THE UNIVERSITY
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A STUDY OF

THE FIFE AND KINROSS DISTRICT ASYLUM

1866-1899.

by

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MPhil DEGREE

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1992.

SIGNED DECLARATION

I declare that this thesis has been composed by myself and that the work contained within it is my own.

Gillian Doody

ABSTRACT

This thesis aims to illuminate the hitherto neglected area of the Scottish Victorian Pauper Asylum. It provides a detailed study of one specific institution, The Fife and Kinross District Asylum between the years 1866 and 1899.

A wealth of archival material is available for this period, including admission registers, consecutive casebooks, post mortem and annual reports. This has afforded a unique insight into asylum life, and the information obtained has enabled the thesis to be divided into two main sections.

The first aims to provide an account of the establishment of the Fife Asylum within its historical context, with particular reference to its doctors and attendants. The second part examines the patient population and focuses on a casenote study of 337 male patients admitted between 1874 and 1899. Sociodemographic characteristics, psychopathology, Nineteenth Century diagnoses, length of stay and outcome are all examined for this population. An attempt has also been made to re-diagnose the psychopathology identified in terms of the Research Diagnostic Criteria of Spitzer et al (1978).

The findings indicate that the Fife Asylum differed from its English counterparts in several important respects. Although inpatient numbers rose as the century progressed there was no evidence of overcrowding with chronic patients, or an excess of 'organic' pathology, as was

seen in English Asylums. These and other distinguishing features are examined critically and discussed in relation to the innovative styles of patient management pioneered at the Fife Asylum in the latter half of the Nineteenth Century.

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INTRODUCTION

The provocative work of Scull (1979) which has portrayed the asylum as a 'museum of madness', where the 'inconvenient' of society were deposited, has inspired more recent studies to use primary sources to define the nature of particular institutions and their patient populations e.g. Renvoize and Beveridge on York, Walton on Lancaster and Turner on Ticehurst.

To date very little research has been directed toward the experience of Scottish asylums. Specifically no study has looked at a Scottish pauper asylum. It is therefore unknown whether they mirrored the development of their English contemporaries, or if they had their own distinguishing features. Did they become overwhelmed by enlarging numbers of incurable patients ? Did their initial therapeutic optimism give way to custodialism ? Did the patient population comprise of those deemed to be the dregs of society, as Scull has suggested, or did it resemble the chronically sick and debilitated population described by Hunter and MacAlpine at Colney Hatch, an English pauper asylum ?

This study therefore aims to illuminate the hitherto neglected area of the Victorian Scottish pauper asylum. In particular it offers a detailed study of one specific institution, the Fife and Kinross District Asylum. The catchment area of this asylum enveloped the working population of the two shires. This large rural area

sustained a wide spectrum of occupations including fishermen, bakers, shoemakers, general labourers and farm hands.

The available archive material provides a wealth of previously untapped information. A complete run of male casenotes, registers of seclusion and restraint, rulebooks for staff, annual asylum reports and post mortem records all survive.

In its early years the Fife and Kinross Asylum was a showpiece of its era. Under the Superintendentship of the young John Batty Tuke, later to become an eminent psychiatrist, the 'open door' system and practice of 'boarding out' were pioneered.

This thesis has been divided into two parts. The first aims to provide an account of the establishment of the Fife and Kinross District Asylum within its historical context, with particular reference to the roles of its doctors and attendants. The second part examines the patient population, focusing on a casenote study of male admissions from 1874-1899. In this, an attempt has been made to apply modern diagnostic criteria to the Nineteenth Century symptomatology elicited.

THE NEED FOR LUNACY REFORM IN SCOTLAND

The Royal Commission on Lunacy in Scotland reported back to Parliament in 1857. The 1851 census had found the total population of Scotland to be 2.8 million, of these one person in three hundred and ninety was known to be 'insane'.

Prior to the end of the Eighteenth Century in Scotland, there had only been private madhouses for the rich and an assortment of bridewells, prisons and bedlams for the poor. In 1781 the first Scottish chartered asylum was founded at Montrose, the money for this enterprise had been provided by an individual female philantropist, Mrs Carnegie.

By 1839 there were in existence in Scotland seven chartered asylums largely founded by similar donations, such as Mrs Crichton's £100,000 endowment to Dumfries.

In 1841 two thirds of the Scottish population were urban dwellers (Smout 1986). Edwin Chadwick's 1842 report on the appalling poverty of the working classes was concentrated mostly in the cities, where conditions were often more squalid than seen in the country and people's existence was 'worse than wild animals'. Speaking of dwelling houses in Edinburgh, he said;

'A few of the lowest poor have a bedstead, but most make up a kind of bed on the floor with straw, on which a whole family are huddled together, some naked and others in the same clothes they have worn during the day.'

It is perhaps no surprise therefore that, those paupers

admitted to asylums were indeed fortunate as conditions were undoubtedly better than the prison, workhouse or in many cases being at home. Perhaps the most influential figure in Scotland for facilitating pauper admission to these 'stately homes for the lower classes' (Jones, 1991), was W.A.F. Browne.

Browne was born in Stirling in 1805. He studied medicine in Edinburgh and graduated at the age of twenty one. The following year he was elected President of the Royal Society of Medicine. He was greatly influenced by George Combe, who fostered in him an interest in phrenology, which led to experimentation in endocranial casting and cranioscopy. Following two years study in France, under Esquirol, Browne returned to Scotland in 1830 and took up the appointment of Medical Superintendent at Montrose. It was whilst here that he published five lectures entitled 'What Asylums Were, Are, And Ought To Be' that were to become, in the words of Hunter and MacAlpine (1963), 'a manifesto for Victorian psychiatry'. So impressed by Browne's vision of good asylum practice was Mrs Crichton, the benefactor of the new Dumfries asylum, that she invited him to become the Physician Superintendent of the new institution. Browne chose to accept this post in 1839. In this role he met the American social reformer Dorothea Dix in 1855 during her visits to Scottish Asylums, following which she requested a review of care for the insane in Scotland from the Home Secretary.

Browne and Skae (Physician Superintendent of the Royal Edinburgh Hospital) provided for a parliamentary sub-committee, The Royal Commission on Lunacy in Scotland, a report on the care of the insane.

The seven Scottish chartered mental hospitals contained 2,132 patients and the one asylum in Elgin for pauper patients contained forty.

Table 1: The distribution of Scottish insane persons, not in Chartered Asylums, in 1857.

TYPE OF ACCOMODATION	TOTAL PATIENTS
Licensed poorhouses	423
Licensed privatehouses	657
Reported houses	41
Prisons	29
Schools for idiots	15
Unlicensed poorhouses	253
Unlicensed private houses	3798
Unlicensed private establishments	24

As can be seen from the above table, poorhouses and private houses could be either licensed or unlicensed, the latter tending to represent the lowest quality of care. A small proportion of the mentally handicapped population were cared for in 'schools for idiots' and an estimate of the mentally ill in the prison population was

made. The largest number of people were residing in poorly maintained unlicensed accomodation.

The Commission's findings made it apparent that there was no legal provision being made for 4750 pauper lunatics in Scotland.

The Commissioners criticised the ineffectuality of visiting medical inspectors and sheriffs to licensed establishments and highlighted what they had seen of gross neglect and improper treatment of patients. Licensed houses were invariably overcrowded, patients were often left to lie on mattresses soaked in urine for several days, in unheated accomodation and with no clothing. Mechanical restraints were freely used, manacles, leglocks and strait waistcoats were commonplace and no recording of their use was ever made.

Many individual cases were described, the following being cited by MacNiven (1960) in his Presidential address to the Medico Psychological Society over one hundred years later;

'A male pauper lunatic aged 68 lived in the hamlet of Auchentee, about 48 miles from Dingwall. He had been insane for forty years. He lived in a turf home, the roof was leaking and the door about four feet high opening directly into the place where the patient was confined and there was no window or any opening for one.The turf walls were damp and the floors were of earth. There was no furniture of any description except the bed to which the patient was chained. No bedding except a quantity of loose straw was provided. The patient was wrapped in a piece of blanket, old and dirty, and two pieces of old bed covering. Except for these bits of rag he was naked. He had been chained for thirty years. The chain was two and a half feet in length and its end was fastened to the end of the bed with an iron staple. The other end was fastened around the patient's ankle. He never left his bed. His knees were now contracted and drawn up to his

chest and completely rigid. He was stated to be occasionally 'furious and excited'. He never washed except twice in the course of the year. His sister, who looked after him was in receipt of 12s.6d. per month from the Parochial Board.

All this was a far cry from Browne's Utopian dream of how the treatment of the insane ought to be. He spoke of 'a spacious building resembling the palace of a peer' with an interior fitted with galleries, workshops and music rooms. Outside there would be 'a hive of industry' as inmates worked eagerly at various delegated tasks, whilst inside ladies would be found reading or playing the harp or piano. All would be 'contented as to forget their misery'.

Following their investigations the Commission came to the conclusion that the lunacy laws that existed in Scotland were unsatisfactory. Their recommendation that district or county asylums should be provided for the pauper lunatics of the working classes became legitimised by the Lunacy Act (Scotland) in 1857.

THE LUNACY (SCOTLAND) ACT 1857

The passing of this act led to the formation of the General Board of Commissioners in Lunacy for Scotland of which Sir James Coxe and W.A.F.Browne were to be the first two paid medical commissioners. The role of the board was to oversee and regulate all matters arising in relation to lunatics, grant and revoke licenses to proprietors of private asylums and enforce regulations in regard to good asylum practice. This was to be achieved by twice yearly visits, when an inspection of the establishments would be performed and records reviewed. Two routes provided the means of access to the asylum by a pauper patient. Compulsory admission of a lunatic could be ordered by a sheriff on receipt of certificates from two medically qualified persons, each specifying the facts on which a diagnosis of insanity had been made. In an emergency, the Superintendent of an asylum could detain a lunatic for up to 24 hours without a sheriff's order, but with one medical recommendation.

The main thrust of the Act established the firm claim of the medical profession to accept responsibility for the management of the mad, putting an end to the free trade in lunacy.

Asylums licensed for more than 100 patients were to have a resident medical attendant, those for more than 50 were to receive daily medical visits and those with less than 50 twice weekly visits. A fine of up to £100 or six months imprisonment was to be imposed on any person found

to be abusing or neglecting a lunatic, and registers of restraint and seclusion were to be meticulously kept. Lunacy districts were created throughout Scotland and district boards appointed to prepare plans, estimates and then provide for the new district asylums.

FIFE AND KINROSS DISTRICT ASYLUM 1866-1899

ESTABLISHMENT

The District Board for Fife and Kinross Shires secured the purchase of a suitable site for the erection of an Asylum for the Paupers of the Combined Counties, near Springfield station in 1858.

The English County Asylum Act of 1808 had recommended that the optimal situation for an asylum was outside the town. Although the Scottish Act made no such recommendation it was generally agreed that this would be desirable. As Jones (1991) observes such 'isolation' later lamented as a stigmatizing feature of the asylum, was infact a sensible prophylactic consideration in the days when sanitary reform was only in its infancy and open cesspools and contaminated water supplies were still a feature of town life.

Building costs were low and land cheap, but even so the District Board encountered the familiar problem of escalating costs, and the building of the asylum exceeded the original budget. The total construction cost was £31,790 16s 1d.

The asylum building was commenced in 1863 but was not completed until July 1866. Following inspection by the General Board it was then declared fit for occupancy. Initially there were 176 beds for patients, 50 for staff and 24 beds in two infirmary wards intended for the 'isolation of patients attacked by other diseases'.

Accomodation consisted of day-rooms, dormitories, kitchens, dining hall, laundry, workshop, and exercising grounds. There was a separate house for the medical superintendent and an enclosing wall around the entire complex. A major oversight in the original plans had been the lack of provision of a water supply and an additional expense was the purchase of a steam engine for pumping water. Initially patients were transferred from other asylums in order to fill the avaliable places.

Table 2: The Nineteenth Century diagnosis of Fife Asylum's initial transferred population.

DIAGNOSIS	MALE	FEMALE	TOTAL
Demented	77	69	146
Chronic or Remittent Maniacs	2	5	7
Epileptic Dements	12	2	14
Chronic Melancholics	0	2	2
Congenital Imbeciles	4	5	9
General Paralytics	2	0	2
TOTAL	87	83	170

Each parochial board paid the sum of £24 per annum per patient, this was committed to repaying the debt of building and ongoing maintenance.

In April 1867 W.A.F.Browne visited the asylum in his capacity as Commissioner in Lunacy. His report

recommended improvements in the general surroundings of the asylum;

'A greater number of evergreens and common shrubs would greatly add to the clothedness and amenity of the grounds.'

