

**Themes in Scottish Asylum Culture.  
The Hospitalisation of the Scottish Asylum  
1880-1914**

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## Abstract

Having embarked on a vast journey of asylum construction from the 1860s, Scottish mental health care faced uncertainty as to the appropriate role of the asylum by the 1880s. Whereas the mid century was dominated by official efforts to lessen the asylum's custodial image, late Victorian asylum culture encompassed both traditional and new themes in the treatment and care of patients. These themes included hospitalisation, traditional moral approaches, and wider social influences such as the poor law, philanthropy, endemic disease and Victorian ethics.

In an age of medical advance, Scottish asylum doctors and administrators introduced hospitalisation in a bid to enhance the status of asylum culture. The hospitalisation of the asylum was attempted through architectural change, transitions in mental nursing and the pursuit of laboratory research. Yet as a movement, hospitalisation was largely ornamental. Although hospitalisation paved the way for impressive new buildings, there was little additional funding to improve asylum infrastructure by raising nursing standards or to conduct laboratory research work.

While the Commissioners in Lunacy proclaimed 'hospitalisation' to be a distinctive part of the Scottish approach of mental health care, the policy's origins lay not with the policy makers but with individual medical superintendents. Although hospitalisation became an official approach by the General Board of Lunacy, like any other theme in asylum culture, the extent of hospitalisation's implementation relied on the support of individual doctors and local circumstance.

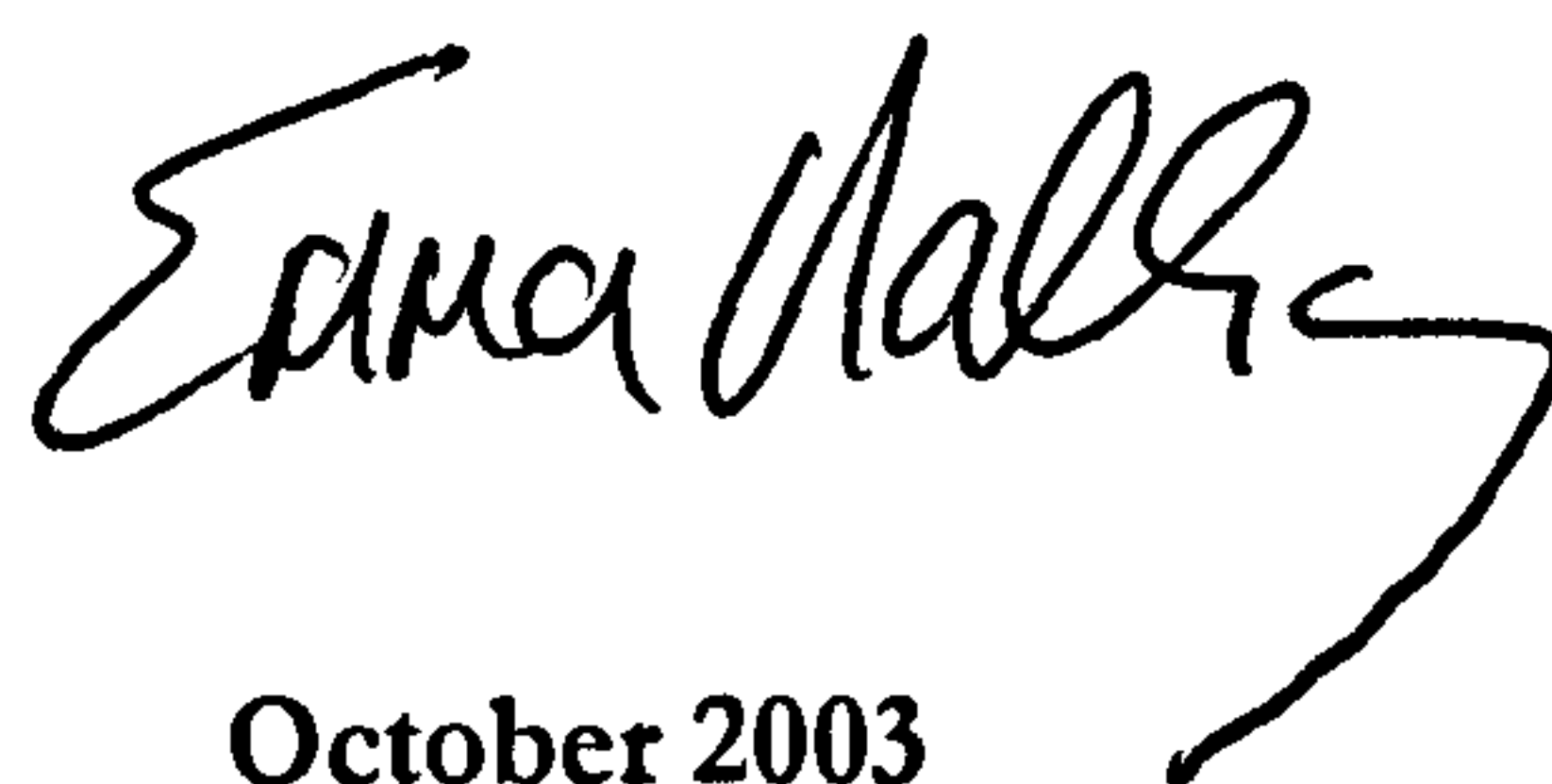
Despite this attempt to emulate modern medicine, moral management rather than hospitalisation methods continued as the fundamental approach of treatment and control in most institutions. The main components of moral management were work and a system of rewards (implemented through liberties and accommodation privileges). The process of mental recovery continued to be linked to industriousness and behaviour.

