 (1)	--
<b>Age</b>		
14-19	69.2 (18)	30.8 (8)
20-29	45.5 (56)	54.5 (67)
30-39	46.5 (53)	53.5 (61)
40-49	51.2 (43)	48.8 (41)
50-59	62.5 (25)	37.5 (15)
60-69	50.0 (8)	50.0 (8)
70+	50.0 (4)	50.0 (4)
<b>Asylum class</b>		
Pauper	47.1 (129)	53.0 (145)
Private	52.9 (83)	47.1 (74)
<b>Marital status</b>		
Single	50.9 (109)	49.1 (105)
Married	48.8 (78)	51.3 (82)
Widowed	54.8 (23)	45.2 (19)
<b>Occupation</b>		
Unskilled	68.5 (76)	31.5 (35)

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## (COMPARISON OF WOMEN AND MEN CONT'D)

	% WOMEN (#)	% MEN (#)
<b>Occupation (cont'd)</b>		
Semi-skilled	47.8 (33)	52.2 (36)
Skilled	16.7 (11)	83.0 (55)
Lower middle class	13.5 (5)	86.5 (32)
Middle class	3.0 (1)	96.7 (29)
Wives	100.0 (36)	
Women at home	100.0 (7)	
Female, no occupation	100.0 (36)	
Male, no occupation		100.0 (27)
Other	25.0 (1)	75.0 (3)
<b>Bodily condition</b>		
Spare/reduced	48.6 (104)	51.4 (110)
Ordinary	48.5 (80)	51.2 (85)
Good	53.1 (26)	47.0 (23)
<b>Mental disorder</b>		
Imbecility	60.0 (3)	40.0 (2)
Amentia	100.0 (2)	
Dementia	47.1 (48)	53.0 (54)
Mania	48.3 (112)	52.0 (120)
Monomania	42.0 (18)	58.0 (25)
Melancholia	62.0 (29)	38.3 (18)
<b>Cause (top eleven)</b>		
Unknown	50.6 (78)	49.4 (76)
Predisposition from previous attacks	69.2 (16)	30.8 (16)
Hereditary	57.0 (20)	43.0 (15)
General paralysis	26.0 (7)	74.1 (20)
Intemperance	30.8 (8)	69.2 (18)
Epilepsy	5.9 (1)	94.1 (16)
Illness	41.7 (5)	58.3 (7)
Childbirth	100.0 (10)	

## (COMPARISON OF WOMEN AND MEN CONT'D)

	% WOMEN (#)		% MEN (#)	
Cause (cont'd)				
Work anxiety	25.0	(2)	75.0	(6)
Emotional stress	71.4	(5)	28.6	(2)
Masturbation	14.3	(1)	85.7	(6)
Education				
Neither reads nor writes	28.6	(16)	71.4	(40)
Reads only	81.1	(60)	18.9	(14)
Reads and writes	52.8	(85)	47.2	(76)
Good education	32.1	(42)	68.0	(89)
Religion				
Protestant	53.3	(188)	46.7	(165)
Catholic	34.7	(17)	65.3	(32)
Other	28.6	(2)	71.4	(5)
Epileptic				
No or unknown	51.3	(202)	48.7	(192)
Yes	36.4	(8)	63.6	(14)
Suicidal and/or dangerous				
Neither or unknown	52.1	(100)	47.9	(92)
Suicidal	61.0	(33)	39.0	(21)
Dangerous	40.1	(49)	59.2	(71)
Both	53.1	(26)	46.9	(23)
Doctors' category				
Idiot	100.0	(1)	--	
Person of unsound mind	50.9	(135)	49.1	(130)
Insane person	65.0	(13)	35.0	(7)
Lunatic	47.0	(14)	53.0	(16)
Lunatic/person of unsound mind	37.1	(23)	63.0	(39)
Insane person/person of unsound mind	69.6	(16)	30.4	(7)
Insane person/lunatic	100.0	(4)	--	

## (COMPARISON OF WOMEN AND MEN CONT'D)

	% WOMEN (#)	% MEN (#)
Insanity in family		
No or unknown	49.3 (177)	50.7 (182)
Yes	56.1 (32)	43.9 (25)
Family members living		
No or unknown	38.5 (20)	61.5 (32)
Yes	51.9 (189)	48.1 (175)
Duration of stay		
1-14 days	33.0 (5)	67.0 (10)
2 weeks-1 month	53.7 (22)	46.3 (19)
1-3 months	51.9 (56)	48.1 (52)
3 months-1 year	51.7 (74)	48.3 (69)
1-3 years	48.6 (35)	51.4 (37)
3-10 years	35.5 (11)	64.5 (20)
Over 10 years	45.0 (9)	55.0 (11)
Exit reason		
Relieved	53.0 (79)	47.0 (71)
Recovered	49.4 (89)	50.6 (91)
Dead	44.3 (43)	55.7 (54)