Praise was lavished on the variety of available work placements for patients, which included shoemaking, joining, gardening, kitchen and laundry chores. Regret was expressed at the lack of a library and the immediate acquisition of this as well as a grand piano was recommended.

THE DOCTORS

Superintendents

The life of an asylum physician was arduous. The Superintendent was expected to oversee the running of the whole institution in addition to displaying clinical acumen.

As Hunter and MacAlpine (1973) observe in their account of the Colney Hatch Asylum, the career prospects of asylum doctors were poor. Generally the job was regarded within medical circles as undesirable, dangerous aand relatively poorly paid. Scull (1979) raises this viewpoint from a slightly different perspective;

'Close and unremitting contact with the stigmatized and powerless delivers its own particular reward - a share of their stigma and marginality.'

Being responsible to the District Board in all things placed untold strain on many superintendents who depended on staff to maintain their professional reputation. The possibility of a suicide occurring in the asylum was always 'a great neverending source of anxiety'(Tomes, 1981).

Amongst his duties the Superintendent was expected to visit all patients daily (more if required), maintain books and registers, engage, suspend and dismiss staff and live within the asylum, 'to which he is to devote all his time and attention and be absent for no more than 24 hours without permission'.

During the period 1866-1899 there were four medical superintendents at the Fife and Kinross District Asylum. All were Edinburgh graduates, who had progressed through training at the Royal Edinburgh under David Skae and latterly Thomas Clouston, to assume the post. By far the most influential of these was the Fife Asylum's first Superintendent Dr John Batty Tuke.

John Batty Tuke (1866-1873)

Born in Surrey in 1835, Batty Tuke was educated in Edinburgh and lived as a boy with his uncle Dr John Smith, a proprietor of Saughton Hall Private Asylum. Having qualified in medicine from Edinburgh University in 1856 he travelled to New Zealand where he became a medical officer to the 65th Regiment and married the daughter of a cleric destined to become the Archbishop of York. He served as senior medical officer in the Maori War until 1863, and then returned to Edinburgh to become assistant physician at the Royal Edinburgh Asylum under Dr Skae. After two years he was appointed Medical Superintendent to the newly built Fife and Kinross District Asylum in 1866. Here his ideas were influential in the development of the fledgling institution. He established a firm foundation based on his own beliefs of the importance of the meticulous histological study of the central nervous system, 'boarding out' and most significantly, the 'open doors' system.

In February 1870, Batty Tuke put forward his views on 'proper organization and elaboration of the system of boarding out lunatics in special dwellings' to the Poor Law (Scotland) Committee of The House of Commons. This followed the success of a paper he presented on the cottage system of managing lunatics, at the half yearly meeting of the Medico Psychological Society, held in the Royal College of Physicians, Edinburgh. Earlier in 1870 he had visited Gheel, 'the city of the simple', in Belgium where 1000 lunatics were boarded out in houses of the villagers - his hopes were to bring about a similar structure in Fife. However, he stressed the necessity of measures to prevent abuse occurring;

'What is needed is superior supervision, increased rates of board and a higher class of guardians.'

On his departure from the asylum in 1873, Batty Tuke expressed his regrets;

'It is not easy to part with what one has, with no small degree of satisfaction, felt waxing under the hand, or to leave it as it has gained its full proportions.'

After leaving Fife he moved to Edinburgh, to succeed his uncle in becoming a partner at the private institution of Saughton Hall.

In 1889 an important paper, 'Lunatics as patients not prisoners' was published by Batty Tuke. This advanced his ideas on the open door system and drew on his experiences in the Fife and Kinross Asylum.

He went on to receive a knighthood in 1898 and remained in academic medical circles (Beveridge, 1991). In 1900 he was elected an M.P. for the Universities of Edinburgh and St. Andrews, a position he held for ten years. In later life he continued his pathological work and described a new brain appearance of 'miliary sclerosis', which we now know as 'senile plaques.'

He died in 1913. In the words of Thomas Clouston on his death;

'His name will go down as one of those who gave an early impetus to the great advance which has taken place in our department of medicine during the last fifty years.'

Junior Staff

To assist the Superintendent in the discharge of his duties was a medical assistant, either a newly graduated doctor eager to ascend to the position of Superintendent himself one day, or one with more experience simply bidding his time. They were generally considered as subordinate beings, who visited patients twice daily, kept casenotes, post mortem records and were not allowed to leave the asylum (without permission from the Superintendent), or marry. Their chances of advancement in a pyramidal structure were slim and many chose to abandon their hopes of promotion and enter into a career of private medicine, where financial rewards were greater. On selecting medical assistants, Russell (1988) quotes the wisdom of Charles Mercier, a Superintendent at the West Riding Asylum, as to their desirable qualities;

'A companionable chap ... a good humoured, pleasant, patient gentlemanly fellow, with no conspicuous ability, and no very firm strength of character.'

THE ATTENDANTS

As Batty Tuke noted on the opening of the new Fife Asylum;

'there is always a difficulty in obtaining suitable staff for a lunatic asylum.'

In the early days this was certainly an understatement. There was no career structure for attendants who were untrained, poorly paid and expected to live in the asylum. Turnover was rapid and dismissal for drunkenness, abuse of patients and laziness frequent.
A rulebook was issued to all employees stating expectations of, 'uniform kindness and perfect self control', in addition to, 'punctuality personal neatness and general propriety of behaviour.' As the recovery of patients was deemed to be the primary object of the institution;

'those attendants will be most suitably rewarded, under whose charge, or through whose means, the greatest number recover.'

A fine could be imposed, in addition to instant dismissal, on any attendant to whom blame was attributed for an escape. The amount of the fine would be proportional to the expense of returning the patient to the asylum.
By 1876 Dr John Fraser, the Superintendent of the Fife Asylum, was frustrated at the large proportion of his time spent hiring and dismissing his attendant staff.

This concern led him to write to the District Board suggesting that cottages be built within the grounds in order to attract married attendants to the posts, who he believed would display greater 'stability'.

In 1851 Browne had started the first organised course for attendants at the Crichton Royal, but this practice was not adopted in Fife until introduced by Dr Adam Turnbull in 1897. A national training scheme for attendants was begun in 1891 by the MPA, following the introduction in 1885 of 'The Handbook For The Instruction Of Attendants On The Insane'. It also became possible, in 1891, to obtain a 'certificate of proficiency in nursing the insane.'

In 1892 Lillian Ames from the Fife Asylum achieved notoriety as the first 'asylum nurse' to be threatened with loss of certification for 'behaving roughly to one of the patients.' Because of uncertainty the case was dropped due to insufficient evidence. However subsequently an average of three mental nurses were removed from the register each year.

Being considered professionally inferior, asylum nurses were ineligible to join the Royal British Nursing Association and to counteract this the Asylum Workers Association was formed in 1896, with the aim of improving status.

However, by necessity asylum nursing work at the turn of the last century remained largely custodial in nature and individual patient care was a distant dream.

THE EARLY YEARS - JOHN BATTY TUKE'S PERIOD OF OFFICE (1866-1873)

In his first report to the General Board in May 1867 John Batty Tuke, Medical Superintendent, comments;

'Not a few were sent to the asylum in a very wretched condition and it has taken months of care and attention to break them of the most degraded habits, and to restore them to an ordinary degree of cleanliness.'

He chose to qualify his remarks by adding;

'This does not apply to those transferred from the Royal Asylums whose patients in the main presented a very marked distinction from those who came from private houses or the lunatic wards of poor houses.'

There was in these early days a general feeling of therapeutic optimism. Batty Tuke expressed this clearly;

'I may here be allowed to remark that the great element of success in the treatment of insanity, amongst pauper patients more particularly, is early removal to an asylum. Delay in such cases is the worst economy.'

The problem of patient violence featured prominently in the first year of the asylum. One patient died following repeated blows to the head from a fellow patient who was subsequently charged with murder. The case was brought before the Circuit Court of Justiciary in Perth, where a plea of insanity was made. The patient was transferred to the criminal ward of Perth prison. A full investigation of the incident was held by the District Board, who did not consider that 'culpability appeared to attach to any individual.'

Fearing further incidents Dr Batty Tuke requested removal of two 'criminal lunatics' in his charge, on the grounds that they were unfit for detention in a district asylum. One had made five separate attempts to stab the head attendant and the other had been committed for attempting to bayonet his regimental sergeant. The first patient was by necessity transferred to a different asylum, but the second patient, not being a 'criminal lunatic in the legal sense' was allowed to stay; if an assault was made then the Procurator Fiscal was to be informed. The District Board considered there should be 'sufficient means for keeping violent lunatics in proper control in a district asylum.'

By the end of the first year 202 patients were resident in the asylum and drawing on the English experience and his own observations, Batty Tuke was aware that the asylum was rapidly filling up;

'The accomodation on the male side of the house is fully occupied, and the probability is, that the female department will soon be in the same condition.'(Batty Tuke, 1867)

The solution was clear in his mind;

'I allude to the boarding out of patients in private dwellings.'

This practice was already extensively employed throughout Scotland, where predominantly mentally handicapped patients, were taken in by volunteers in the community. The practice was the forerunner of today's guardianship

legislation and was to receive much support in the years ahead.

The Annual Report of 1868 showed that the asylum was still experiencing many teething problems, mostly of a domestic nature. As only an elementary knowledge of sanitation was available, a great problem had presented itself, to the large institution removed from the town, in the form of sewage disposal. As with most things, Batty Tuke devised a practical solution;

'The utilization of the sewage has been carried out either by carting it onto the stubbles and grass, or by running it onto heaps of earth in the neighbourhood of the tank. By this means none is lost, and no further complaints of defiling the River Eden can arise.'

The asylum now had a flourishing farm which produced the majority of vegetables for the institution. As well as working placements, patients enjoyed amusements and recreational activities, weekly dances, readings, lectures and concerts were often arranged. The importance of exercise was never underestimated and a weekly half holiday had been introduced, for both patients and staff to compete in cricket, quoits and athletics.

During these formative years Batty Tuke was assisted by Charles Skae, whose father David was the Superintendent of the Morningside Asylum. In 1869, Charles was appointed Superintendent of the Ayrshire District Asylum. His place was filled by W.F. Morrison and thereafter medical assistants changed annually.

By 1870, the population of the asylum had swollen to 244 patients. A new block had been opened which could accomodate 30 male and 30 female patients and a building had been designated as a convalescence block. Here patients were placed immediately prior to discharge and given increased freedom and the possibility of parole. It was considered that this facility provided 'a means of removing the convalescent patient from worrying and unhealthy association with the chronic lunatic.'
In 1871 Batty Tuke reported that nine patients had been successfully boarded out over the course of the preceding year, and 'that none of these patients have been returned to the asylum'. In the same year, Batty Tuke introduced the 'open door system' into the asylum. This began as a tentative experiment in the newly opened wing and gradually extended into the main asylum.

'First of all, the doors between the various wards and corridors were left unlocked, and, subsequently on the male side, the outer doors have stood open. I have no reason to regret this step, on the contrary, believe it has conduced materially to the welfare of my patients; only one escape has occurred in consequence in four months,and that one of no moment. My conviction is that the locked door and grating key induce a desire to abscond from the very irritation caused by their constant obtrusion on the sight and hearing... I hold it to be cruelty to apply to the contented majority the maximum of restraint, in order to confine the minority who require its application.'

A visit from Arthur Mitchell, Commissioner in Lunacy, in 1872 confirmed that Batty Tuke had stamped his mark on the asylum;

'In going through the house few of the doors were opened with a key, most of them being supplied with ordinary handles, and being left unlocked though shut... This greater freedom has led to no difficulty in the management, and has not increased the number of escapes; but it is believed to have made the patients more contented and to have lessened the destruction of property... In the male convalescent wards, which are now in full operation, the patient enjoys a very unusual degree of freedom, a large proportion of them coming and going out just as they choose. It is stated that patients who are transferred to these wards improve in mind and body.'

When reviewing the first seven years of the asylum in 1873 Batty Tuke, expressed concerns for its future;

'The usefulness of an asylum is within certain limits, in inverse ratio of the size; the enlargement of the institution would be most detrimental to the interests of all concerned. Were it ever to exceed its present limits, the difficulties of management would be so much increased as to necessitate a rigid discipline and consequently obliteration of its special feature.'

JOHN FRASER'S PERIOD OF OFFICE 1873-1878.