The thesis acknowledges the impact of local forces and wider society upon attitudes towards mental health care, such as the economically driven district lunacy boards and to a lessening extent the parochial boards and philanthropy. In viewing the asylum within the wider context of Scottish society, the asylum shared some characteristics with other Victorian institutions. Finally, although the patient's autonomy within the system should not be overplayed, the asylum doctor was also affected by the patients' co-operation with treatment and the involvement of family and friends in admission.

## Declaration

I hereby declare that this thesis has been composed by myself, and that the work it embodies has been done by myself, and has not been included in any other thesis.

Signed:

A handwritten signature in black ink, appearing to read "Emma Hall". The signature is written in a cursive style with a long, sweeping tail that extends downwards and to the right.

October 2003

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The thought of researching Scotland's former asylums initially conjured up images of lonely research in disused hospitals. However, the help and interest that I experienced throughout this thesis, thankfully proved me wrong. First and foremost, I am indebted to Jacqueline Jenkinson for her unfailing support throughout my time at Stirling University, always prompt return of chapters and helpful advice. Thanks also to George Peden, for his help and encouragement over the past few years. Many thanks also to: Mike Barfoot, for his expertise and enthusiasm in my topic; Gayle Davies, for her moral support 'in the field'; the staff of the archives and libraries in Ayr, Edinburgh, Glasgow, Lochgilphead and Perth; thanks also to the hospital staff at Bangour, Perth and Lochgilphead, for their whole-hearted assistance in locating dusty hospital records and accommodating me in their offices; Morag Williams in Dumfries, for her assistance and hospitality; the History departmental secretaries and staff at the University of Stirling. For a more recent perspective on mental health care, I have been motivated by my fellow researchers in the Primacy Care Research Group, Department of General Practice, Edinburgh. Equally as important are friends and family who have served as constant reminders of life outside the Ph.D. Thank you especially to Helen and Jennie; and also Kevin for his technical expertise. Finally, but most importantly, to my parents for their generosity and ever positive encouragement.

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## Notes on Usage

Language used to describe mental illness in the nineteenth and early twentieth century is subject to generalisation. 'Insanity', 'lunacy', 'madness' and 'mental disorder' were terms used to describe a range of mental illnesses. Although the term 'mental illness' is used in non source material, diagnostic labels used by doctors are retained to denote contemporary attitudes. Patient anonymity is maintained throughout the thesis. When reference to a patient is made, his/her initials are used and their gender stated.

## Abbreviations

### *Asylums and Hospitals*

ABDA	Argyll and Bute District Asylum
ADA	Ayr District Asylum
CRI	Crichton Royal Institution
FKDA	Fife and Kinross District Asylum
MPDA	Midlothian and Peebles District Asylum
PDA	Perth District Asylum
REA	Royal Edinburgh Asylum
RIE	Royal Infirmary, Edinburgh
RVH	Royal Victoria Hospital
SDA	Stirling District Asylum

### *Committees and Associations*

MPA	Medico-Psychological Association
GTC	Glasgow Trades Council
WAC	Woodilee Asylum Committee

### *Charitable Organisations*

BES	Brabazon Employment Society
MACA	Mental After Care Association

### *Journals*

AJI	American Journal of Insanity
BJT	British Journal of Tuberculosis
BMJ	British Medical Journal
EMJ	Edinburgh Medical Journal
JMS	Journal of Mental Science
SMSJ	Scottish Medical and Surgical Journal

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## Chapter One

### Introduction, Methods and Sources

*The Hospitalisation of the Asylum* is still, on the whole, an ideal to be aspired to.<sup>1</sup>

#### Introduction

The Scottish tradition of asylum care through a lay and community response was in decline by the mid Victorian era. The right to some form of care for the mentally ill poor was provided under the Poor Law Amendment Act of 1845. The subsequent establishment of the General Board of Lunacy under the 1857 Scottish (Lunacy) Act formed part of the general legislative and institutional approach towards health care in this period. The consequence of the 1857 Act was the construction of over 20 District Asylums by 1914 that initially relied on a moral approach to mental illness, primarily through the prescription of work.