TABLE 3  
 FREQUENCIES FOR WOMEN AND MEN  
 Ages 14-19 and 50-59

	% women 14-19 (#)	% women 50-59 (#)	% men 14-19 (#)	% men 50-59 (#)
<b>Patient admission history</b>				
Never admitted	77.8 (14)	64.0 (16)	100.0 (8)	73.3 (11)
Previously admitted/transfer	22.2 (4)	36.0 (9)	--	26.7 (4)
Transfer from Sheriff/prison	--	--	--	--
<b>Duration of attack before admission</b>				
Brief	66.7 (12)	12.0 (3)	37.5 (3)	73.3 (11)
Moderate	22.2 (4)	20.0 (5)	37.5 (3)	6.7 (1)
Lengthy	5.6 (1)	24.0 (6)	--	13.3 (2)
Longstanding	--	28.0 (7)	--	--
From birth	--	--	--	--
<b>Asylum class</b>				
Pauper	77.8 (14)	32.0 (8)	100.0 (8)	73.3 (11)
Private	22.2 (4)	68.0 (17)	--	26.7 (4)
<b>Marital status</b>				
Single	100.0 (18)	32.0 (8)	100.0 (8)	20.0 (3)
Married	--	24.0 (6)	--	33.3 (5)
Widowed	--	44.0 (11)	--	46.7 (7)
<b>Occupation</b>				
Unskilled	44.4 (8)	32.0 (8)	12.5 (1)	26.7 (4)
Semi-skilled	27.8 (5)	4.0 (1)	25.0 (2)	26.7 (4)
Skilled	--	8.0 (2)	50.0 (4)	26.7 (4)
Lower middle class	--	--	--	6.7 (1)
Middle class	--	--	--	13.3 (2)
Wives	--	16.0 (4)	--	--
Women at home	5.6 (1)	8.0 (2)	--	--
Female, no occupation	22.2 (4)	32.0 (8)	--	--
Male, no occupation	--	--	--	--
Other	--	--	12.5 (1)	--

## (FREQUENCIES AGES 14-19 AND 50-59 CONT'D)

	% women 14-19 (#)		% women 50-59 (#)		% men 14-19 (#)		% men 50-59 (#)	
<b>Bodily condition</b>								
Spare/reduced	38.9	(7)	48.0	(12)	50.0	(4)	66.7	(10)
Ordinary	38.9	(7)	36.0	(9)	50.0	(4)	20.0	(3)
Good	22.2	(4)	16.0	(4)	--		13.3	(2)
<b>Mental disorder</b>								
Imbecility	5.6	(1)	--		--		--	
Amentia	5.6	(1)	--		--		--	
Dementia	16.7	(3)	24.0	(6)	--		33.3	(5)
Mania	66.7	(12)	52.0	(13)	100.0	(8)	26.7	(4)
Monomania	--		12.0	(3)	--		20.0	(3)
Melancholia	5.6	(1)	12.0	(3)	--		20.0	(3)
<b>Cause</b>								
Unknown	33.3	(6)	36.0	(9)	75.0	(6)	33.3	(5)
Predisposition from p. attacks	22.2	(4)	8.0	(2)	--		20.0	(3)
Hereditary	11.1	(2)	8.0	(2)	--		6.7	(1)
General paralysis	--		4.0	(1)	--		13.3	(2)
Intemperance	--		12.0	(3)	--		13.3	(2)
Epilepsy	--		--		--		--	
Illness	--		4.0	(1)	--		--	
Childbirth	5.6	(1)	--		--		--	
Work anxiety	--		4.0	(1)	--		6.7	(1)
Emotional stress	--		4.0	(1)	--		--	
Masturbation	--		--		12.5	(1)	--	
Congenital	11.1	(2)	--		--		--	
Fright	5.6	(1)	--		12.5	(1)	--	
Menstruation	5.6	(1)	--		--		--	
Puberty	5.6	(1)	--		--		--	
Sorrow	--		4.0	(1)	--		--	
Change of life	--		8.0	(2)	--		--	
Unemployment	--		4.0	(1)	--		--	
Predisposition and hereditary	--		4.0	(1)	--		--	
Hereditary and anxiety	--		--		--		6.7	(1)