Following Batty Tuke's departure his post was filled by his Medical Assistant after a unanimous vote by the District Board. Dr John Fraser may have felt overshadowed by his predecessor, but he rose to the challenge before him. His beliefs had been moulded by Batty Tuke and he continued the development of the systems of boarding out and open doors. Additionally, he firmly believed in reducing the numbers of those who were idle during the day to a minimum, and had plans of turning the asylum into a 'veritable bee-hive' in keeping with the beliefs of Browne (1837).

The rationale behind this philosophy lay firmly in society's expectations of the able-bodied working to support themselves. Therefore the ability to work well was possibily one of the greatest prerequisites for discharge.

By 1875 the asylum had acquired additional farmland and a dairy farm had been established which was able to supply a large quantity of milk. In this year the asylum attracted various eminent visitors, all interested in viewing the results of Batty Tuke's 'open door system'. In his Annual Report Fraser notes;

'They came incredulous, as most physicians in the speciality are, but after a day's thorough insight went away convinced of the truthfulness and reality of the movement. It is the opinion of an American physician that this open-door system is in the future likely to be classed with those great movements of Pinel and Samuel Tuke towards the end of the last, and of Connolly and Greisinger about the middle of the present century. This

bold advancement in the treatment of the insane is, as you are aware, wholly due to Dr Batty Tuke.'

The American physician referred to was Charles Folborn, who following his visit to Scotland, requested a description of a 'Scotch asylum' from Fraser which was subsequently published in the Boston Medical and Surgical Journal.

However, by 1876 the acclaimed asylum of Fife was facing the predicted consequences of overcrowding - this served to jeopardise the very ethos of the institution. There were 266 patients in the asylum. In his Annual Report Fraser despaired;

'The accomodation of the House is fully taxed in the female department. The dormitories already contain extra beds.'

Previously it had been possible to offer a bed to those 'private patients' able to pay, although only ninety had been admitted since opening. This practice was now discontinued in order to ensure adequate pauper provision.

JOSEPH BROWN'S PERIOD OF OFFICE 1878-1881

John Fraser left the asylum in order to assume the post of Deputy Commissioner in Lunacy, he was to continue visiting the asylum in this capacity until the end of the century.

The position of Medical Superintendent was filled by Joseph Brown - missing asylum reports during the period of his leadership make any assessment of his regime difficult. He met an untimely death in 1881, falling from his carriage on the road from the Asylum to Springfield. In the Royal Edinburgh Asylum report of that year Clouston lamented;

'I never saw more sincere grief than was manifested by many of Dr Brown's former patients the morning after his death. In many cases it lighted up emotion in minds that I thought were blank, and elicted tears and tender expressions of sorrow from women who had never been known to weep for years.'

ADAM TURNBULL'S PERIOD OF OFFICE 1881-1899+

Dr Turnbull was appointed new Medical Superintendent in 1881, Clouston commented on his promotion;

'A man with the Morningside stamp on him seldom turns out bad metal.'

By 1882 the inpatient population had risen once again and there were 317 patients in the asylum. Additional dormitories and a new 'West Wing' had been added to the buildings to provide 11 new male and 64 new female beds. Many patients continued to board out in the nearby village to keep asylum numbers manageable.
A reduction in charges per annum per patient, due to a surplus of funds, from £24 to £20 in 1886 resulted in the cost of keep in the asylum being less than the cost of keep in the poorhouse. This proved attractive to inspectors of the poor, as the Fife Asylum was now the cheapest in Scotland, the average cost elsewhere being £25 2s. The inpatient population in 1887 of 363 reflected, amongst other factors, this new found popularity and it resulted in the continued refusal to admit private patients, whose relatives were eager to pay such a reduced rate compared with other institutions.
The growth of the institution resulted in a new concern for safety. This was prompted by several fatal fires in other asylums. The risk of fire was deemed high because of the 'mischevious propensities of inmates'. There had been three arson attempts in 1886.

The asylum water supply originated in nearby Cupar. The town had the first access to the supply, and hence the pressure of the Asylum water was severely depleted and too low to sustain hose pipes. Turnbull suggested that partitions be erected in the larger parts of the buildings and an agreement be reached with Cupar, that in the event of fire water would be diverted to supply the Asylum first. In 1887 catastrophy literally struck and Turnbull's plan was put to the test.

On the nineteenth of May 1887 at 4am the chapel roof caught fire, not through arson, but apparent divine intervention as lightning struck. The water supply could not be diverted and pressures were too low for hoses to be used. Fire Brigades from Cupar and the local flax mill arrived and provided hand pumps which enabled water to be used from large underground rain tanks. Despite these measures the fire gutted the Chapel and adjacent dormitories. The dining hall was damaged from water but amazingly there were no casualties. Temporary accomodation was provided in the form of wooden huts in the grounds and application was made for rebuilding to incorporate a further extension.

By 1897 the total population had once again risen to 482 although another extension had already been added in 1895 to cope with the continued demand on beds. A quarter of all admissions were readmissions and the problems of a revolving door syndrome were surfacing.

In a bid to keep pace with the new technology Fraser, suggested that the introduction of electric lights into the Asylum was a matter worthy of consideration of the District Board. He felt it would be;

'safer, cleaner, cooler and healthier than gas and it also increases the efficiency of the asylum in many ways.'

Sadly the new illumination was not forthcoming and in 1899, with an average daily population of 517, the asylum was becoming shabby and dingy. Indeed the acquisition of electric lights, it was hoped, would ;

'greatly reduce the amount of painting and decorating necessary to keep it clean-looking and cheerful.'

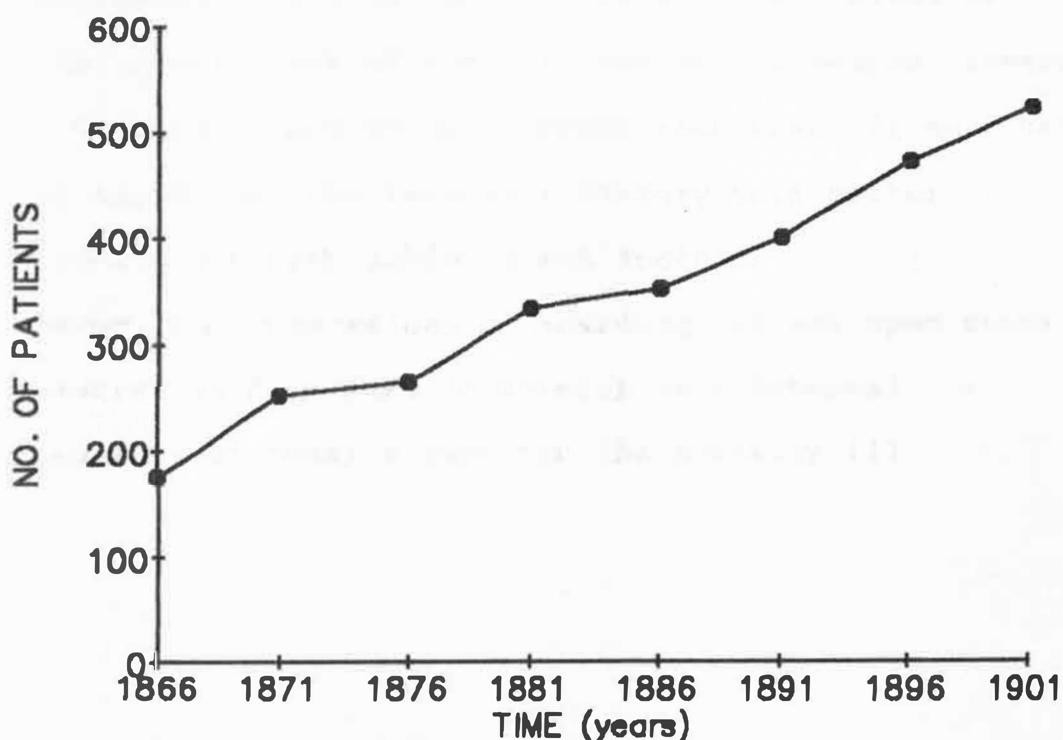
Such preoccupation with the appearance of the asylum was perhaps indicative of a new disillusionment which was beginning to overtake the previously held therapeutic optimism of asylum doctors.

THE FIRST THIRTY-THREE YEARS

Rising patient numbers placed pressure on accomodation for staff and patients alike.

Graph 1 shows the growth of the Asylum's patient population over the latter portion of the Nineteenth Century.

GRAPH 1: Growth of Fife And Kinross Asylum patient population over time.



There has been much debate focused on the reasons why asylum populations expanded so rapidly. As graph 1 shows the actual rise in patient numbers in the Fife Asylum was linear and not exponential, as it was for some English Asylums. A multifactorial explanation for rising numbers would encompass such issues as, greater public

acceptability of asylums, an increase in the prevalence of schizophrenia (Hare, 1963), rising birth rates and overcrowding due to an influx of chronic patients. The contribution of each of these, in the case of the Fife Asylum, will be considered in the second part of this thesis.

At the end of the Nineteenth Century medical journals reflected the despondency widely felt by asylum doctors throughout the Country. The problems of asylum overcrowding, falling 'cure rates', large numbers of readmissions, lack of autonomy and poor financial rewards for doctors seemed to loom larger than ever. It must have been hoped that the Twentieth Century held better prospects for both patients and doctors.

However, the innovations of boarding out and open doors pioneered in Fife were to develop into integral components of today's care for the mentally ill.

A Retrospective Study Of The Inpatient Population Of The Fife And Kinross District Asylum, 1874 - 1899.

AIMS

To date very little is known about the nature of mental disorder exhibited by the Scottish working class population during the second half of the nineteenth Century.

In the case of the Fife and Kinross District Asylum, a wealth of archival material has survived. This describes many facets of the institution including the symptoms, treatments, diagnosis and outcomes of its patients, in varying degrees of detail.

Between 60 and 115 patients were generally admitted to the asylum in any one year.

By studying surviving records it is hoped that a picture will emerge of the spectrum of disorders treated within the institution.

A 26 year period was studied from 1874-1899. This ensured that the incomplete records of the initial population, admitted in 1866 and consisting in the main of patients transferred from other asylums, could be disregarded.

There are five main aims of the study:

1. To create a sociodemographic profile of patients admitted to a Scottish pauper asylum in the Nineteenth Century.

2. To analyse the Nineteenth Century psychopathology recorded and describe this both qualitatively and quantitatively.

3. To gather information on perceived aetiology of insanity and diagnosis during the period, and then attempt to redefine the psychiatric morbidity of the population in modern terms using the Research Diagnostic Criteria.

4.To assess length of patient stay, outcome and cause of death, and relate this to the changing characteristics of the patient population over time.

5. To derive a statistical profile of the patients admitted to the Fife District Asylum and compare this with similar research, which has studied the populations of English asylums during the Victorian era.

METHOD

The case records of 337 male patients admitted to the Fife and Kinross District Asylum between 1874 and 1899 were examined. The casenotes contained information on name, age, occupation, religion and admission dates for most patients, generally a rudimentary mental state examination was included on admission. Subsequent entries were made daily or weekly for acutely ill patients and six monthly to annually for chronic patients. Additional information was obtained by cross reference to admission registers, sheriff's orders, annual asylum reports and post mortem records. These records represented a chronological one in four sampling of all male patients admitted during the twenty six year period. Male records were chosen exclusively as these were complete for the years under study, whilst vital components of the female records were missing.

Seventy-five patients had previous admissions to the Fife District Asylum and were excluded from the study. For the remaining 262 patients the age, dates of admission and discharge, place of residence, marital status, occupation, religion, family history of psychiatric disorder and alleged cause of psychiatric illness were recorded.

On the basis of their occupation, patients were assigned to one of four social classes;

1. - Professional
2. - Skilled

3. - Semi-skilled

4. - Unskilled.

Each patient's records were scrutinized from admission to their discharge or death and information sought on the presence and content of delusions, hallucinations and first rank symptoms (Schneider, 1959). Entries of aggressive, dangerous or suicidal behaviour were noted, as was any occurrence of seclusion. Where treatment was specified this was recorded, as was the use of force feeding.

The diagnosis used by the Nineteenth Century asylum physician was recorded for each case where it had been specified. It is appreciated that interpretation of psychopathology during this period is difficult in the context of the present day. However, using the Reseach Diagnostic Criteria (RDC) of Spitzer et al (1978) clinical information in the caesnotes was used to reassign patients to one of three functional diagnostic categories, schizophrenia, affective disorder or neurotic disorder. A fourth category of 'organic' was used for patients judged as having a predominantly organic cause for their insanity. A final fifth category of 'unclassifiable' was used for those patients who did not fulfil criteria for inclusion into the preceding four groups.

