

# 'Noisy, restless and incoherent': puerperal insanity at Dundee Lunatic Asylum<sup>1</sup>

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## **Abstract**

Puerperal insanity has been described as a nineteenth-century diagnosis, entrenched in contemporary expectations of proper womanly behaviour. Drawing on detailed study of establishment registers and patient case notes, this paper will examine the puerperal insanity diagnosis at Dundee Lunatic Asylum between 1820 and 1860. In particular, the study aims to consider whether the class or social status of the patients had a bearing on how their conditions were perceived and rationalised, and how far the puerperal insanity diagnosis, coloured by the values assigned to it by the medical officers, may have been reserved for some women and not for others. This examination of the diagnosis in a Scottish community, suggesting a contrast in the way that middle class and working class women were diagnosed at Dundee, engages with and expands on work on puerperal insanity elsewhere.

**Keywords:** puerperal insanity, women, lunatic asylums, Scotland, nineteenth century, case notes

## **Introduction**

In the summer of 1835, Marjory Lowson was admitted to Dundee Lunatic Asylum after the delivery of her first child, having begun to 'wander in her mind' and becoming 'confused and silly'. Her husband, a Dundee shipmaster, sought medical advice and took her on a trip to London to 'avert her attention and draw her from herself', but to

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no avail. On the homeward voyage, she attempted suicide by throwing herself overboard and on returning to Dundee was 'indifferent to her infant' and 'utterly unable to take charge of her house' (DUA, THB 7/8/9/6). According to the asylum notes, this was a case of 'puerperal mania' brought on by 'parturition, mismanaged afterwards'. The young woman remained in the asylum from July until September, during which time she remained mostly miserable, declaring that she was 'lost, inextricably lost' and that 'no mortal understood her case'. She believed that she had not eaten for years, on account of not being able to swallow, although the superintendent thought she ate very well. She was treated with mild purgatives, and her bowel movements and menstrual cycle were closely monitored. She was 'discharged, improved' but not cured, from the asylum at the request of her husband, who was paying 21/- per week for her board and a fee to the physician. The medical superintendent 'believe[d] that she will recover from the attack, but be subject to others' (DUA, THB 7/8/9/6), a prescient statement for she was indeed readmitted to the asylum the following September. This time, she had become restless and violent following the birth of another child, trying to bite the nurse attending her (who then 'declined to take further charge of her') and attempting to throw herself out of a window. On this occasion, her husband was at sea and her relatives 'refused to interfere 'this time' '. It was left to her medical attendant to decide the best course of action: his choice was to have her removed to the asylum, where she remained, 'noisy, restless and incoherent', until her death late in the afternoon on 9th October, 1836 (DUA, THB 7/8/9/9).

This narrative, unfolding over 17 neatly-written pages of case notes in the files of Dundee Lunatic Asylum offers not only an insight into Marjory Lowson's symptoms and illness, but also into the dilemmas faced by her family, the attitudes and practices of the asylum staff and the opportunities for treatment available to her. Her husband clearly sought to deal with her condition, and there is evidence of a family dispute over her removal to the asylum. When no longer able to take charge of her home and family, however, she was admitted to the asylum. Busfield and Campling (1996: 261) describe madness as 'an evaluative, socially constructed category with fluid, imprecise boundaries'. While there is a real and observable base to Marjory's illness, its

interpretation by others and the treatment received was shaped by contemporary understandings of madness, disease, and socially acceptable behaviour, and by the circumstances in which her illness was treated.

The history of 'puerperal mania', madness associated with childbirth, has principally been documented by Marland (1999, 2003a, 2003b, 2004, 2012), who explores the experience of the condition by women themselves and the evolution of the diagnosis in a changing professional landscape. Significant British work has also been conducted by Day (1985), Nakamura (1999) and Quinn (2002, 2003), and in the United States by Theriot (1990). Nakamura's work, using records of Ticehurst and Hanwell asylums, focusses on puerperal insanity as a concept through which to explore Victorian psychiatric ideas related to the treatment of women, while Quinn draws on records of asylums in Devon to relate the rise of this diagnosis to 'middle-class constructions of the idealisation of maternity' (Quinn, 2003: 2). More recently, Kilday (2013) and Cossins (2015) have examined the puerperal insanity diagnosis in cases of infanticide.