## (FREQUENCIES AGES 14-19 AND 50-59 CONT'D)

	% women 14-19 (#)	% women 50-59 (#)	% men 14-19 (#)	% men 50-59 (#)
<b>Education</b>				
Neither reads nor writes	22.2 (4)	4.0 (1)	12.5 (1)	26.7 (4)
Reads only	33.3 (6)	28.0 (7)	12.5 (1)	13.3 (2)
Reads and writes	16.7 (3)	36.0 (9)	62.5 (5)	33.3 (5)
Good education	22.2 (4)	32.0 (8)	12.5 (1)	26.7 (4)
<b>Suicidal/dangerous</b>				
Neither/unknown	44.4 (8)	56.0 (14)	37.5 (3)	26.7 (4)
Suicidal	5.6 (1)	20.0 (5)	--	20.0 (3)
Dangerous	44.4 (8)	8.0 (2)	62.5 (5)	53.3 (8)
Both	5.6 (1)	16.0 (4)	--	--
<b>Doctors' category</b>				
Idiot	--	--	--	--
Person of unsound mind	44.4 (8)	72.0 (18)	62.5 (5)	66.7 (10)
Insane person	16.7 (3)	4.0 (1)	--	6.7 (1)
Lunatic	16.7 (3)	--	--	6.7 (1)
Lunatic/person of unsound mind	22.2 (4)	8.0 (2)	25.0 (2)	20.0 (3)
Insane person/person of un. mind	--	12.0 (3)	--	--
Insane person/lunatic	--	--	--	--
<b>Duration of stay</b>				
1-14 days	--	4.0 (1)	--	--
2 weeks-1 month	5.6 (1)	8.0 (2)	12.5 (1)	6.7 (1)
1-3 months	16.7 (3)	40.0 (10)	25.0 (2)	33.3 (5)
3 months-1 year	50.0 (9)	12.0 (3)	50.0 (4)	40.0 (6)
1-3 years	16.7 (3)	16.0 (4)	12.5 (1)	13.3 (2)
3-10 years	5.6 (1)	8.0 (2)	--	6.7 (1)
Over 10 years	5.6 (1)	12.0 (3)	--	--
<b>Exit reason</b>				
Relieved	33.3 (6)	32.0 (8)	37.5 (3)	26.7 (4)
Recovered	50.0 (9)	44.0 (11)	62.5 (5)	46.7 (7)
Dead	16.7 (3)	24.0 (6)	--	26.7 (4)

TABLE 4  
 COMPARISON OF OCCUPATION AND ASYLUM CLASS  
 (Total population in actual numbers)

	<u>Pauper</u>	<u>Private</u>	<u>Row total</u>
Unskilled	94	17	111
Semi-skilled	68	1	69
Skilled	52	14	66
Lower middle class	9	28	37
Middle class	--	30	30
Wives	21	15	36
Women at home	--	7	7
Female, no occupation	4	32	36
Male, no occupation	20	7	27
Other	1	3	4
Column total:	269	154	423

TABLE 5

COMPARISON OF DOCTORS' CATEGORY AND SUICIDAL/DANGEROUS  
(Total population in actual numbers)

	<u>Neither/ unknown</u>	<u>Suicidal</u>	<u>Dangerous</u>	<u>Both</u>	<u>Row total</u>
Idiot	--	--	1	--	1
Person of unsound mind	123	39	73	30	265
Insane person	9	3	6	2	20
Lunatic	16	1	10	3	30
Lunatic/person of unsound mind	30	3	22	7	62
Insane person/person of unsound mind	7	6	6	4	23
Insane person/lunatic	1	--	2	1	4
Column total:	186	52	120	47	405

TABLE 6

COMPARISON OF DURATION OF ATTACK AND ASYLUM CLASS  
 (Women and men aged 50-59 in actual numbers)

	WOMEN		MEN	
	<u>Pauper</u>	<u>Private</u>	<u>Pauper</u>	<u>Private</u>
Brief (less than one week)	2	1	10	1
Moderate (one week to one month)	--	5	1	--
Lengthy (one month to one year)	1	5	--	2
Longstanding (over one year)	1	6	--	--
Column total:	4	17	11	3

TABLE 7

COMPARISON OF OCCUPATION AND MARITAL STATUS  
(Women and men aged 50-59 in actual numbers)

	WOMEN			Row total	MEN			Row total
	Single	Married	Widowed		Single	Married	Widowed	
Unskilled	2	1	5	8	2	1	1	4
Semi-skilled	--	1	--	1	--	--	4	4
Skilled	1	--	1	2	1	2	1	4
Lower middle class	--	--	--	--	--	--	1	1
Middle class	--	--	--	--	--	2	--	2
Wives		2	2	4				
Women at home	2	--	--	2				
Female, no occupation	3	2	3	8				
Column total:	8	6	11	25	3	5	7	15

Note: Neither "male, no occupation" nor "other" was listed.