The asylum's own assessment of outcome was recorded for each patient, this could be;

Discharged - recovered

Discharged - improved

Discharged - not improved

Transferred.

The actual length of stay in the asylum was recorded for each patient.

If a patient died, clarification of the cause of death was sought by reference to post mortem records.

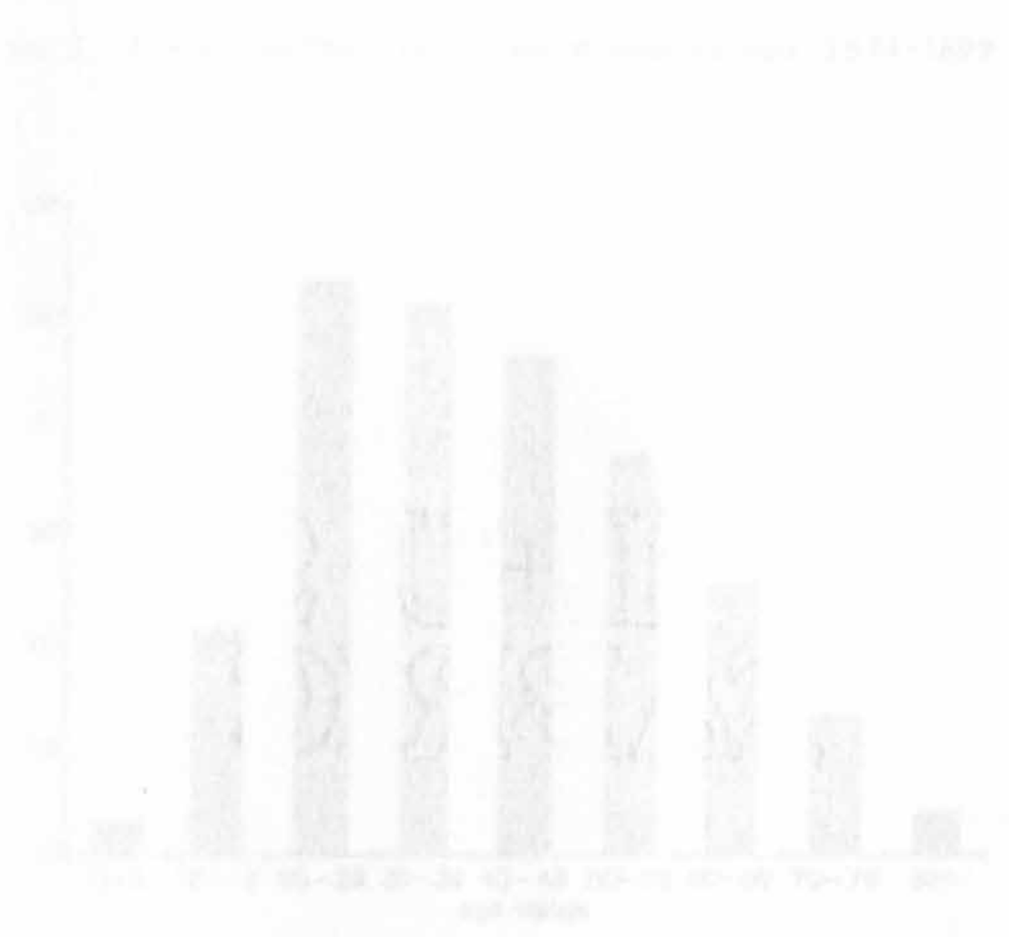
In order to facilitate comparative analysis of results, all available patient data obtained was entered into a specifically designed computer database. The database format was modelled on a standardized form used to collect patient information (Figure 1).

Figure 1 : Standard format for patient data collection.

Name:	
Age:	
Date of admission:	
Date of discharge:	
Marital status:	
Occupation:	1.
	2.
	3.
	4.
Place of residence:	
Religion:	
Family history:	
Cause of insanity:	1 Moral a) masturbation b) alcohol
	2 Physical
	3 Hereditary
Secluded:	
Aggressive:	
Dangerous:	
Suicidal:	
Delusions:	Scientific content
	Religious content
	Persecution
	Grandeur
	Guilt
	Love
	Ill health
	Nihilism
	Demonic possession
	Poverty
	Mis-identification
	Sexual interference
	Reference
	Infestation
	Infidelity of spouse
	Unworthiness
	Control
Hallucinations:	Auditory
	Visual
	Olfactory
	Bodily sensation
	Gustatory
First rank symptoms:	
Treatment:	Drugs
	Morphine
	Force fed
	Bath
	Walk
	Bowels
Outcome:	Discharged - recovered
	Discharged - improved
	Discharged - not improved

Transferred
Died
Removed against medical advice
Removed by police
Discharged - not insane
Escaped

Cause of death:
Length of stay:
Nineteenth Century diagnosis:
RDC Diagnosis: Schizophrenia
Affective disorder
Neurotic disorder
Organic
Unclassifiable



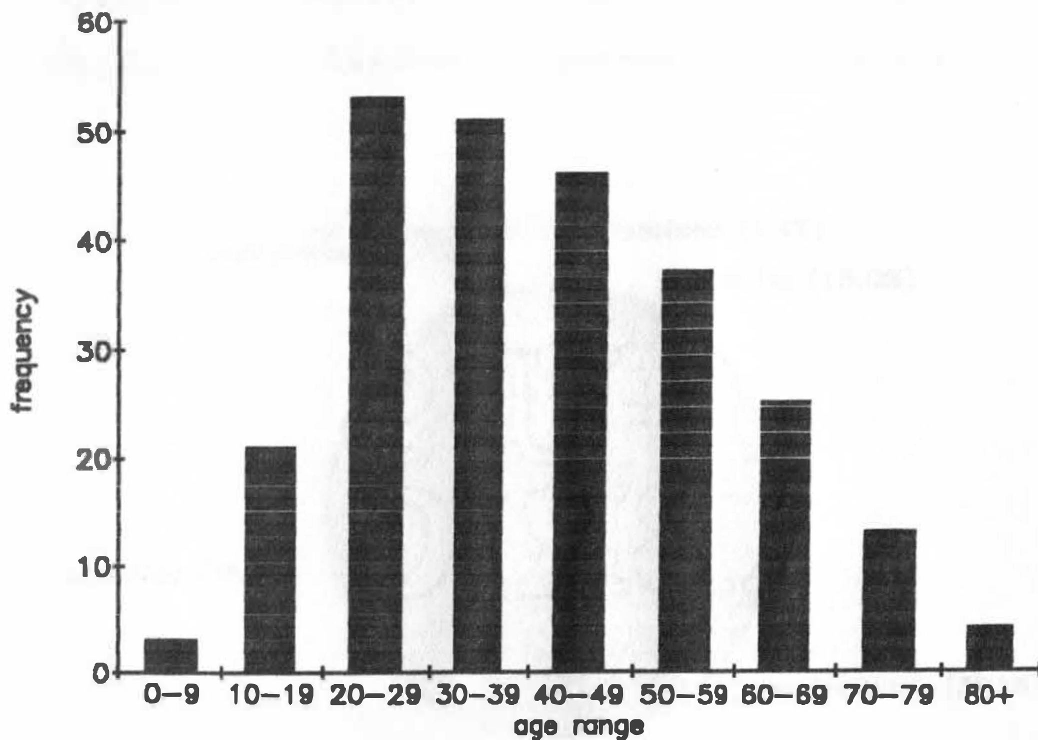
RESULTS

Sociodemographic Characteristics of patients

Age

The average age on admission to the asylum was 40 years. Of the 262 patients under study only three were under 9 years and four over 80 years when admitted.

Graph 2. Age distribution of male admissions 1874-1899



Religion

The majority of the patients were Protestant, only 8% claimed to belong to another religion, these included three atheists.

Marital Status

Although the majority of men were single, 42.0% were married and 7.3% were widowed.

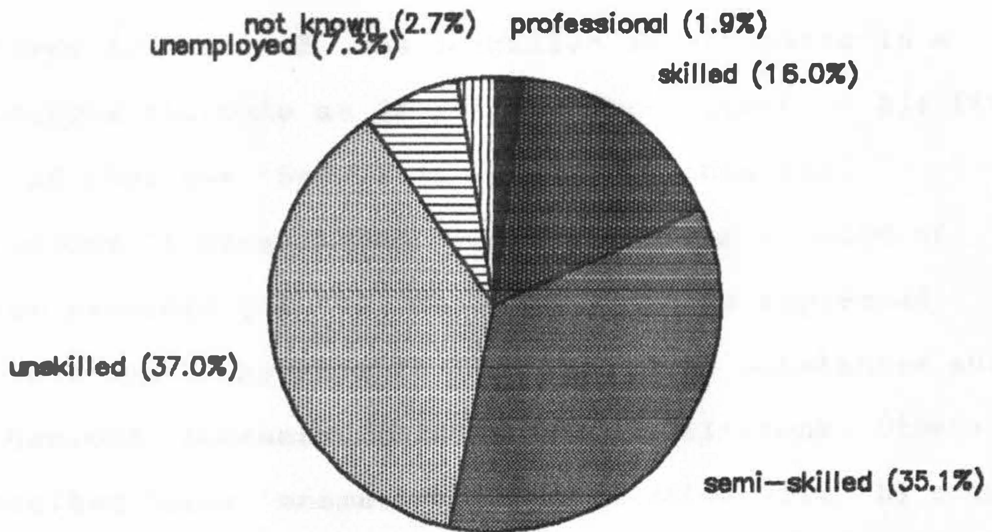
Place of residence

Home addresses varied throughout Fife and only a small minority came from other parts of Scotland, one foreigner was admitted prior to repatriation.

Occupation

Patients generally had a semi-skilled occupation e.g. Fishermen, Linen Weaver, Ploughman or unskilled occupation e.g. Hawker, Labourer, Infantry soldier.

Graph 3. Social class by occupation of admissions.



Psychopathology

Delusions

Case record analysis indicated that delusions, as determined by today's standards, were present in 63% of patients at some time during their stay. Medical Officers recorded patients as, 'labouring under delusions' or 'suffering from extravagant ideas'. Delusions were sometimes noted to be 'fleeting', 'troublesome', 'mischievious' or 'foolish'.

5.6% of delusions had a scientific theme, often refering to electricity, telegraphs or flying machines. A religious preoccupation was evident in 17.5%. In the case of W.B., a 22 year old man, restraint was required to prevent him going to London to be 'turned into an angel'. Whereas Alexander B. was described as 'standing in a grotesque attitude as if praying' consequent on his firm belief that the 'Spirit of God' was within him.

Delusions of persecution represented over a third of those recorded (38.7%). Numerous patients expressed beliefs that they were to be poisoned by substances such as hemlock, laudanum, chloroform and brimstone. Others described being 'mesmerised' and 'meddled with' by occult forces, or 'haunted by Balloon Folk'. One patient attempted to escape from the asylum because of his belief that he was being persued by, 'humpy-backed buggers with eyes like bulls'.

Delusions of grandeur accounted for 19.1% of the total and often manifested as 'fine schemes for the future or

exaggerated notions of the past'. Claims of owning millions of pounds, or having extensive gold mines abroad were commonplace. One patient prone to stealing the possessions of other inmates and regarding himself as the 'Thane of Fife', was said to have 'kleptomaniacal proclivities'.

In addition to the Thane, patients claiming to be King William IV, The Emperor of India, Elijah the Prophet and self-styled Admiral Rice could all be found residing in the pauper asylum. Admiral Rice wrote to Inspector General McAndrew, Commanding Officer of Her Majesty's Forces;

'You will march the troops up here immediately and take possession of the asylum.'

His letter, like those of many other patients, was intercepted by the medical officer and placed in the casenotes.

Mood congruent delusions of guilt were regularly seen (10.6%). One patient believed he would be 'dissected for his sins', others feared, 'being burnt alive' or 'affected by leprosy'. Perceived punishments for delusional crimes were often horrific and ranged from, being 'bound in golden chains' to being 'covered in foul-smelling vermin'.

Only three patients displayed delusions of love. One of these patients claimed to 'have connections with over one hundred women every night'. While Admiral Rice proclaimed

his limitless love for 'Queen Victoria, Empress Of India' and was convinced of the inevitability of their marriage.