The puerperal insanity diagnosis surfaced in British medical literature early in the nineteenth century, reached its 'heyday' in the later-1800s, and basically vanished as a diagnosis by the early-1900s (Marland, 2004: 3). While it can be understood as 'a real condition with real sufferers', Marland claims that it was nevertheless a 'product' of its time, shaped by nineteenth-century beliefs about disease and mental illness, but also by Victorian morals and values (Marland, 2004: 4, 201). Although physician-accoucheur Thomas Denman had referred in 1807 to 'that aberration of the mental faculties, which sometimes, though happily very rarely, we have the opportunity of observing', the condition was first clearly described in Britain by obstetrician Robert Gooch in a late-1819 paper delivered to the College of Physicians (Denman, 1807: 430; Gooch, 1820: 263). The idea that women following childbirth could be prone to violent or erratic behaviours, or extreme misery, had long been recognised by women and midwives (Marland, 2003b), but the nineteenth century saw a medicalisation of childbirth and associated conditions, with women steadily removed from a province previously theirs very much their own (Marland, 2012: 79). Puerperal insanity was a contested area sitting 'uncomfortably somewhere between obstetrics and psychiatry',

a battleground for the opposing and competing interests of the rising psychiatric and obstetric professions, which nonetheless gradually 'coalesced' into a recognised 'body of medical literature' (Loudon, 1988: 76; Nakamura, 1999; 299).

There are doubtless similarities to the modern day diagnoses of postnatal psychosis and depression, not least in the common event of childbirth. Turner, in an examination of case notes at Ticehurst Asylum, tests the 'social mutability' of mental illness, noting 'a sameness, a form of symptoms independent of the transitions of society', and concluding that core conditions and syndromes can be teased from the physician's notes (Turner, 1992: 61). Rehman and colleagues, in a comparison of postnatal patients in the nineteenth and twentieth centuries, identify strong similarities but 'more florid' and 'more numerous' symptoms in the nineteenth century cohort (Rehman et al., 1990: 863). Scull (2009: 11) has warned against the dangers of retrospective diagnosis, however, stating that 'disease entities are complex cultural productions' which 'depend upon layers of interpretation being placed upon whatever underlying physiological and psychological disturbances give rise to them'.

Much existing research into puerperal insanity has focussed on its contemporary definition relative to ideals of 'proper womanly behaviour' – the diagnosis both reflected contemporary sexual ideology and supported it (Theriot, 1990: 74-75). As motherhood was considered a woman's 'paramount duty and most rewarding purpose in life', the consequences of rejecting this role posed a threat to the fabric of Victorian society, striking at the heart of family life (Marland, 2004: 6). At the extreme end of the spectrum, women who killed their children 'represented the very antithesis of womanhood' (Marland, 2004: 200). The diagnosis of puerperal insanity hence allowed a 'neat societal explanation for [this] outrageous behaviour' which relieved such women of liability while still protecting the 'state of femininity' (Pegg, 2009: 220).

### **Puerperal insanity, the Dundee Lunatic Asylum and using case notes**

While Marland's research uses patient notes and letters from the Royal Edinburgh Asylum, there has been little other research on the condition in Scotland. In the mid-nineteenth century, Dundee was Scotland's third largest city, boasting 'forty-three

spinning mills, eight powerloom factories and sixty-two handloom factories employing 11,382 people, over 8,000 of whom were women' (Miskell, 2000: 52). As many as a quarter of married women in Dundee were working in mid-nineteenth century Dundee, the majority in the textile mills but middle- and working-class women were also employed in shops, offices and domestic service (Whatley et al., 1993: 113-114). Working women here as elsewhere enjoyed 'a degree of economic independence, freedom from direct patriarchal control' and were seen to 'flaunt their independence' (Gordon, 1987: 29-32). The city's asylum was one of eight charitable institutions for the care of the insane founded and built in Scotland by public subscription between 1782 and 1839, forming 'the mainstay of Scottish provision in the first half of the nineteenth century' (Walsh, 1999: 180). The charitable asylums initially accommodated both private and pauper patients, providing 'a dual, class-demarcated service' (Gayle, 2008: 44).

In her study of syphilis in four asylums from Central Scotland, Davis (2008: 17) demonstrates how the detailed examination of a particular subject of study at local level, if set within a wider framework, can 'reveal how the Scottish situation forms part of a larger story'. Dundee's high proportion of working women, particularly married women, Dundee's so-called 'defiant sisterhood', makes an interesting environment in which to study the incidence and experience of puerperal insanity (Whatley et al., 1993: 117). This paper hence considers this condition at the Dundee asylum, looking particularly at how the presentation of the diagnosis aligned with the Dundee community, and examining too the values assigned by the Dundee physicians in their diagnosis of the patients. The paper also examines communities of women unrepresented in the asylum records, and how far the diagnosis may have been reserved for some women and not for others at this establishment. The paper draws mainly on the case notes of 43 patients admitted to Dundee Lunatic Asylum between 1835 and 1860 whose illness was attributed to puerperal causes.