TABLE 8

COMPARISON OF OCCUPATION AND MARITAL STATUS  
 (Women and men from total population in actual numbers)

	WOMEN			Row total	MEN			Row total
	Single	Married	Widowed		Single	Married	Widowed	
Unskilled	44	24	8	76	21	11	3	35
Semi-skilled	24	7	2	33	14	17	5	36
Skilled	8	1	2	11	26	26	2	54
Lower middle class	3	2	--	5	21	8	3	32
Middle class	--	--	1	1	11	14	4	29
Wives	--	31	4	35				
Women at home	4	3	--	7				
Column total:	109	78	23	210	103	77	18	198

Note: "Female, no occupation," "male, no occupation," and "other" have been left out.

TABLE 9

COMPARISON OF MENTAL DISORDER AND SUICIDAL/DANGEROUS  
(Total population, women and men in actual numbers)

	TOTAL POP.				Row total	WOMEN				Row total	MEN				Row total
	N/U	S	D	B		N/U	S	D	B		N/U	S	D	B	
Imbecility	2	--	2	1	5	1	--	1	1	3	1	--	1	--	2
Amentia	--	--	2	--	2	--	--	2	--	2					
Dementia	61	9	19	10	99	34	6	4	4	48	27	3	15	6	51
Mania	95	15	84	31	225	47	10	37	16	110	48	5	47	15	115
Monomania	19	7	10	1	37	8	4	3	1	16	11	3	7	--	21
Melancholia	15	23	3	6	47	10	13	2	4	29	5	10	1	2	18
Column total:	192	54	120	49	415	100	33	49	26	208	92	21	71	23	207

Note: "N/U"=neither/unknown; "S"=suicidal; "D"=dangerous; "B"=both.

TABLE 10

COMPARISON OF DURATION OF ATTACK AND SEX  
(total population in actual numbers)

	<u>Female</u>	<u>Male</u>	Row total
Brief (less than one week)	97	101	198
Moderate (one week to one month)	42	35	77
Lengthy (one month to one year)	35	31	66
Longstanding (over one year)	18	13	31
From birth	1	--	1
Column total:	193	180	373

TABLE 11

COMPARISON OF DURATION OF ATTACK AND ASYLUM CLASS  
 (Women and men admitted due to  
 predisposition from previous attacks in actual numbers)

	PAUPER		Row total	PRIVATE		Row total
	Women	Men		Women	Men	
Brief (less than one week)	19	9	28	3	3	6
Moderate (one week to one month)	3	1	4	3	--	3
Lengthy (one month to one year)	1	--	1	4	--	4
Longstanding (over one year)	--	--	--	1	--	1
Column total:	23	10	33	11	3	14

Note: "From birth" is left out due to lack of cases.

TABLE 12

COMPARISON OF AGE AND MARITAL STATUS  
 (Women and men admitted due to  
 predisposition from previous attacks in actual numbers)

	WOMEN			Row total	MEN			Row total
	Single	Married	Widowed		Single	Married	Widowed	
14-19	4	--	--	4	--	--	--	--
20-29	6	1	--	7	6	--	--	6
30-39	5	4	1	10	2	2	--	4
40-49	3	6	1	10	1	1	1	3
50-59	--	--	2	2	--	1	2	3
Column total:	18	11	4	33	9	4	3	16

Note: Other ages are left out due to lack of cases.