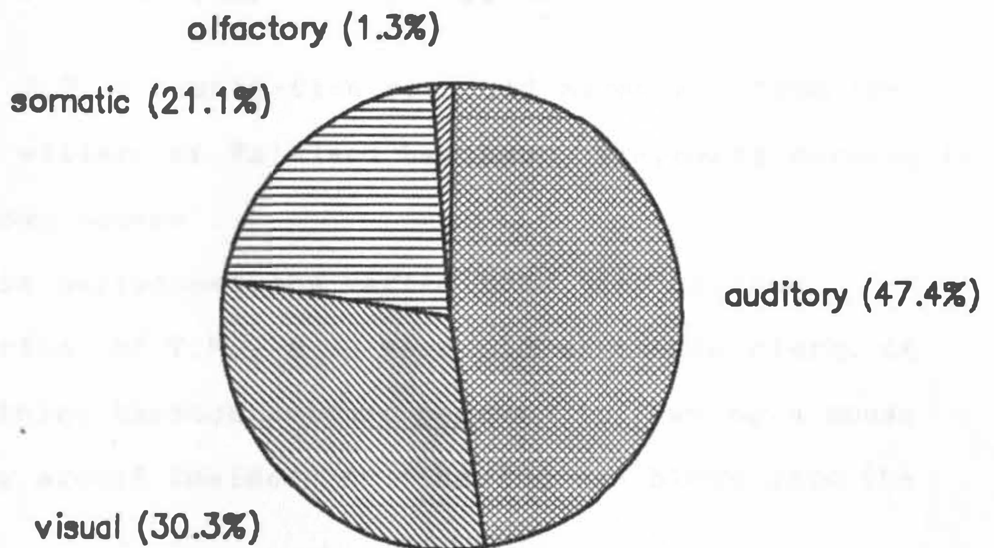
Table 3: Types of delusions in males admitted to Fife Asylum 1874-1899.

Type of delusion	Frequency N=235	Percentage of Total
Persecution	91	38.7%
Grandeur	45	19.1%
Guilt	25	10.6%
Mis-Identification	13	5.5%
Unworthiness	12	5.1%
Nihilistic	10	4.3%
Poverty	10	4.3%
Ill-Health	8	3.4%
Infidelity	5	2.1%
Control	5	2.1%
Demonic Possession	4	1.7%
Love	3	1.3%
Infestation	3	1.3%
Reference	3	1.3%
Sexual Interference	1	0.4%

Hallucinations

Hallucinations were present in 60 of the patients studied (22.9%). The hallucinations documented were in four modalities as shown in Graph 4.

Graph 4: Types of hallucinations in male patients admitted to the Fife Asylum 1874-1899.



The co-existence of delusions and hallucinations was seen in 18.3% of the total population.

Auditory hallucinations were the most common. James H. claimed to be 'receiving messages from the waxworks in Edinburgh', while a 22 year old fisherman was 'conversing with his Uncle Jack in Australia'. Other patients heard 'abusive whisperings', or the 'Voice of God'. In the

chilling case of P.B., a 25 year old man, God had told him he 'would die in a lunatic asylum.' When he told his peers of this prophecy he was promptly certified insane and taken to the asylum. Having arrived he became suddenly unwell and died within twelve hours, the post mortem record shows death from pneumonia.

30.3% of the hallucinations were visual. Fergus N.,a sixty year old hawker, saw;

'wee folk two or three feet high with brown dresses on, who can change shape and disappear into the wall.'

While J.D. a fourty-five year old alcoholic from the small village of Falkland had seen 'elephants dancing in the town square'.

Somatic hallucinations varied from the 'curious sensation' of T.M., a 22 year old warehouse clerk, of 'breathing through another person',to 'having a mouse moving around inside', or ' having gas blown onto the body'.

Only one patient experienced olfactory hallucinations, this being in the context of an epileptiform aura.

First Rank Symptoms

These were present in 6.9% of patients, the majority were somatic hallucinations.

Three instances of delusional perception were determined. R.R. knew that he was ill in some way having seen his neighbour eating a turnip and D.M. was cerain that all dogs could read his thoughts after looking at a dog's eye. Only one case of thought withdrawal was identified,

a 24 year old man, told how his 'mind has been influenced and taken away by unknown persons'.

Aetiology, Nineteenth Century Diagnosis, And RDC Diagnosis.

The alleged causes of mental illness were stated in 202 cases. These were divided into four categories, moral, physical, adolescence and hereditary.

Table 4: Alleged causes of psychiatric illness in patients

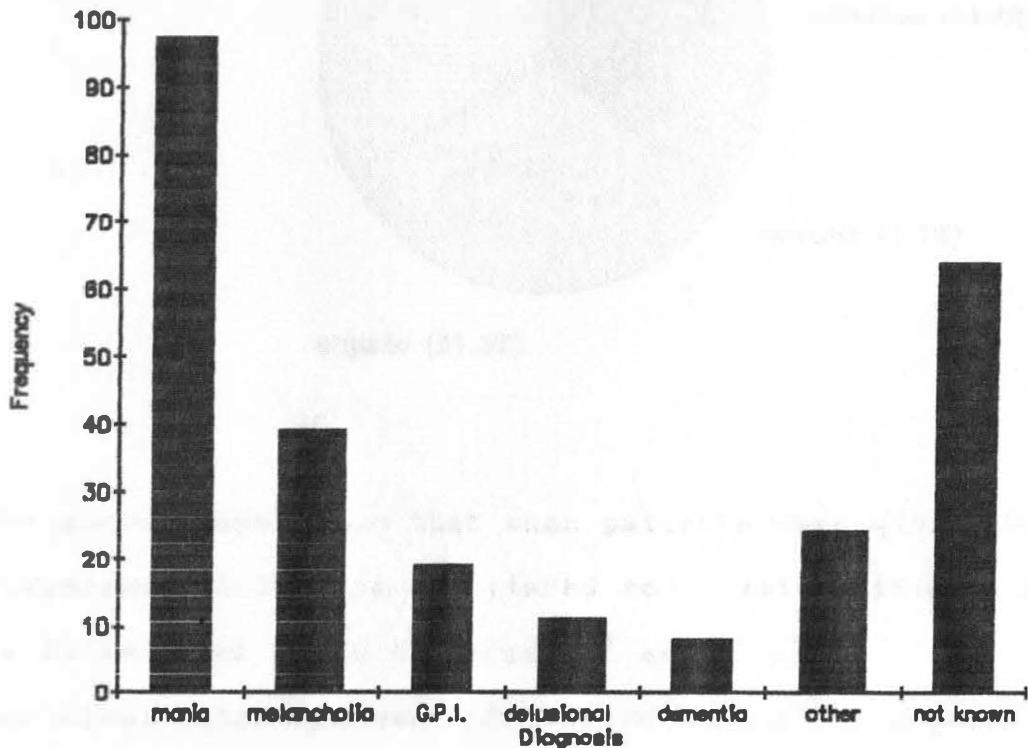
Cause	Percentage of total
Moral	45.8%
Physical	19.5%
Hereditary	11.1%
Adolescence	0.8%
Not Known	22.9%

In the moral group, 12 cases were attributed to masturbation and 41 to alcohol (15.6% of the total population).

A Nineteenth Century diagnosis was avaliable for 75.6% of cases. The most popular diagnosis was that of mania followed by melancholia. Together these two diagnoses accounted for over fifty percent of all admissions. A group was identified which was neither mania nor melancholia, but contained the term 'delusional', followed by a qualification e.g. 'idiopathic delusional hypochondriasis'. This group accounted for 4.2% of cases.

The 24.4% in which the Nineteenth Century diagnosis is unknown largely represents a group of patients admitted after 1892, for whom the admission register was missing.

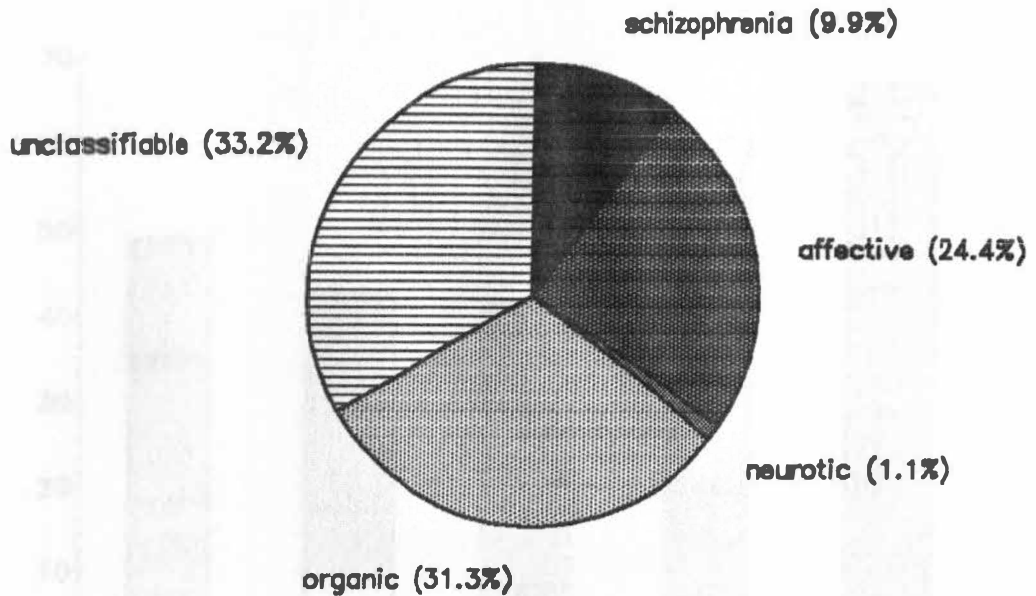
<u>Graph 5:</u> Nineteenth Century Diagnoses of Admissions.



Graph 5 shows the variation in the Nineteenth Century diagnoses used. The most frequently used category was mania, which was assigned to 97 of the admissions studied.

Twentieth Century diagnoses made using the Research Diagnostic Criteria yielded the following results;

Graph 6: RDC Diagnoses of admissions

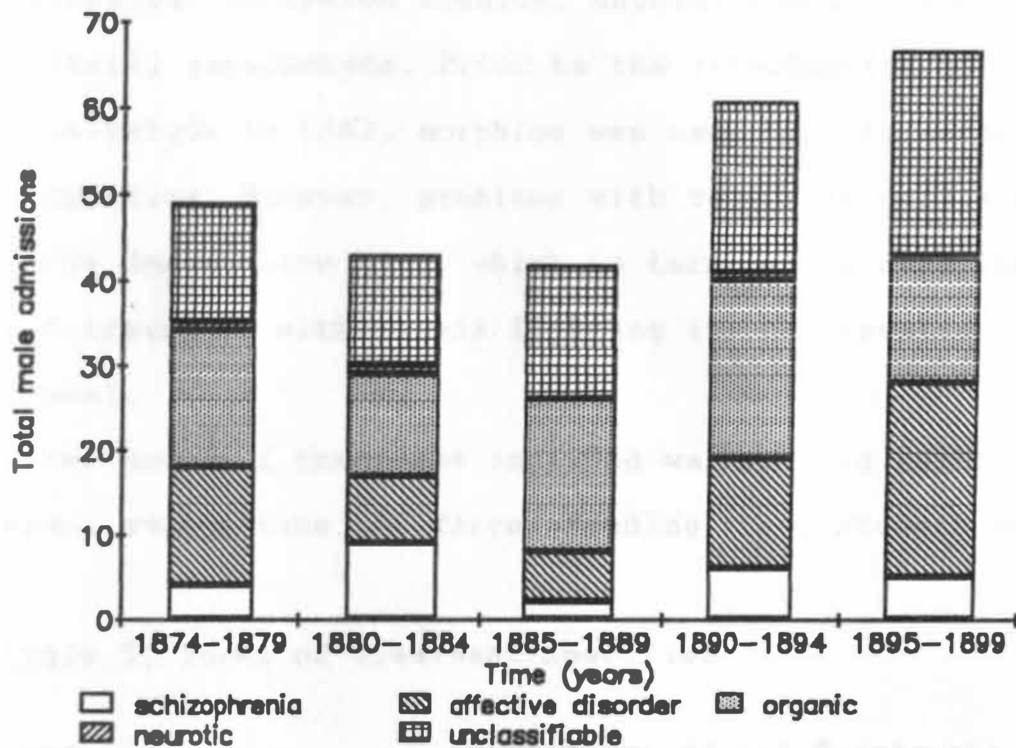


The above graph shows that when patients were given RDC diagnoses, 33.2% were considered to be unclassifiable and 31.3% believed to be of 'organic' aetiology.

Two clear subgroups were identified within the organic category, 14.6% of all organic admissions (4.5% of the total) had G.P.I. and 9.7% suffered predominantly from epilepsy (3.1% of the total).

In an attempt to define the changing pathology of the population over time, the RDC Diagnoses were studied at five yearly intervals.