Although there was no legal requirement for the early Scottish public asylums to keep case notes, or indeed any kind of records, case notes were taken from even the early days of the philanthropic institutions, partly because at the time they offered 'a key

means to augment medical knowledge of insanity' (Andrews, 1998: 256-258). The patient history drawn from case notes, a 'linear narrative arrangement of information', could be written up for publication in one of the many professional journals circulating for the dissemination of scientific and medical knowledge, providing a means to 'put the reader at the bedside' (Berkenkotter, 2008: 18). In practice, asylum records were 'idiosyncratic and inconsistent', their form and content largely reflecting the particular medical interests of the writer, and varying considerably between institutions until a more standard format was imposed in the mid-nineteenth century (Marland, 2004: 105; Davis, 2005: 28; Berkenkotter, 2008: 19). Andrews nonetheless claims that 'case notes constitute an especially important and extensive resource', albeit one 'much neglected by British scholars', while Davis notes that 'clinical records still remain a rich but neglected source among historians of medicine' (Andrews, 1998: 255- 256; Davis, 2005: 26). While their analysis can be approached in various ways, from Turner's contentious use of the Ticehurst case notes to perform a retrospective analysis of the patients, to the Berkenkotter's analysis of the place of narrative accounts within changing psychiatric practices, the case notes in this study have been utilised to examine the discourse within which the women's illnesses have been constructed (Turner, 1992: 28; Berkenkotter, 2008).

In the original regulations of Dundee Lunatic Asylum, drawn up in 1817, the responsibility for keeping case books was assigned to the Apothecary, with the proviso that this and other duties should be carried out by the Superintendent until such time as it was deemed necessary to employ an apothecary. In fact, no such appointment was ever made, and the task of keeping the case books permanently fell to a succession of resident Medical Superintendents (Rorie, 1887: 9). The case notes – essentially private, in-house documents – take the form of an initial assessment, detailing the illness history of each patient with observations on her current condition, followed by more basic notes on the progress of the condition, often very brief and perfunctory, until the final discharge, removal or death of the patient. Supporting records, such as the establishment register and the petitions for admission, give little information other than details required for administrative purposes, and there are no surviving letters or correspondence from patients in this group nor from their families. Beyond some

words and phrases noted as significant by the physicians, selected and 'recontextualised' in the context of the case notes, the direct voices of the women themselves cannot be heard (Berkenkotter, 2008: 34). The physicians framed the symptoms and behaviours of the women through their own beliefs and contemporary understandings of madness, choosing to report those aspects which conformed to their own sense-making of the situation. The case notes are thus compendia of highly selective observations, reflecting the interests and expertise of the Dundee asylum medical officers as well-educated, ambitious men keen to put new ideas into practice. On his appointment in 1830, indeed, the Surgeon-Superintendent Alexander Mackintosh undertook a tour of 'all the most celebrated Lunatic Hospitals in Britain, and also of the Salpêtrière in Paris, and the Royal Lunatic Asylum, and Dr Esquirol's private establishment at Charenton' (DUA, THB 7/4/2/2, p.7). These case notes - inevitably 'mediated accounts' - can arguably still reveal a more intimate picture of a local asylum world than can reports and publications primarily intended for public consumption, providing an insight into the everyday grain and application of contemporary 'theory, discourse and practice' (Davis, 2005: 27).

### **A challenge to body, mind and morality**

To the nineteenth-century physician, the whole course of a woman's reproductive career, from adolescence to menopause, 'was seen as fraught with biological crisis during which [morbid deviations from the normal female personality] were likely to appear' (Showalter, 1980: 169). Physicians looked upon natural processes such as pregnancy, childbirth and menstruation as conditions which could affect the delicate balance of a woman's mind. Women's nervous systems were reckoned to be more 'finely tuned', meaning that they were more liable to suffer mental breakdown than men when faced with difficulties (Theriot, 1993: 8). Fundamentally instinctive, the basic 'maternal impulses' governing a woman's desire to bear and care for children could lead her to 'flout that which is considered moral and reasonable', being led more by these instinctive impulses than by 'steely rationality' (Hogan, 2006: 23). Women's madness was linked to the workings of their reproductive systems, childbirth being not only 'a woman's paramount duty and most rewarding purpose in life, but also ... a challenge to her body and mind' (Marland, 2004: 6). Mental disturbances associated

with childbearing were seen as forming a group, regardless of how the condition manifested itself. In 1863, Scottish physician David Skae, in his *Rational and Practical Classification of Insanity* (Skae, 1863: 314), stated that:

... we ought to classify all the varieties of insanity, to use a botanical term, in their natural orders or families; or, to use a phrase more familiar to the physician's ear, ... we should group them in accordance with the natural history of each. ... Puerperal mania forms a distinct group, whether the patient is maniacal, suicidal, or melancholic.

Linked as it was to a natural event, however, the prospects for patients suffering from puerperal insanity – particularly the more maniacal cases – tended to be good, with most discharged cured within a few months; and the high success rate, claimed Thomas Clouston, helped to 'keep up the standard of curability' for an asylum (Theriot, 1990: 74, Marland, 2003b: 309).