TABLE 13

COMPARISON OF WOMEN AND MEN ADMITTED DUE TO INTEMPERANCE  
(Frequencies in percentages)

	WOMEN (#)	MEN (#)
<b>Patient admission history</b>		
Never admitted	75.0 (6)	66.7 (12)
Previously admitted/ transfer	25.0 (2)	22.2 (4)
Transfer from Sheriff/ prison	--	11.1 (2)
<b>Duration of attack</b>		
Brief	75.0 (6)	66.7 (12)
Moderate	12.5 (1)	11.1 (2)
Lengthy	--	11.1 (2)
Longstanding	--	--
From birth	--	--
<b>Age</b>		
14-19	--	--
20-29	12.5 (1)	22.2 (4)
30-39	12.5 (1)	22.2 (4)
40-49	25.0 (2)	27.8 (5)
50-59	37.5 (3)	11.1 (2)
60-69	--	5.6 (1)
70+	12.5 (1)	--
<b>Asylum class</b>		
Pauper	62.5 (5)	72.2 (13)
Private	37.5 (3)	27.8 (5)
<b>Marital status</b>		
Single	12.5 (1)	27.8 (5)
Married	50.0 (4)	55.6 (10)
Widowed	37.5 (3)	5.6 (1)

## (COMPARISON CONT'D)

	WOMEN (#)	MEN (#)
<b>Occupation</b>		
Unskilled	50.0 (4)	11.1 (2)
Semi-skilled	25.0 (2)	5.6 (1)
Skilled	--	38.9 (7)
Lower middle class	--	33.3 (6)
Middle class	--	--
Wives	12.5 (1)	
Women at home	--	
Female, no occupation	12.5 (1)	
Male, no occupation		11.1 (2)
Other	--	--
<b>Bodily condition</b>		
Spare/reduced	37.5 (3)	33.3 (6)
Ordinary	50.0 (4)	44.4 (8)
Good	12.5 (1)	22.2 (4)
<b>Mental disorder</b>		
Imbecility	--	--
Amentia	--	
Dementia	--	5.6 (1)
Mania	87.5 (7)	94.4 (17)
Monomania	12.5 (1)	--
Melancholia	--	--
<b>Education</b>		
Neither reads nor writes	--	5.6 (1)
Reads only	37.5 (3)	11.1 (2)
Reads and writes	37.5 (3)	38.9 (7)
Good education	25.0 (2)	44.4 (8)

COMPARISON CONT'D)

	WOMEN (#)	MEN (#)
<b>Suicidal/dangerous</b>		
Neither/unknown	12.5 (1)	16.7 (3)
Suicidal	25.0 (2)	5.6 (1)
Dangerous	12.5 (1)	44.4 (8)
Both	50.0 (4)	22.2 (4)
<b>Doctors' category,</b>		
Idiot	--	--
Person of unsound mind	87.5 (7)	50.0 (9)
Insane person	--	11.1 (2)
Lunatic	--	11.1 (2)
Lunatic/person of unsound mind	12.5 (1)	16.7 (3)
Insane person/person of unsound mind	--	--
Insane person/lunatic	--	--
<b>Duration of stay</b>		
1-14 days	--	5.6 (1)
2 weeks-1 month	37.5 (3)	27.8 (5)
1-3 months	25.0 (2)	27.2 (4)
3 months-1 year	12.5 (1)	22.2 (4)
1-3 years	--	22.2 (4)
3-10 years	25.0 (2)	--
Over 10 years	--	--
<b>Exit reason</b>		
Relieved	12.5 (1)	16.7 (3)
Recovered	87.5 (7)	77.8 (14)
Dead	--	5.6 (1)

TABLE 14

COMPARISON OF FEMALE AND MALE EPILEPTICS  
(Frequencies in percentages)

	WOMEN		MEN	
	<u>Epileptic (#)</u>	<u>Cause epilepsy (#)</u>	<u>Epileptic (#)</u>	<u>Cause epilepsy (#)</u>
<b>Patient admission history</b>				
Never admitted	87.5 (7)	100 (1)	57.1 (8)	62.5 (10)
Previously adm./transfer	--		42.9 (6)	37.5 (6)
Transfer from Sheriff/pris.	12.5 (1)		--	--
<b>Duration of attack</b>				
Brief	25.0 (2)	100 (1)	35.7 (5)	37.5 (6)
Moderate	37.5 (3)		7.1 (1)	12.5 (2)
Lengthy	--		21.4 (3)	12.5 (2)
Longstanding	12.5 (1)		14.3 (2)	12.5 (2)
From birth	12.5 (1)		--	--
<b>Age</b>				
14-19	12.5 (1)		--	--
20-29	25.0 (2)		28.6 (4)	31.3 (5)
30-39	25.0 (2)	100 (1)	57.1 (8)	37.5 (6)
40-49	25.0 (2)		14.3 (2)	18.8 (3)
50-59	--		--	--
60-69	--		--	6.3 (1)
70+	--		--	--
<b>Asylum class</b>				
Pauper	75.0 (6)	100 (1)	85.7 (12)	93.8 (15)
Private	25.0 (2)		14.3 (2)	6.3 (1)
<b>Marital status</b>				
Single	37.5 (3)		42.9 (6)	37.5 (6)
Married	62.5 (5)	100 (1)	57.1 (8)	43.8 (7)
Widowed	--		--	12.5 (2)