Graph 7: RDC Diagnoses of admissions against time



Graph 7 illustrates the male admissions studied in five yearly periods, excepting the first division from 1874-1879, which represents a six year period. The total number of admissions is shown and these have been sub-divided by RDC diagnostic categories. From this it can be seen that no excess of any one category is evident as time progressed. Additionally, the prevalence of all five diagnostic categories within the asylum population remains relatively stable over time.

EX BIBL. UNIV. EDINBURGER.

Treatment

Therapeutic measures were only specified in 32.4% of casenotes studied. A variety of drugs were in use including, potassium bromide, chloral hydrate and latterly paraldehyde. Prior to the introduction of paraldehyde in 1882, morphine was used for its sedative properties. However, problems with tolerance necessitated large doses being used, which in turn led to constipation and traumatic withdrawals limiting its therapeutic appeal.

Other modes of treatment included walks, cold baths, bowel evacuations and forced feeding via a stomach pump.

Table 5: Forms of treatment specified

Type	Percentage of all Treatments N=114
Drugs	57.9%
Force Fed	27.2%
Bath	4.4%
Bowels	9.6%
Walk	0.8%

Violence and suicide

On Admission 33.2% of patients were considered to be 'dangerous' and 22.9% to be 'suicidal'. Subsequently 16.8% became aggressive at some time during their stay and 13.4% were secluded in either a padded, glass or strong room on at least one occasion.

Length Of Stay

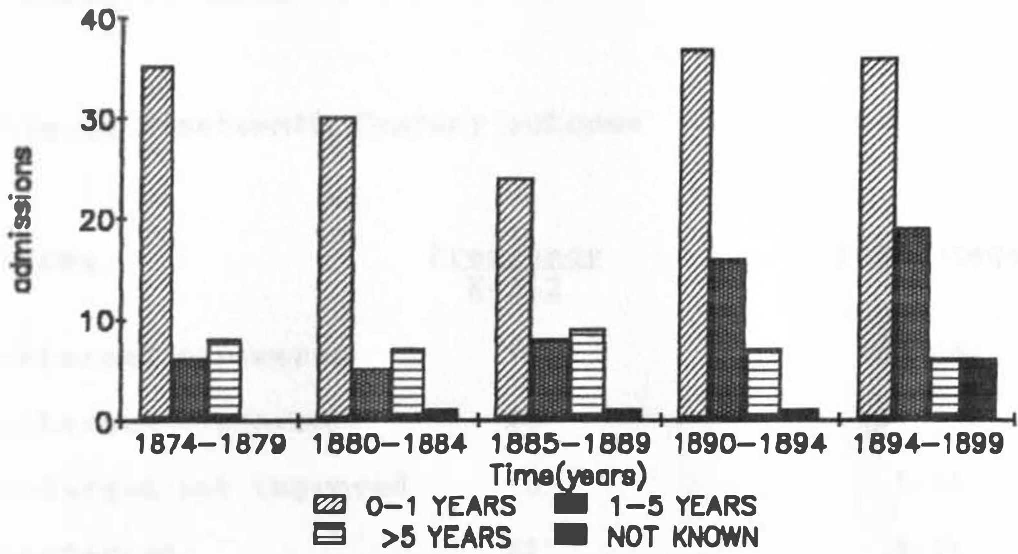
The mean length of stay in the asylum was three years and three months, however, most patients stayed less than twelve months. Table 6 illustrates this point, although 61.8% of admissions stayed in the asylum for less than a year, a small percentage were resident for more than five years.

Table 6: Length of stay from date of admission

Length of stay	Frequency N=262	Percentage
0-1 Year	162	61.8%
1-5 Years	54	20.6%
>5 Years	37	14.1%
Not Known	9	3.4%

As with the RDC diagnosis, a plot of length of stay of admissions at five yearly intervals was performed. Graph eight shows that the majority of all admissions were of short duration. As the years progressed a slight rise was seen in the group of patients remaining in the asylum between one and five years. However, there was no increase in the number of patients who resided in the asylum for more than five years and were generally considered to be representative of the chronically mentally ill.

Graph 8: Length of stay against year of admission.



Outcome

The outcome of patients, as stated by the Asylum Doctor, is shown in Table 7.

Table 7: Nineteenth Century outcome

Outcome	Frequency N=262	Percentage
Discharged-recovered	98	37.4%
Discharged-improved	28	10.6%
Discharged-not improved	3	1.1%
Transferred	21	8.0%
Died	99	37.8%
Removed by police	1	0.4%
Discharged-not insane	1	0.4%
Removed against advice	1	0.4%
Escaped (never found)	1	0.4%
Not Known	9	3.4%

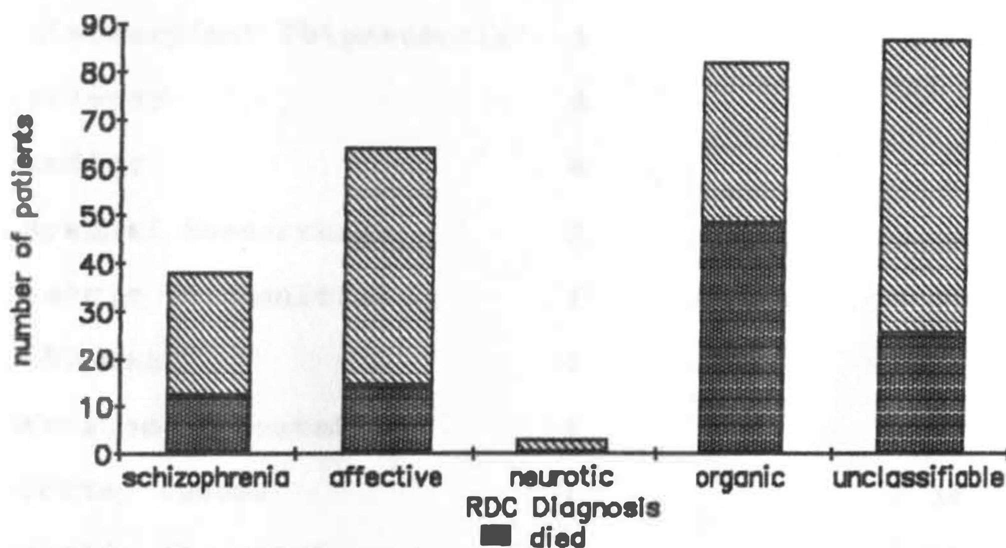
The majority of patients were either 'discharged-recovered' or died. One patient was removed by the police to Perth Prison and another, a quadriplegic mute who was a key witness in a murder trial, eventually discharged with a diagnosis of 'not insane'. There was only one successful escapee and one patient whose relatives insisted on removing him from the Asylum.

Of the 99 patients who died in the Asylum, 42.4% had been resident for less than one year, and 33.3% for more than

five years. The average age at the time of death was 39.9 years.

An RDC diagnosis of 'organic' was made in 48.4% of those who died by examination of records made prior to death. These patients accounted for 58.5% of all organic diagnoses made.

Graph 9: Mortality and RDC Diagnosis



Graph nine shows the relative mortalities for each RDC diagnostic category. The 'organic' category had the greatest mortality rate, followed by schizophrenia. All three patients admitted with neurotic disorders survived, as did the majority of patients admitted with affective disorders.

The Post Mortem records were studied to determine certified causes of death. The twenty cases who were admitted before 1899, but died after 1900 were excluded.

Table 8: Post mortem causes of death

Certified cause	Frequency N=79	% of deaths
G.P.I.	17	21.5%
Tuberculosis	15	19.0%
Not Known (no PM)	13	16.5%
Pneumonia	9	11.4%
Brain softening	5	6.3%
Pulmonary(not TB\pneumonia)	4	5.1%
Epilepsy	4	5.1%
Cardiac	4	5.1%
Cerebral Haemorrhage	2	2.5%
Gastric (duodenitis)	1	1.3%
Influenza	1	1.3%
Carcinoma (prostate)	1	1.3%
Glottal oedema	1	1.3%
Suicide (hanging)	1	1.3%

The commonest causes of death were G.P.I. and Tuberculosis. Ten percent of deaths were attributed to chest infections and 6.3% to non-specific 'brain softening'. Four patients died in Status Epilepticus and two from cerebral haemorrhages secondary to head injury. One patient was found to have died from glottal oedema after superficially cutting his neck with a rusty blade and another committed suicide by hanging himself with a rope in the curling shed.

DISCUSSION

Sociodemographical characteristics of the population.

The inpatient population of the Asylum consisted predominantly of the lower social classes of rural Fife. Most patients were members of a productive labour force and were not therefore the flotsam of society envisaged by Scull.

The average age on admission was 40 years. In 1871, 75% of all English males were under 45 years of age (Renvoize and Beveridge, 1989). Those admitted therefore tended to represent a relatively elderly cross-section of the population.

Half of the inpatients studied either were or had been married, this concurs with the findings of Thompson (1984) for the pauper West House of the Royal Edinburgh Asylum 1874-1894. However this is not mirrored by a study of the more affluent population of the York Retreat during 1880-1884 (Renvoize and Beveridge, 1989), where most of the patients were single. It would therefore appear that, in the pauper community, patients with serious psychiatric illnesses were either more likely to be married than their wealthier counterparts, or more likely to be cared for in the community if they were single.

Psychopathology

The methodological problems of retrospective diagnostic interpretation are great. The psychopathological terms used by Nineteenth Century psychiatrists cannot be equated with those of today.

In 1820 delusions and hallucinations were conceptually separated for the first time (Berrios, 1991). Skultans (1975) cites John Charles Bucknill in 1854;

'Delusions of the insane person possess characteristic features by which they may be distinguished from the absurd opinions of the foolish and ignorant.'

The finer points of these 'characteristic features' were to remain relatively obscure until the work of later Twentieth Century writers, notably Jaspers (1963).

The application of modern concepts of the form of symptoms, compared to the content, of Nineteenth Century psychopathology, is limited by the paucity of information. For example, it is rarely stated in medical records whether the voice the patient heard echoed his own thoughts, or spoke in the third person. This inevitably leads to a considerable margin of error in a retrospective search for symptoms of first rank. However a comparative overview is possible by study of content.

Content

The content of the delusions identified widely reflected the nature of Victorian culture.

The 1851 census indicated that 40% of the population of England and Wales regularly attended church on Sundays.

Klaf and Hamilton (1961) compare this to a figure of 10% for the same population one hundred years later. Religious themes were therefore a prominent aspect of Victorian life and a reflection of this is their occurence in nearly a fifth of the psychopathology studied.

Porter (1991), recalls Tausk's account of an 'influencing machine', and describes this as 'the classic engine of oppression experienced by the paranoid'. Such imaginary machines have tormented the persecuted throughout the ages and have been powered by whatever technology is in vogue from steam to microchips. Delusions therefore often reflected the scientific aspirations of the era. James K, a 25 year old patient, was deluded that he was a great inventor and was 'continually inventing something new - his latest is a flying machine which looks fine theoretically, but is no good in practice.'

In modern times complex beliefs relating to computers, space travel and bugging devices have replaced those involving flying machines, carriages and telegraphy.

Hallucinations

As described by Turner (1989) in his account of the Ticehurst Asylum, delusions were considered by asylum doctors to be the 'key symptoms of insanity'. Hallucinations, were until the last decade of the Nineteenth Century, phenomena which could co-exist with sanity (Berrios, (1991). Although this concept is

acceptable in certain cases today , it unfortunately may have resulted in the under-reporting of perceptual abnormalities in the casenotes of the past. The finding that 18.3% of patients had both delusions and hallucinations may therefore be accepted as accurate; as hallucinations were considered relevent to the insanity if delusions were also present, and they were therefore documented. However, the further 3.9% of patients who experienced hallucinations alone should once more be considered an under-estimate as in many cases it is likely that isolated hallucinations were not considered to be of importance.

<u>The causes of insanity.</u>

William Willis Moseley, author of 'Eleven Chapters On Nervous And Mental Complaints', wrote in 1838 of his belief that;

'Disease in the organ of the brain and not in the mind, is the cause of nervous complaints and insanity'

Thus inspired, he defined the predisposing and exciting causes of insanity. The exciting causes numbered thirty one and included alcohol, 'solar heat', lightning and 'the horrors of a storm at sea' (Skultans, 1975).

In the Fife Asylum casenotes no distinction was made between 'predisposing and exciting'causes but three categories of alleged causes, moral, physical and hereditary were in general use.

Within the moral category alcohol featured prominently. 15.7% of all male admissions to the asylum were believed

to be either wholly or partly due to the consumption of liquor. Thomas Clouston expressed his belief in 1884, that alcoholism was a factor in 15-20% of all cases of insanity nationwide. He substantiated this claim with figures from the Royal Edinburgh Asylum indicating that 16% of all paupers admitted suffered from alcohol related insanity.