The asylum at Dundee received its first patients in 1820, soon after Gooch's address to the College of Physicians, and so it is unsurprising that this new diagnosis of puerperal insanity was deployed with caution during the asylum's first decade. Brief references were made to recent childbirth or insanity during pregnancy, but little was made of the events. Indeed, in the case of Mary Morrison, a 'poor woman' admitted in 1825, her illness was ascribed to 'domestic misfortune', it being noted that 'whether her state of pregnancy has had any share in either the attack or the cure is very uncertain: by affecting the circulation and distribution of the blood, it may have considerable effect either way' (DUA, THB 7/8/3/1; THB 7/8/9/2: 285). By 1829, however, asylum officials were confidently marking mania or melancholy due to 'puerperal causes' in the establishment register. The incidence of the puerperal insanity diagnosis at Dundee accounted for approximately 7% of female admissions over the period 1835 to 1860, a figure broadly consistent with those recorded at other asylums mid-century: circa 7% of female admissions to the Royal Edinburgh Asylum from 1846 to 1864 and generally between 6% and 10% across English public asylums (Marland, 2003b; 2004: 36–37). The majority of admissions to Dundee were pauper patients, and most puerperal insanity cases here were married women, excepting three unmarried patients over the period.



Women suffering from puerperal insanity were shocking in that they defiled 'the mysterious beauty of motherhood' (Theriot, 1990: 74):

Cases of puerperal insanity seemed to violate all of Victorian culture's most deeply cherished ideals of feminine propriety and maternal love. Women with puerperal mania were indifferent to the usual conventions of politeness and decorum in speech, dress, and behaviour; their deviance covered a wide spectrum from eccentricity to infanticide. (Showalter, 1857: 58)

These were women who should have rejoiced at becoming a mother, it was widely assumed, but were instead rejecting their maternal role and turning their backs on their families. Their behaviours 'challenged notions of domesticity and femininity and flouted ideas of maternal conduct and feeling' – they swore and used obscene language, rejected their husbands, were indifferent to or even endangered their children, were unable to manage their households and displayed inappropriate sexual behaviour (Marland, 2004: 5). Physicians were shocked by the behaviour of Mary Crichton, a 'Lady', recorded as 'speaking fast and obscenely' and 'using language totally unfit for insertion and acting in such a manner as we have never seen and which cannot be written' (DUA, THB 7/8/9/6: 5). Jane Myles, a coachman's wife, was 'naturally quiet' but had 'struck her husband and attempted to strike others' and had 'broken windows and furnishings' (DUA, THB 7/8/9/16: 152). Transgressions could be more minor, and Ann Cairncross, a ship-owners wife, was accused of having an 'extravagant love of dress' and 'manners and conversation so eccentric as to have attracted the attention of her neighbours' (DUA, THB 7/8/9/22: 164).

Descriptions of patients' former dispositions, possessing the desirable attributes of a respectable sane woman, reflected 'deeply cherished ideals of feminine propriety' (Showalter, 1987: 58). Mrs Nicol McNicol, a gamekeeper's wife, was 'originally of a cheerful, happy disposition, of industrious, discreet and temperate habits, and of average intelligence' (DUA, THB7/8/9/18: 215). Jane Sandeman, a weaver's wife, was described as 'a tidy, clever, active housewife' (DUA, THB 7/8/9/19: 65). The notes of the higher-paying private patients emphasised ideal attributes associated with gentility, refined occupation, good manners and social graces, rather than the ability to

work, stay sober and keep the house clean. Sophie Fenton, a merchant's wife, was described less hardily: 'gentle and amiable; she had a fondness for solitude, and her intellectual powers were good and well educated' (DUA, THB 7/8/9/21: 225). On the whole, however, temperate and regular habits seem to have been considered a woman's most important qualities, with a certain degree of fashionable nerviness expected and tolerated. Charlotte Symon, a banker's wife, had been 'everything a woman should be' with a 'temperament almost purely nervous' and 'habits regular' (DUA, THB 7/8/9/6: 169).

In contrast to these visions of feminine virtue, madness manifested itself in the shape of the woman unable to take care of her home and family, foresaking her duty as housekeeper and mother. Janet Davidson, a sailor's wife, had 'neglected her child and her house and in short was unable to do anything' (DUA, THB 7/8/9/19: 88). Jane Myles, a coachman's wife, was guilty of 'inattention to her duty, and wandering' (DUA, THB 7/8/9/21: 14). The rejection of children was especially shocking and contrary to expectations of the motherly role, as in the case of Sophie Fenton, who believed 'that the birth of her infant was a great misfortune' and showed 'none of a mother's feelings or maternal instincts towards it' (DUA, THB 7/8/9/21: 225).