## (COMPARISON CONT'D)

	WOMEN		MEN	
	<u>Epileptic (#)</u>	<u>Cause epilepsy (#)</u>	<u>Epileptic (#)</u>	<u>Cause epilepsy (#)</u>
<b>Occupation</b>				
Unskilled	50.0 (4)		14.3 (2)	18.8 (3)
Semi-skilled	--		42.9 (6)	37.5 (6)
Skilled	--		14.3 (2)	25.0 (4)
Lower middle	--		7.1 (1)	6.3 (1)
Middle class	--		7.1 (1)	--
Wives	25.0 (2)	100.0 (1)		
Women at home	--			
Female, no occ.	12.5 (1)			
Male, no occ.			7.1 (1)	--
Other	--		--	--
<b>Bodily condition</b>				
Spare/reduced	37.5 (3)		28.6 (4)	37.5 (6)
Ordinary	25.0 (2)		57.1 (8)	56.3 (9)
Good	37.5 (3)	100.0 (1)	14.3 (2)	6.3 (1)
<b>Mental disorder</b>				
Imbecility	--		7.1 (1)	--
Amentia	12.5 (1)			
Dementia	37.5 (3)		50.0 (7)	43.8 (7)
Mania	50.0 (4)	100.0 (1)	42.9 (6)	50.0 (8)
Monomania	--		--	6.3 (1)
Melancholia	--		--	--
<b>Cause (for those listed as epileptics)</b>				
Unknown	7.1 (1)		--	
Predisposition	--		--	
Hereditary	--		12.5 (1)	
General paralysis	14.3 (2)		12.5 (1)	
Intemperance	--		12.5 (1)	
Epilepsy	64.3 (9)		12.5 (1)	
Illness	--			

	WOMEN		MEN	
	<u>Epileptic (#)</u>	<u>Cause epilepsy (#)</u>	<u>Epileptic (#)</u>	<u>Cause epilepsy (#)</u>
Childbirth	--		--	
Work anxiety	--		--	
Emotional stress	--		--	
Masturbation	--		--	
Congenital	7.1 (1)		12.5 (1)	
Epilepsy/drink	7.1 (1)		--	
Disease at birth	--		12.5 (1)	
Fright	--		25.0 (2)	
<b>Education</b>				
Neither reads "				
nor writes	25.0 (2)		35.7 (5)	18.8 (3)
Reads only	25.0 (2)	100.0 (1)	--	12.5 (2)
Reads and writes	25.0 (2)		28.6 (4)	31.3 (5)
Good education	12.5 (1)		35.7 (5)	37.5 (6)
<b>Suicidal/dangerous</b>				
Neither/unknown	37.5 (3)		50.0 (7)	50.0 (8)
Suicidal	37.5 (3)	100.0 (1)	--	6.3 (1)
Dangerous	12.5 (1)		35.7 (5)	31.3 (5)
Both	--		14.3 (2)	6.3 (2)
<b>Doctors' category</b>				
Idiot	12.5 (1)		--	--
Person of				
unsound mind	62.5 (5)	100.0 (1)	71.4 (10)	43.8 (7)
Insane person	--		7.1 (1)	12.5 (2)
Lunatic	12.5 (1)		14.3 (2)	12.5 (2)
Lunatic/person of				
unsound mind	--		--	18.8 (3)
Insane person/				
person of				
unsound mind	--		7.1 (1)	6.3 (1)
Insane person/				

## (COMPARISON CONT'D)

	WOMEN		MEN	
	<u>Epileptic (#)</u>	<u>Cause epilepsy (#)</u>	<u>Epileptic (#)</u>	<u>Cause epilepsy (#)</u>
<b>Duration of stay</b>				
1-14 days	--		14.3 (2)	6.3 (1)
2 weeks-				
1 month	12.5 (1)		--	6.3 (1)
1-3 months	12.5 (1)		42.9 (6)	43.8 (7)
3 months-				
1 year	25.0 (2)	100.0 (1)	7.1 (1)	6.3 (1)
1-3 years	50.0 (4)		7.1 (1)	18.8 (3)
3-10 years	--		--	6.3 (1)
Over 10 years	--		21.4 (3)	6.3 (1)
<b>Exit reason</b>				
Relieved	25.0 (2)		21.4 (3)	31.3 (5)
Recovered	37.5 (3)	100.0 (1)	28.6 (4)	25.0 (4)
Dead	37.5 (3)		42.9 (6)	37.5 (6)