Alcohol was freely avaliable in Victorian Scotland. The migration of Highland workers to the industralised cities of Edinburgh and Glasgow increased the accessibility of whisky in the immediate surroundings (Thompson, 1988). To consume spirits became cheaper, and therefore more popular than beer amongst paupers as no spirit tax was levied.

In the Annual Report of the Fife Asylum for 1875, Dr John Fraser, having reported that in that year intemperance was the cause of 25% of all admissions, stated;

'It is well known that alcoholism leads to a diminished or deranged intellectual or moral force, and thereby predisposes to insanity.'

It seemed that little had changed since Moseley's original observation forty years earlier that;

'Inebriation is a temporary madness, if often repeated it may become a permanent madness'.(Moseley, 1838)

The other popularly assigned moral cause of insanity was masturbation. As described by Hare (1963), the notion that self abuse could result in insanity had been accepted since the anonymous publication of the

book,'Onania, or the Heinous sin of self pollution' in 1726.

David Skae (1863) on classifying mental disorders by natural history, rather than associated symptoms recognised 'masturbators' as a group distinct from idiots and epileptics.

'The vice produces a group of symptoms which are quite characteristic and easily recognised, and give the cases a special natural history'

Skae (1863)

Just as Turner (1989) demonstrated at Ticehurst, entries in the Fife records such as, 'his general appearance seemed to belong to a masturbator' were common. However unlike studies at York (Renvoize and Beveridge, 1989) and Ticehurst, no specific treatments were described for the habitual self abuser.

Of those patients in whom masturbation was thought to be the cause of their insanity, 25% received an RDC diagnosis of schizophrenia. This supports the hypothesis of Hare (1963) that the term 'masturbator' equated with a schizoid constitution. However, Hare's claim that the comment of 'masturbational insanity' rapidly declined between 1885 and 1900 is refuted, 75% of the cases in Fife were reported in this period.

Family History

The presence of a positive family history of psychiatric illness in only 17.9% of the population, is almost certainly an under-representation. Entries in the case records such as, 'no familial predisposition admitted to'

indicates both the reluctance of individuals to be associated with relatives thought to be insane and the difficulty of obtaining a clear history on admission, usually due to the absence of informants.

The large numbers of admissions due to organic illness e.g. G.P.I. would not be expected to display any genetic associations.

Diagnoses: Nineteenth Century and RDC.

One half of all patients studied received a diagnosis from the attending physician of either mania or melancholia.

In 1868 Sir William Gull first used the term 'depression' in relation to hypochondriasis, it was not until 1898 that depression had become synonymous with melancholia (Berrios, 1988). Unfortunately from the Fife archives Nineteenth Century diagnoses are not available for the years 1898 and 1899, therefore the use of the new term cannot be confirmed.

7.3% of patients admitted received a Nineteenth Century diagnosis of general paralysis of the insane, this being regarded as a distinct entity from 'syphilitic insanity', the aetiology of which was unclear. The course of the illness once diagnosed was known to be terminal and many more cases were retrospective diagnosed from post mortem findings.

Generally asylum doctors were very familiar with the constellation of symptoms presented by those patients with G.P.I..

There was a standard medical examination by which the diagnosis was confirmed. Examination of the pupils enabled their symmetry, regularity and responses to light to be determined. The patient would then walk along a plank laid on the ground and any ataxia was noted. The tongue and speech were examined for fibrillation and slurring respectively. Finally, a sample of handwriting was obtained and placed in the notes, as a yardstick by which deterioration could be monitored.

On admission Mr H., a 49 year old fisherman was examined and the findings noted;

'Pupils contracted (but size varies), the right is rather the longer sensitive. The articulation is affected, halting, hesitating and somewhat stuttering. He slurs over long words and groups of consonants. His walk is stumbling - there is a roll in his gait like that of a seaman. He can walk a plank easily and steadily, no difficulty turning. Handwriting is jerky and stiff.'

The application and subsequent validity of RDC diagnoses to Nineteenth Century patients is recognized as controversial. Many difficulties within this area arose throughout the study.

Initially affective disorders were split into unipolar and bipolar. However, given that only first time admissions were included, bipolar equated with hypomania and therefore the category was changed.The inclusion of organic and unclassifiable categories corrupted the 'best fit' protocol of the RDC, by introducing another two potential categories to be considered in all cases. Therefore where any doubt existed as to the diagnosis it

was obligatory to incorporate the patient into the unclassifiable category. Hence this category became larger than anticipated, not only due to the paucity of information, but also to over-inclusion as a result of poor correlations with other categories.

The prevalence of schizophrenia in the Fife Asylum is much reduced relative to the York Retreat in the years 1880-1884 (Renvoize and Beveridge, 1989). This discrepancy may be partly explained by the omission of organic and unclassifiable categories in the York study; although this study drew from a different population and epileptic patients were likely to be transferred to other institutions (Beveridge, personal communication).

In Turner's study of Ticehurst Asylum the same five RDC categories were used. The prevalence rates of schizophrenia in Ticehurst are therefore more comparable with those obtained in this study (17.7% c.f. 9.9% respectively), although Fife figures remain lower.

On reviewing the pattern of RDC diagnoses over time, no relative rise in the diagnosis of schizophrenia was seen. Taking the 26 year period, an increase in affective disorder was noted for the period 1895-1899. In the preceding five years (1890-1895) 21.3% of the new admissions received a diagnosis of affective disorder compared to 34.3% for the following five years.

The validity of results based on RDC determination of major psychoses must remain questionable. Therefore the ability to hypothesize as to whether or not there was a

relative or apparent rise in insanity in the Scottish pauper population of the Victorian era is profoundly limited.

It is therefore unknown whether or not the Asylum population reflected the prevalence of mental illness in the community. Although the numbers of patients did increase over the 26 years studied it is not clear whether this was the result of social factors as proposed by Scull, or a real increase in the incidence of schizophrenia suggested by Hare. Results show no increase in the prevalence of schizophrenia within the asylum over the period studied. Equally there was no real increase in the numbers of chronic and debilitated patients admitted to the Asylum. A major factor in the enlargement of the inpatient population must therefore have been a greater public accceptance of the Asylum and willingness to utilise its facilities.

To concur with Henry Maudsley;

'Truth is a pleasant abstraction, a visionary and ever-receding ideal to be persued.. We shall not capture it; the joy lies in the pursuit.'
Henry Maudsley (1917)

Length of Stay

In complete contrast to figures derived from English asylums, the length of stay in Fife's Asylum was usually less than one year. This figure remained constant throughout the period of study.

The English Asylums were rapidly becoming 'dumping grounds for workhouse geriatrics', as Walton described at

the pauper Lancaster Asylum (1981). There is little evidence that this was the case in Fife as the mean age at admission was constant and there was no increase in the frequency of organic admissions over time.
Undoubtedly the asylum philosophy, initiated by Batty Tuke, of 'boarding out' chronic patients considerably eased the workload of the asylum. It served to reduce the length of stay of those who were chronically disabled, and was of particular benefit to the mentally handicapped population.

<u>Outcome</u>

Batty Tuke in his paper 'Lunatics as patients not prisoners' emphasized the importance of striving to make any asylum 'a truly curative institution'. The extent to which the Fife District Asylum fulfilled this expectation in the latter half of the Nineteenth century is disappointing. This study has shown that statistically a male admitted had an equal chance of being 'discharged-recovered' or dying. Additionally the assessment of recovery was an arbitrary one, based on a junior doctor's clinical judgement and little else. Casenotes indicate there were many occasions when patients were discharged as recovered, when in fact their mental state appears to have beeen little altered from admission.
The was a clear bimodal distribution of length of stay in those patients who died in the asylum. The majority died within one year of admission. A third of all deaths

represented the chronic population and they died following at least five years residency in the institution.

Post mortem reports show the commonest cause of death to be G.P.I., the terminal phase of which usually lasted between six months and a year. Therefore the high mortality rate may be partially attributed to a subgroup of men who were relatively young (average age at death 39.9 years), who once admitted with end stage G.P.I. died within one year.

Tuberculosis was also rife within the confines of the institution and was the second commonest cause of death. Perhaps unsurprisingly, a noticeable increase in the T.B. mortality was seen following the decision to use the cows of the Asylum Farm to provide all the milk. The idea that tuberculosis and insanity were part of the same constitutional tendency was propagated by Thomas Clouston. He conducted post mortem research which found an unexpectedly high incidence of tuberculomas in the insane.

Subsequently high mortality rates from tuberculosis in the mentally ill have been reported for periods up to the 1940's. Although Baldwin (1979), comments on the recent decline and virtual disappearance of tuberculosis mortality in the present inpatient population; he notes a significant proportion of schizophrenic patients have had a history of tuberculosis prior to admission. It remains questionable if this association reflects social

conditions, or a biological predisposition to the disease in schizophrenic patients.

CONCLUSION

The work of Scull has been severely criticized by Grob (1991), for its dogmatism and failure to consult patient casenotes of the Victorian era. Scull's view that asylums were 'convenient places in which to place inconvenient people' is not upheld by this Scottish study. There is no evidence that the asylum silted up with chronically debilitated patients who could no longer be profitably employed in the workhouse.
Additionally, this study lends no support to Scull's suggestion that the industrialization of Victorian Britain led to a disintegration in local communities' ability to care for their mentally ill. On the contrary, the 'boarding out' system promoted by Batty Tuke was successful and ensured that the asylum had a rapid patient turnover and numbers remained manageable.
Despite Batty Tuke's early fears that swelling numbers may jeopardise the 'open door' system, the policy remained intact until the end of the Century.
In summary, The Fife and Kinross District Asylum differed from its English counterparts, in both the private and pauper sectors. In particular the proportion of the population suffering from severe mental illness remained static and numbers of chronic patients were low. As the century progressed the increase in the incidence of organic illness described by Hunter and MacAlpine (1973) at Colney Hatch did not develop.

Although mortality rates were high, these would have been considerably lowered by the availability of antibiotics, to treat the commonest killers of G.P.I., Tuberculosis and chest infections.
With respect to mental illness, the philosophy of the institution was directed at cure. The extent to which the Fife Asylum achieved this objective is, by modern standards, severely lacking. However, given the social and economic structure of its time, and placed in broader perspective relative to the plight of the pauper mentally ill prior to the 1857 Lunacy Act, the establishment of the Fife Asylum was an important development in the psychiatric care of the Scottish rural pauper population.
As Jones (1991) observes;

'In the second half of the Twentieth Century, the mental hospital system once so solid and seemingly impregnable, has virtually collapsed.'

Despite criticism of the asylum era, key elements from the approach to asylum management at The Fife And Kinross Asylum remain influential in today's new wave of community care.

APPENDIX A

HISTORICAL OVERVIEW (excluding psychodynamic theories)

1603	Edward Jorden A Brief Discourse On A Disease Called Suffocation Of The Mother.
1621	Burton The Anatomy Of Melancholy.
1707	1st lunatic admitted to St. Peters Hospital, Bristol.The first Public Hospital for the insane.
1734	George Cheyne The English Malady
1744	The Vagrancy Act (England and Wales) First legislation permitting treatment of the insane.
1781	First Scottish 'Royal' asylum opens in Montrose
1784	William Cullen Derives term 'Neuroses'.
1792	William Tuke Founded Retreat at York.
1798	Phillipe Pinel Removing chains of lunatics in Paris.
1808	Johann Reil Used word 'Psychiatry' to describe new treatment.
1808	First County Asylum Act (England and Wales).

1810	Anton Mesmer continues to develop theories of 'animal magnetism'
1813	Royal Edinburgh Asylum opens.
1828	Second County Asylum Act (England and Wales).
1835	Pritchard Describes 'moral insanity'.
1837	W.A.F. Browne What Asylums Were, Are, And Ought To Be.
1838	Esquirol Phenomenologically separated illusions from Hallucinations.
1841	Founding of Association Of Medical Officers Of Asylums And Hospitals For The Insane.
1842	Edwin Chadwick Report on the sanitary conditions of the working classes.
1845	Baillarger Description of 'folie a double forme'
1845	Lunacy Act (England and Wales).
1845	National Lunacy Commission formed (England and Wales).
1852	Morel Described Demence Precoce.
1856	John Connolly The treatment of the insane without mechanical restraints.
1857	Bromides introduced as sedatives.