### **Recovery and redemption**

The women were watched as they reached small milestones of achievement and gradually began to regain proper womanly attributes. Good behaviour in church was noted and the physician was delighted to observe Charlotte Symon being 'rather witty' (DUA, THB 7/8/9/6: 216). More emphasis was laid on returning the lower-class patients to industriousness and fitness to work, rather than their being witty and amiable. The Superintendent was pleased when Christian Anderson, a house servant, was 'spinning or winding – nearly quite well – what a change to be sure – it is delightful to see it' (DUA, THB 7/8/9/1: 105). Willingness to work was indeed an important criteria by which the woman's progress towards cure was measured, and as soon as feasible the puerperal patient was put to work at some occupation. Mary Bissett, a 'poor woman', was considered to be 'recovered perfectly' when 'working in the wash house', while Jane Stewart was 'going on most favourably – and working' (DUA, THB 7/8/9/10:

100; THB 7/8/9/11: 54). The private patients were occupied in knitting, sewing or darning in the day rooms, walking in the airing courts or, in the case of Charlotte Symon, playing with a pack of cards (DUA, THB 7/8/9/6/p.216).

The most significant and universal indication that all was well again, however, was the patient's willingness, or even anxiety, to return home to her children. Christian Stewart, a flesher's wife, became anxious to return home to her sixteen 'bairns' (DUA, THB 7/8/9/16: 154). In the case of Jane Myles, it was considered in the interests of her health that she should be reunited with her family when fit to do so, having become 'daily more anxious about her children' to the extent that 'this anxiety might injure her' (DUA, THB 7/8/9/19: 41). The physician perceived the 'natural' state of womanhood as wishing to take charge of home and family, and to return to the role of dutiful wife and mother. Charlotte Symon was noted as having successfully regained her family role when observed at home 'teaching her children' (DUA, THB 7/8/9/19: 89).

The physicians were, on the whole, extremely sympathetic and even defensive of their patients. They were unwilling to see their patients discharged before they considered them cured. While in the case of private patients, this reluctance could perhaps be attributed to the high fees paid by patients' fees, it is also evident in pauper patients who it was felt had not recovered fully on discharge. This sympathy even extended to those who might have been expected to have received less favourable treatment. Two of the unmarried mothers seem to have been regarded as victims rather than condemned for the illegitimacy of their infants, although the physicians had little hope of a positive outcome in these cases. Christian Anderson had been 'seduced by a villain with the promise of marriage' – her troubled home life and the proximity of 'her seducer' to her mother's home would, it was feared, have a negative effect on her recovery (DUA, THB 7/8/9/10: 106). Mary Lauder, a servant, was admitted to the asylum in 1859. Her ill treatment at the hands of her own father, who assaulted her on finding her on the point of giving birth in a cart shed, combined with childbirth, was seen as the cause of her illness (Anon., 1859a). No reference was made to the father of her child, and her 'incoherent talking about the birth of her child and her supposed marriage' was dismissed as ravings (DUA, THB 7/8/9/22: 225).

Cases such as Mary's, and others finding their way into the newspapers, tended to illustrate a wider public sympathy towards women who found themselves pregnant and desperate. In the local newspaper article on Mary's attack, the full weight of the report's disgust was directed at her father and the revulsion felt at an 'assault by a man on his own daughter', but little was made of her attempts to give birth in solitude in an outhouse, an act consistent with an intention to dispose of the baby soon after – women who had concealed their pregnancies were obliged to 'give birth in private, in silence and without assistance' (Kilday, 2013: 59). The case against her father collapsed, and Mary found herself in the lunatic asylum when the authorities perhaps rather conveniently side-stepped the issue.

Even in cases of infanticide, the murder of a new-born or young infant, the courts and the public were loath to inflict harsh sentences on women who had been forced to take such action. Much of the legislation surrounding cases of child murder hinged on the difficulty of proving that a child had been born alive and had subsequently been killed, a difficulty partly overcome by the introduction in 1809 of the lesser and more easily definable charge of concealment (Cossins, 2015: 184; Kilday, 2013: 116, 124-125). Nevertheless, even in clear-cut cases, judges and authorities were inclined to recognise 'the susceptibility of women to their natures' and to treat them mercifully, seeing the infanticidal woman as 'a victim of circumstance rather than the perpetrator of an evil act' (Cossins, 2015: 84; Abrams, 2002: 180). The reprieve of the harshest sentence, capital punishment, was common, as such sentences were increasingly regarded as 'outdated' (Kilday, 2013: 125). The insanity plea was offered and accepted, sometimes without medical evidence, as a 'humanitarian' response to the cases of destitute or desperate women (Cossins, 2015: 86). Although sentenced to hang for murdering their infants in 1841 and 1860 respectively, Catherine Symon and Bridget Kiernan had their sentences reprieved, although they and similar others still faced penal servitude for as much as ten years or even transportation (NRS AD14/41/193; AD14/60/61; JC26/1860/18; Anon., 1860). Jean Anderson, who had killed her new-born daughter and hidden the body in a jar in her house, had fallen foul of a mill-manager's attentions and, found guilty of concealment rather than murder, was sentenced to 12 months