TABLE 15

COMPARISON OF WOMEN AND MEN WHO DIED  
(Frequencies in percentages)

	WOMEN (#)	MEN (#)
<b>Patient admission history</b>		
Never admitted	83.7 (36)	81.5 (44)
Previously admitted/transfer	16.3 (7)	14.8 (8)
Transfer from Sheriff/prison	--	3.7 (2)
<b>Duration of attack before admission</b>		
Brief	32.6 (14)	46.3 (25)
Moderate	30.2 (13)	14.8 (8)
Lengthy	14.0 (6)	9.3 (5)
Longstanding	16.3 (7)	11.1 (6)
From birth	--	--
<b>Age</b>		
14-19	7.0 (3)	--
20-29	14.0 (6)	16.7 (9)
30-39	25.6 (11)	29.6 (16)
40-49	27.0 (12)	31.5 (17)
50-59	14.0 (6)	7.4 (4)
60-69	9.3 (4)	5.6 (3)
70+	2.3 (1)	5.6 (3)
<b>Asylum class</b>		
Pauper	69.8 (30)	63.0 (34)
Private	30.2 (13)	37.0 (20)
<b>Marital status</b>		
Single	37.2 (16)	29.6 (16)
Married	44.2 (19)	50.0 (27)
Widowed	18.6 (8)	16.7 (9)

## (COMPARISON CONT'D)

	WOMEN (#)	MEN (#)
<b>Occupation</b>		
Unskilled	44.2 (19)	13.0 (7)
Semi-skilled	11.6 (5)	16.7 (9)
Skilled	4.7 (2)	29.6 (16)
Lower middle class	2.3 (1)	5.6 (3)
Middle class	2.3 (1)	24.1 (13)
Wives	20.9 (9)	
Women at home	4.7 (2)	
Female, no occupation	9.3 (4)	
Male, no occupation		5.6 (3)
Other	--	3.7 (2)
<b>Bodily condition</b>		
Spare/reduced	62.8 (27)	57.4 (31)
Ordinary	34.9 (15)	35.2 (19)
Good	2.3 (1)	7.4 (4)
<b>Mental disorder</b>		
Imbecility	--	--
Amentia	--	--
Dementia	48.8 (21)	55.6 (30)
Mania	34.9 (15)	31.5 (17)
Monomania	--	9.3 (5)
Melancholia	16.3 (7)	3.7 (2)
<b>Cause</b>		
Unknown	39.5 (17)	25.9 (14)
Predisposition from previous attacks	2.3 (1)	5.6 (3)
Hereditary	11.6 (5)	3.7 (2)
General paralysis	16.3 (7)	31.5 (17)
Intemperance	--	1.9 (1)
Epilepsy	--	11.1 (6)

Cause (cont'd)

Illness  
Childbirth  
Work anxiety  
Emotional stress  
Masturbation  
Fright  
Fatigue  
Change of life  
Excitement  
Sorrow  
Overwork/study  
Senility  
Epilepsy/drink  
Disappointment  
Irregular habits

Education

Neither reads nor writes  
Reads only  
Reads and writes  
Good education

Suicidal/dangerous

Neither/unknown  
Suicidal  
Dangerous  
Both

Doctors' category

Idiot  
Person of unsound mind

(COMPARISON CONT'D)

WOMEN (#)	MEN (#)
4.7 (2)	3.7 (2)
11.6 (5)	
--	1.9 (1)
--	1.9 (1)
--	1.9 (1)
4.7 (2)	--
2.3 (1)	--
2.3 (1)	
2.3 (1)	--
2.3 (1)	--
--	3.7 (2)
--	1.9 (1)
--	1.9 (1)
--	1.9 (1)
--	1.9 (1)
7.0 (3)	31.5 (17)
34.9 (15)	3.7 (2)
32.6 (14)	25.9 (14)
14.0 (6)	38.9 (21)
62.8 (27)	57.4 (31)
18.6 (8)	5.6 (3)
18.6 (8)	20.4 (11)
--	13.0 (7)
--	--
55.8 (24)	50.0 (27)