1857	The Lunacy Act (Scotland) passed.
1859	Charles Darwin The Origin Of The Species
1863	Kahlbaum Described catatonia.
1863	First Scottish district asylum opens in Lochgilphead.
1863	Virchow Cellular theory.
1866	The Fife and Kinross District Asylum opens.
1866	Down Observations On Ethnic Classification Of Idiots.
1868	Harlow Frontal lobe syndrome described (case of Phineas Gage)
1869	Chloral introduced.
1872	Huntington Described Huntington's Chorea.
1874	John Batty Tuke Presented use of open door system at FKDA to Parliamentary subcommittee.
1877	Parkinson Described 'Shaking Palsy'
1882	Paraldehyde introduced.
1882	Koch isolated TB Bacillus.
1883-4	Hughling Jackson Series of lectures on the nervous system

	Psychoses = 'eruption of primitive behaviour.'
1884	Pasteur
	Germ Theory
1885	Publication of 'Handbook For The Instructions Of Attendants Of The Insane'
1888	Sulphonal introduced.
1890	William James
	The Principles Of Psychology'
1892	Hack Tuke
	'Dictionary Of Psychological Medicine'
1892	Pick
	Described Picks Disease
1893	Kraepelin
	Described 'Dementia Praecox' and 'Manic Depressive Insanity'.
1903	Spirochaete identified
1903	Barbital introduced
1906	Wasserman test introduced
1906	Alzheimer
	Described Alzheimers Disease.
1913	Noguchi
	Demonstrated spirochaetes in GPI brains at PM
1927	Wagner Jauregg
	Nobel Prize - Malarial Treatment of GPI
1929	Berger
	Developed EEG
1930	Mental Treatment Act (England and wales)
	Introduced Voluntary status

1931	Meduna
	Cardiazol shocks for psychoses.
1938	Cerletti and Bini
	First administration of Electro-convulsive Treatment.
1939	Cade
	Introduced Lithium.
1948	Formation of The National Health Service
1949	Egas Moniz
	Nobel Prize - Leucotomy in psychoses.
1952	Delay and Deniker
	Introduced Chlorpromazine
1957	Kuhn
	Introduced Imipramine
1959	R.D. Laing
	The Divided Self.
1960	Cohen
	Introduced Benzodiazepines
1961	Goffman
	Asylums
1961	Szasz
	The Myth Of Mental Illness
1963	Jaspers
	'Textbook Of General Psychopathology'
1971	The Royal College Of Psychiatrists formed
1975	DHSS Paper
	Better Services For The Mentally Ill
1980	Franco Basaglia
	'Psichiatria Democratica'

APPENDIX B

Six case histories will be used to illustrate the patient's experience of the Fife Asylum.

1. The Case Of James B.

A 34 year old single engine fitter was transferred from Govern Parochial asylum to the Fife Asylum in 1882.
On his transfer no detailed history was available, other than this was believed to be his first attack of insanity and it was believed to have lasted for one month and no cause could be identified.
He was excited and showed 'exhaultation' on arrival. He was talkative and answered questions well - although if 'left to his own devices he became rambling and irrelevant.'
He claimed to have no friends or family, as they were all dead.
He was quickly sent out to work in the gardens and was regarded as a model patient who 'eats and sleeps well and does not give much trouble'. His inner world revealed a different picture as depicted by his poem;

> God's tools from living don't retain,
> mind talents are rare genius in
> brain,
> For sowing, man's life is but brief,
> it's wasted time falls wise with
> grief.

Say will I here be longer stay'd ?

It's wasted time makes one dismay'd.

Straightforward truth rush'd in the ear,

dispels all doubt - no room for fear.

A year later he was discharged 'recovered', having regained his senses and awareness of his brothers' existence.

2. <u>The Case Of Thomas H.</u>

A six year old boy was admitted from Dunfermline Poorhouse. He was an illegitimate child and had been called an imbecile since birth. He suffered from epilepsy. His medical certificate of admission states;

'His whole conduct is that of a lunatic - he is restless, stupid and uneasy. He laughs and talks of nonsense continually.'

The governor of the Poorhouse felt he could no longer be responsible for the boy's safety. He would 'eat all sorts of dirt and was constantly in danger on the walls of falling.'

On admission he was three stone in weight and three feet and eight inches tall. His hair was 'thick, short, dark and dry.' He was 'unable to sit still for more than a moment at a time, has a silly expression on his face and laughs foolishly. He can answer questions as to his age pretty easily and knows his name and his mother's name. The main feature is enfeeblement of mind.'

He had two or three grand mal seizures each day - sleeping soundly after each. When awake Thomas tested the patience of both staff and inmates;

'This little imp would be constantly in hot water if not carefully watched. He bolts along the corridors in a twinkling and gets to the female side pretty frequently He readily takes to some of the older and kindlier patients but will not chum with Joe Smith, the little idiot in number two gallery.'

He contracted scabies, resistant to sulphur ointment, but which ultimately resolved. He continued to have severe epileptic attacks and during these frequently cut his head and sustained bruises. In order to minimise his injuries, 'a cap with a lock has been made which is well padded and he can't take off.'
Ten years after his admission, at the age of sixteen, Thomas died in Status Epilepticus.

3. The Case Of 'Admiral Rice'

A 53 year old married sailor was transferred from Inverness Asylum in 1884.

He had became ill following an accident, when his head was crushed between the side of a vessel and the pier at Inverness Docks. As a result of the accident he was briefly admitted to the Inverness Infirmary, but outrageous behaviour of 'fits of passion' necessitated his transfer to the Inverness Asylum.

Here he became violent and unmanageable - he cut open an attendant's head with a chair and set fire to a window sash. His belief that he was being assaulted by attendants at Inverness prompted transfer to the Fife Asylum. On arrival in Fife he was disorientated, but understood questions. He claimed to be blind in his left eye, but on testing this was found to be untrue. The asymmetry of his pupils was remarked upon.

He was put to work in the gardens, but 'every day became more of a nuisance.' He developed grandiose delusions that he owned £2000 and six steamships. He spent time 'praying or singing, abusing officials and annoying everyone near.'

His occupation was changed and he worked in the hair-teasing room by day and was placed in a padded room by night, in order to minimise his disturbance to others. During this time he had proclaimed himself to be Admiral Rice and wrote to Queen Victoria;

To Her Most Gracious Majesty Queen Victoria Empress Of India,

May it please your most Gracious majesty to listen to my humble petition. I am a soldier of honour and distinction, from 1820 to the year 1884 in all the wars and campaigns throughout the world, and never received any honour as distinction for my long services of 54 years. But I am thankful that I served you faithfully for so long a period that is however enough that I have done my duty to God and my country. When I am lying on my death-bed after the Battle Of Coumarrie the Lord of Heaven and Earth appeared to me in a vision, or dream, and told me to seek thy hand and to conquer the world for him. So I intend to fulfil my duty to God and man, as well as Army and Navy. Such as the world never saw it was my fortune to get your hand and heart.

Admiral Rice

He became more violent as time went on, and frequently required to be placed in the seclusion room. Finally, having set fire to his bed and clothing, he was given a 'special attendant for his maniacal state'. His symptomatology was now described as 'characteristic of a General Paralytic.' Admiral Rice was discharged - not improved, back to the Inverness Asylum six months after admission. He was a stone and a half lighter than on arrival.

4. The Great Philosopher - The Case Of James K.

A 25 year old single mechanic from Kirkcaldy was admitted to the Fife Asylum in 1887. He had been out of employment for 'some time' and his mother described him as being, 'strange and unsettled for the last year'. His brother had been a patient in the Asylum in 1886.

On admission he was endeavouring to invent 'some electrical apparatus' but was considered to be 'dull and melancholic'. He believed that people were conspiring against him and that Ministers of all denominations preached against him, as he had committed an unnatural crime eleven years ago. He showed no insight into his illness, claiming that there was 'nothing to worry about and he was quite well'.

After four months in the Asylum he made an escape and took with him a fellow patient's best Sunday coat and vest, in addition to an attendant's boots. It was, therefore, 'quite a deliberate affair'.

One month after his escape nothing had been heard of him, although his own clothes had been found deserted on a nearby racetrack. He was formally discharged.

Six years later he was readmitted. He had 'been in Kirkcaldy for some time and did not seem to be in control'.

Since the last admission he had married, but immediately prior to admission had separated from his wife, and was staying with his parents. Neither parent felt able to

care for him, his mother was bedridden and father afraid. He was expressing ideas that his food had been poisoned and was refusing to eat.

On admission physical examination was unremarkable. However, it was noted with concern that his urine showed, 'the clouding of phosphates on boiling'.

Over the next few weeks it was felt he was, 'doing well although prone to be rather irritable at times'. He began writing a book on 'a new theory of atoms', and declared himself to be a great philosopher. The casenotes record, 'his magnum opus will be a funny mixture of politics, palmistry, physics and folly'.

After three years in the Asylum, he continued to write his book, although its emphasis had shifted and it had been given a new title, 'A philosophic inquiry into palmistry'. He spent large portions of the day making 'numerous drawings of hands with all the lines and areas carefully mapped out.'

As time went by he was, 'always inventing something new'. He put six inch long willow twigs up his nose 'for antiseptic purposes' and heated a penholder in the fire so he could apply it 'red hot to his cheeks to remove freckles. He succeeded.'

At the age of 37 he was noted to be getting 'very stout'. He asked to speak with the Superintendent one morning during a daily round of the Asylum and protested;

'This Asylum is fit for the artificial production of insanity and not for its cure'.

J.K. continued this rebellious theme by writing a letter to the Public Prosecutor in which he complained about the treatment he was receiving in the Asylum;

'I am feeling greatly insecure in this circumstance owing to the Dragonistical aggression to which I am exposed in this Public Institution. I have been considerably maltreated and wilfully neglected and abused, even to the extent of sometimes serious assault by various of the male attendants and their subordinates in this Lunacy Asylum... Healthy well invigorated public opinion ought rightfully to be omnipotently influential in a circumstance like ours but the strong hand of the law ought to be readily available also in our Asylums.

His complaints were filed in the casenotes having been returned from the office of the Public Prosecutor. Until the end of his life in 1907 J.K. continued to write 'extravagant pseudophilosophic treatises', which were latterly 'indecently illustrated'. He died in the Asylum at the age of 45 from tuberculosis.

5. Not Insane - The Case Of John M.

J.M. had been paralysed all his life. He was not able to speak or do anything for himself. He was admitted to the Fife Asylum in 1883 when his mother disappeared suddenly. He was 24 years old.

He had 'always been incontinent of urine and had little power in his sphincter ani and would not let anyone know when a motion was to be passed, resulting in an accident of a disagreeable nature.' The medical certificates indicated that although he was a congenital imbecile, he was 'wonderfully intelligent'. On admission he was able to answer questions by making movements of his head, lip and eyes. Physical examination revealed a pronounced curvature of the spine and chest deformity. His lower limbs were 'thrust to the left side at the hip joints and the legs flexed partially on the thighs'. He had a total quadriplegia and maldescended testes.

After he had been in the Asylum for two and a half weeks he received a visit from the Procurator Depute and was precognosed as a witness in a murder trial. It had been reported that he had been present when his mother and sister had killed his brother-in-law. His brother acted as interpreter for this purpose and a concise testimony was obtained. A 14 day repent was applied for and granted, he was discharged certified 'not insane' to the Dysart Poorhouse.

6. Suicide By Hanging - The Case Of J.W.

In 1890 J.W., a 42 year old tobacco pipe maker, was admitted to the Fife Asylum. He was married but accompanied to the Asylum by Mr F., 'an intimate acquaintance but no relative'.

The admitting medical officer was told that his usual disposition was to be bright and cheerful, but that over the preceding year he had been anxious and depressed about his business affairs. He had been 'feeling dull and unable to work and spoke of having impulses to do away with himself.' He expressed concerns that he would never be well again in a 'clear and sensible way which was to the point'.

Over the next week he became 'distinctly better', but was 'by no means rid of the unpleasant feelings in his head.' After spending five months in the Main Asylum building he was sent to the convalescent house. His family complained that 'his brain is not right yet', but it was the appearance of an ischiorectal cyst that necessitated his transfer back to the Main Buildings. Following the surgical excision of the cyst, he once again became 'unsettled in mind' and repeatedly expressed a wish to go home.

By May of 1892 he was fully active in Asylum life. He played cricket in the grounds and was 'cheerful and interested'. The following day he asked for permission to go for a walk, which was granted. He failed to return for

lunch or tea and a search was mounted. When finally found;

'He was hanging in the old curling house near the farm steading having suspended himself by a short piece of rope from a hook on the wall. He was quite dead and had apparently been so for some time.'

The certified cause of death was suicide by hanging.

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