(Anon., 1859b; 1859c). In 1863, Isabella Wright, mill-worker, and Euphemia Williamson, farm servant, both came before the courts charged with the murder of their infants, one by strangulation and one by throwing the child into the sea from the cliffs at St. Vigean. Both had unfulfilled promises of marriage or support from the fathers of their children, a circumstance which justified 'giving as lenient a sentence as possible' (Anon., 1863a, 1863b).

While insanity was not mentioned as a cause in these newspaper reports, the judge told Isabella that, 'when you did take the life of the child[,] it was when some circumstances had emerged which you had not the control, and which goes to make the crime not murder' (Anon., 1863). In June 1866, a general item in the local *Dundee Courier & Argus* argued the case against the capital punishment of women, citing as one reason 'the peculiar liability of women to influences of sudden, unexpected, or previously latent, violent insanity arising from puerperal causes or other sexual and physiological conditions' (Anon., 1866). When Helen Robb appeared in court in 1875, having slit the throats of two of her young children in the middle of the night, the same newspaper related that Dr Anderson of Carnoustie confirmed a case of 'puerperal insanity', and that the jury saw 'no use in their retiring' as the accused had clearly been 'of unsound mind' (Anon., 1875). Mrs Robb was duly acquitted, although 'ordered to remain in strict custody in the prison of Dundee until her Majesty's pleasure be known' (NRS JC26/1875/ 333). Such narratives illustrate the willingness of courts and the public to refute the culpability of women committing this drastic violation of motherhood, preferring instead to see a loss of control and temporary insanity. In cases where married women killed their children, insanity was the most obvious and rational explanation (Kilday, 2013: 65), while deviations from a previous intent to be a good mother – having prepared for the baby's birth in some way or shown affection to their infants – also implied a mother's temporary loss of her senses.

Puerperal insanity cases at Dundee were treated with compassion, and many were able to rejoin their families within a few months. Their path to recovery necessarily required the resumption of the feminine ideal, for respectable and moral behaviour had to be resumed and observed. A third unmarried mother in the puerperal insanity

group, Helen Lowden, a washerwoman, failed to show remorse and continued her lascivious behaviour within the asylum. Despite her apparent willingness to work, she was considerable irredeemable: as the Superintendent noted, 'this woman was always considered a fool and the child she gave birth to is illegitimate ... [She] has been much employed since last report but notwithstanding her bad disposition is always apparent' (DUA, THB 7/8/9/3: 690). Helen's 'animal' and 'evil propensities' and 'lascivious' nature allowed her to be 'cured up to a certain point and no further', while Mary Bissett, an 'indifferent person', left the asylum 'well advised' but with the expectation of a relapse (DUA, THB 7/8/9/3: 690; THB 7/8/9/10: 100).

In describing the characteristics and attributes of woman sane and mad, the Dundee doctors highlighted those conducts which illustrated how far they felt the women had deviated from the ideal vision of womanhood. In their cure, their journeys towards regaining the ideal were charted in terms of readopting their family roles, regaining normal maternal love, anxiety to see family and children, and willingness to work. It is nonetheless important to note that many of the women presented severe symptoms far beyond simply being unable to function as good housewives and mothers, and such symptoms also appeared in the case notes, often graphically. Many had attempted suicide and self-harm, and had threatened their husbands and children. Nevertheless, the notes placed greatest emphasis on behaviours revealing the extent to which the women were unable to take charge of their households, while concentrating – when addressing recoveries – on women changing their attitudes towards children and families. Reading the notes clarifies how the women's rejection of home and family was seen as fundamental to their madness, whereas restoration of sanity rested in bringing them back to embracing feminine characteristics, practices and acceptance of the woman's role in the family.

### **Small acts of rebellion: working women, 'ordinary mothers'**

Although this study of Dundee patients has included women from different social backgrounds, it has only considered women who were diagnosed by the doctors as suffering from puerperal insanity, when many of the symptoms and behaviours reported in the case notes were likely also applied to other female patients. Women

admitted to the asylum following childbirth but *not* diagnosed with puerperal insanity were likewise excluded from the study group. An interesting point given Dundee's predominately female workforce was the scarcity of paid female workers diagnosed with puerperal insanity. Of the 43 women admitted between 1835 and 1860 diagnosed with puerperal insanity, only 6 were listed with paid occupations in their own right. This figure echoes the women studied by Marland in Edinburgh, who only included a small number employed as 'needlewomen, dressmakers, shop assistants and mill workers' (Marland, 2004: 107). That said, in a city with a substantial female workforce, it is perhaps surprising that there was not a higher proportion of working women within the group receiving this diagnosis.