(COMPARISON CONT'D)

	WOMEN (#)	MEN (#)
Doctors' category (cont'd)		
Insane person	9.3 (4)	--
Lunatic	9.3 (4)	13.0 (7)
Lunatic/person of unsound mind	11.6 (5)	27.8 (15)
Insane person/person of unsound mind	11.6 (5)	1.9 (1)
Insane person/lunatic	--	--
Duration of stay		
1-14 days	7.0 (3)	9.3 (5)
2 weeks-1 month	16.3 (7)	5.6 (3)
1-3 months	14.0 (6)	20.4 (11)
3 months-1 year	16.3 (7)	18.5 (10)
1-3 years	32.6 (14)	14.8 (8)
3-10 years	4.7 (6)	14.8 (8)
Over 10 years	9.3 (4)	16.7 (9)

TABLE 16

COMPARISON OF CAUSE AND OCCUPATION  
(Women and men who died in actual numbers)

	WOMEN						Row total	MEN					Row total
	UN	SEMI	S	LM	M	W		UN	SEMI	S	LM	M	
Unknown	7	3	1	--	--	4	15	1	3	5	--	2	11
Predisposition	1	--	--	--	--	--	1	1	--	1	1	--	3
Hereditary	2	--	--	--	--	1	3	--	--	1	--	1	2
General paralysis	3	2	--	--	1	1	7	3	4	4	--	4	15
Intemperance	--	--	--	--	--	--	--	--	--	1	--	--	1
Epilepsy	--	--	--	--	--	--	--	1	1	3	1	--	6
Masturbation	--	--	--	--	--	--	--	--	--	--	--	1	1
Column total:	13	5	1	0	1	6	26	6	8	15	2	8	39

Note: UN=unskilled; SEMI=semi-skilled; S=skilled; LM=lower middle class; M=middle class; W=wives.

TABL 17

CAUSES, 1870  
(in actual numbers and percentages)

	<u>Frequency</u>	<u>Percent</u>
Unknown	135	42.1
Predisposition from previous attacks	43	13.4
General paralysis	25	7.8
Intemperance	22	6.9
Hereditary	21	6.5
Epilepsy	16	5.0
Childbirth	8	2.5
Illness	7	2.2
Emotional stress	6	1.9
Congenital	5	1.6
Sorrow	3	.9
Fright	3	.9
Work anxiety	3	.9
Religion	2	.6
Menstruation	2	.6
Fatigue	1	.3
Hysteria	1	.3
Senility	1	.3
Change of life	1	.3
Unemployment	1	.3
Excitement	1	.3
Epilepsy/drink	1	.3
Hereditary/marriage proposal	1	.3
Lactation	1	.3
Religion/masturbation	1	.3

Total of 318 valid cases; 3 missing cases.

TABLE 18

CAUSES, 1880  
(in actual numbers and percentages)

	<u>Frequency</u>	<u>Percent</u>
Unknown	19	17.3
Hereditary	14	12.7
Predisposition from previous attacks	9	8.2
Masturbation	5	4.5
Work anxiety	5	4.5
Illness	5	4.5
Intemperance	4	3.6
Fatigue	3	2.7
General paralysis	2	1.8
Religion	2	1.8
Sorrow	2	1.8
Senility	2	1.8
Childbirth	2	1.8
Change of life	2	1.8
Menstruation	2	1.8
Lactation	2	1.8
Overwork/study	2	1.8
Irregular habits	2	1.8
Physical injury	1	.9
Epilepsy	1	.9
Emotional stress	1	.9
Congenital	1	.9
Unemployment	1	.9
Excitement	1	.9
Disappointment	1	.9
Nervous debility	1	.9
Puberty	1	.9
Anxiety paralysis	1	.9
Disease at birth	1	.9
Hereditary/lactation	1	.9
Hereditary/pregnancy	1	.9
Hereditary/anxiety	1	.9
Hereditary/sorrow	1	.9
Hereditary/intemperance	1	.9
Hereditary/predisposition from previous attacks	1	.9
Predisposition/disappointment	1	.9
Predisposition/sorrow	1	.9
Predisposition/bad health	1	.9
Predisposition/anxiety	1	.9
Predisposition/religion	1	.9
Anxiety/intemperance	1	.9
Excitement/amenorrhoea	1	.9
Sorrow over masturbation	1	.9
City life/masturbation	1	.9

Total of 110 valid cases; 0 missing cases.