In her study of women in Devon asylums from 1860 to 1922, Quinn (2003: 154) observed that women admitted suffering from puerperal insanity were 'notable for their unremarkableness', just being 'ordinary mothers'. In fact, in their struggle to raise their families according to strict moral standards, they were *exactly* the type of women valued by Victorian moralists:

Puerperal insanity, rather than afflicting those who deviated from the borders of what was considered to be natural motherhood, affected those who were upholding those ideals. Puerperal insanity was an occasional consequence of trying to uphold middle class ideals of maternity. (154)

While there was a mixture of middle-class and pauper women in the puerperal insanity group at Dundee Asylum, the majority were married women viewed as trying to bring up their families in a respectable manner. The few unmarried women were seen as victims, with the exception of the lascivious Helen Lowden, whose admittance to the asylum and puerperal diagnosis may have resulted from the patronage of a well-respected local businessman – her security was in fact offered by the husband of one of the more affluent puerperal insanity patients.

Dundee's unusually high number of women in paid employment, even after marriage, presented a challenge to the Victorian ideology which sought to place women in the private sphere of home and family:

The centrality of women's employment to Dundee's labour market, particularly married women's work, violated all the precepts of Victorian domestic ideology which was defined by the interrelationship between respectability, the domestic ideal and the ideology of separate domestic spheres. (Gordon, 1987: 28)

The working women of Dundee were known not only for their resilience and independence, but also for their bawdy behaviour and intemperance. Married or otherwise, these women would have been perceived as transgressing moral standards, and the asylum officials may have interpreted their symptoms accordingly, possibly entering a diagnosis of insanity caused by intemperance instead. It would be difficult to confirm this supposition, as the birth of a child may indeed not have been considered or even noted. Women not conforming to socially accepted standards were hence perhaps seen as *unsuitable* for the puerperal insanity diagnosis, whereas normally respectable and moral women acting in ways seemingly quite different from their usual personalities were the perfect candidates.

Theriot claims that puerperal insanity was a way in which women rebelled against the constraints imposed on them by their gender and that, in order to understand puerperal insanity, it is necessary to examine 'the meaning of [the women's] behaviour within the context of women's lives' (Theriot, 1990: 72). It would be equally pertinent to consider how this behaviour was received by the physicians. The behaviour of those patients who openly rebelled against authority, leaving the home-space and squandering their husbands' money, could be taken as rebelling against the restrictions of daily lives offering scant freedom from 'household duties' and the production of children (Theriot, 1990: 81-82). This attitude contravened the ideal of the submissive, passive woman. In accepting the women's actions as symptoms of insanity, the asylum doctors allowed the women a brief respite from these constraints, forging a kind of partnership between doctor and patient (Theriot, 1990: 81-82). In addition, within this framework, the women's incomprehensible behaviours were noted and rationalised; once cured, the woman left these behaviours behind, perhaps even having no memory of her actions, as in the case of Jane Stewart. In this way, the woman's frustrations and problems were addressed and she was able to return to her usual role in the family and wider society.



It is tempting to imagine that Mary Crichton, normally in charge of a large household with governess and servants, took pleasure when released from these pressures in 'contriving to destroy the water closet by putting in flower plants from the garden', an action regarded by the asylum as 'very wrong' (DUA, THB 7/8/9/6: 9). Marjory Lowson went further, and even demanded 'a separate maintenance from her husband' so she might 'go and live with [her] own relations' (DUA, THB 7/8/9/6: 89). Such actions and statements were considered symptoms of madness. In these and other cases the patients were reported as making unreasonable demands on their husbands and, unacceptably, attempting to claim their independence. Marjory Whitton, a manufacturer's wife, 'had every comfort but she became dissatisfied; wished her husband to change his house; seemed not to care or be totally unable to look after her only child' (DUA, THB 7/8/9/21: 5). Flouting her husband's authority, she 'left her husband's house often to go to her mother's house when she ought to have remained at home' (DUA, THB 7/8/9/21: 5). Mary Bissett 'suddenly left her bed, insisting on getting her husband's wages [to] squander them away in the most unreasonable manner' (DUA, THB 7/8/9/10: 98).

Theriot interprets puerperal insanity as a manifestation of how women reacted against situations in which they had little power, suggesting that 'whether on a conscious or unconscious level, women who suffered from puerperal insanity were rebelling against the constraints of their gender'. In this scenario, women 'played out their rebellion against the male physician, and doctors translated that rebellion into an acceptable medical category' (Theriot, 1990: 81-82). This move offered women 'a kind of permission' to rebel, if within the safety of the asylum, an environment 'grotesquely like the one in which women normally functioned' (Showalter, 1980: 169) but which offered a temporary respite – including a solution which did not disrupt the feminine ideal. The puerperal insanity diagnosis therefore formed part of a complex collaboration between the doctor, the patient and her family: 'male physicians and their female patients, together, created puerperal insanity; and that creation both reflected and contributed to sexual ideology and medical specialisation' (Theriot, 1990: 72). This hypothesis, that puerperal insanity resulted from both the constraints

imposed on women and a 'partnership' with the doctors, leads to the conclusion that this diagnosis was only open to women who had access to this interaction. The admission of a patient to the asylum demonstrated that family and friends, kirk officials and poor inspectors, were all willing to accept that the asylum was the best course of action for resolving the immediate problem. This option, and therefore the puerperal diagnosis, may simply not have been open to all women, where those around them did not seek help through the authorities.

## **Conclusion**

Puerperal insanity in the nineteenth century fixed postnatal mental illness as a distinct disease with a common cause, encompassing different symptoms and behaviours, but by the end of the century understandings were changing and use of the term declined. Theriot (1990: 84) claimed that this shift was due to a change in the constraints on women's agency, and also to physicians ceasing to legitimise puerperal insanity as an illness (Theriot, 1990: 84). New models for understanding insanity developed, underlining 'the power of nosology to consign a disease to oblivion' (Loudon, 1988: 76). Just as puerperal insanity had been 'classified into existence' at the beginning of the century, by the end it had fallen victim to new ideas and new methods of classification. The 'mere coincidence of insanity and childbirth' was no longer considered enough to designate it as a distinct disorder of puerperal insanity' (Marland, 2004: 28, 203-204). Instead, childbirth simply became seen as a stressor which could, like many others, cause mental illness in predisposed women (Cossins, 2015: 206).

Marland's detailed analysis of puerperal insanity from the Royal Edinburgh Asylum case notes contributes to understanding nineteenth century-attitudes to female insanity, particularly the link with contemporary expectations about motherhood. This study of Dundee patients has uncovered fundamental similarities in the incidence and patterns of diagnosis. Marland claims that puerperal insanity could affect women 'worlds apart from each other' (Marland, 2004: 2); and, while the puerperal insanity diagnosis was certainly applied to women from all social backgrounds admitted to Dundee Lunatic Asylum, it is notable that there are some groups of women 'missing'

among the female patients so diagnosed. While this asylum was by no means the only locus of care, as many families, particularly the more affluent, may have tried to care for the woman at home, only resorting to the asylum when unable to cope, the women who were admitted and diagnosed with puerperal insanity were, with few exceptions, women apparently conforming to the ideal vision of womanhood, or with the potential to do so. The lack of women in paid employment among the study group, in the light of Dundee's high numbers of working women, is therefore significant, supporting Quinn's view that puerperal insanity was a diagnosis for those who strived for the ideals of 'natural motherhood' (Quinn, 2003: 154).

Embedded within the Dundee case notes are underlying 'truths' about the nature of puerperal insanity. It was a medical condition which could be cured, with the right treatment and in the right place; and curing the patient meant restoring her to a condition fit for return to home, family and the responsibilities of her role as wife and mother. A narrow focus on patients diagnosed with puerperal insanity, however, obscures the extent to which all female patients may have been encouraged to adhere to the feminine ideal and which patients fell outside the boundaries of the diagnosis. In order to explore these hypotheses fully, a detailed study is required of all female patients admitted to the asylum, not just those diagnosed with the condition.

There is still much debate about the causes of postnatal mental illness, and, while we should see the 'puerperal insanity' diagnosis itself as unique to the nineteenth century, women do still suffer from depressive and psychotic episodes in the puerperal period. While presentations of postnatal depression vary culturally and socially, biological factors, including rapid hormone changes, are now seen as a factor (O'Hara and McCabe, 2013). That being the case, regardless of the strategies and mechanisms that may have been employed by working women in Dundee, a proportion of these women must have suffered some form of mental illness following childbirth and did not seek help, were not given help, or were not classified as sufferers from 'puerperal insanity'. While this may reflect on the specific beliefs and attitudes of the Dundee officials, it may also infer selectiveness in the diagnosis of puerperal insanity, and assumptions related to class and gender both more generally and locally inflected within Dundee.

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THB 7/8/9/6 1826-1834; THB 7/8/9/9 1835-1836; THB 7/8/9/10 1837-1841;

THB 7/8/9/11 1838-1842; THB 7/8/9/16 1842-1845; THB 7/8/9/18 1844-

1849; THB 7/8/9/19 1844-1848; THB 7/8/9/21 1848-1854; THB 7/8/9/22

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