In the 1880s, hospitalisation emerged as a new approach in asylum care. Further details of its features are set out in the next chapter. In summary, the overall objectives of hospitalisation were to build hospital buildings at asylums and therefore adopt some 'hospital' approaches in treatment and diagnosis; the pursuit of scientific research and links with general hospitals through psychiatric and observation wards. A further product of hospitalisation was the introduction of female nursing to male wards.

Historiography acknowledges that hospitalisation existed as an official policy that was promoted by the General Board of Lunacy and supported by many asylum doctors. Jonathan Andrews discusses hospitalisation on a number of occasions in his work on Scottish psychiatry.



...Commissioners had also placed considerable emphasis on...the incorporation of "hospital" features in their stead...Sibbald's belief in the hospitalisation of the asylum regime was broadly shared by asylum specialists during the 1890s.<sup>2</sup>

Yet the power and influence of the Commissioners in promoting hospitalisation should not be overestimated. As with any movement, its origins were as much to do with initiatives by individual doctors as the influence of the central authority. Similarly, changes in asylum care should not only be viewed as a power struggle between the General Board of Lunacy in Edinburgh and the locally scattered medical superintendents. Hospitalisation and asylum culture in general, was not devoid from the wider context of Scottish society and medicine. Neither should asylum culture be understood without consideration of local factors and players including district lunacy boards, the family and the poor law parochial board.

Paying attention to only one strand of mental health care such as hospitalisation fuels the danger of overshadowing what else was happening as a local level, either in an individual asylum or community. As such, this thesis attempts to uncover any regional initiatives, however localised these developments might appear. Similarly, it is important to bear in mind the continuation of traditional approaches towards mental illness between 1880 and 1914. The research examines the ongoing importance of moral approaches and work in Scottish asylum culture.

Far from the intention of sounding 'late Whiggish'<sup>3</sup> the thesis acknowledges that late Victorian psychiatry faced tremendous failures in the treatment of mental illness. The inability of the asylum to 'cure' was not only apparent in the district asylums but also the traditional Royal institutions that increasingly catered for a private clientele. In this context then, the attempt to infiltrate asylum life with hospital features was an attempt

to lift declining recovery rates and curb spiralling admissions. By attempting to emulate general medicine through hospitalisation techniques, asylum doctors hoped that their control of psychiatry would be tightened and that an image of modernity would be propagated to the wider society and medical community.

### Reviewing the Literature

Although historiography of psychiatry is occasionally slightly jaded in its repetition of Scull and Foucault's arguments, the two men are important figures within any discussion of psychiatric history. As such, this thesis has engaged with their work and has also attempted to highlight the imbalance between the local – central interface that Revisionists are apt to overlook. While similarities in research findings are identified with both Scull and Foucault's arguments, the thesis takes into consideration the weaknesses of the men's theories when applied to Scottish asylum culture.

Traditionally reiterated is the optimistic tale of how eighteenth century barbarity towards the mentally ill evolved into the early nineteenth century's moral treatment. Such accounts are synonymous with the progress made in institutional care and the professionalisation of the medical community. Whiggish accounts were generally provided by those within the medical profession and psychiatrists strongly linked to their own institutions.<sup>4</sup> Whig history tends to regard asylumdom as fundamentally progressive. For example, the Scottish psychiatrist Drummond Hunter sees the move towards hospitalisation as a successful modernisation of asylum care.<sup>5</sup>

In the 1960s, the anti-psychiatry movement attacked the fundamental basis of the asylum and urged de-institutionalisation. Erving Goffman termed the phrase 'total institution' in order to describe a variety of social institutions that shared similar



attributes in terms of discipline and daily activity. Goffman argued that the total character of the institution was most vividly symbolised by the barriers placed between the patient and social intercourse with the outside world. As such, an artificial environment was enforced within the 'total institution.' While inmates were forced to accept the discipline meted out by the staff, daily life was also strict for the staff in the institution.<sup>6</sup>

Revisionists also turned their attention to the 'evils' of the Victorian institution and attempted to draw parallels between the 'total institution' and nineteenth century workhouse, prison and asylum. In Ignatieff's study of prison life he argues that it was no accident that penitentiaries, asylums and workhouses all looked the same and imposed strict discipline on their residents.

The institute of the prison took its place within a structure of other institutions so interrelated in function, so similar in design, discipline and language of command that together the sheer massiveness of their presence in the Victorian landscape inhibited further challenge to their logic.<sup>7</sup>

Such institutions shared similarities such as surveillance and control alongside a belief in reform, hard labour and routine. These institutions were apparently a part of the vision of social order that was fiercely supported by both the rich and powerful.

Foucault provided one of the most influential piece of work in psychiatric historiography that gives a critique of the asylum and its psychiatrists. *Madness and Civilisation* generated extensive debate from historians who have both praised his vision and criticised his generalisation. Foucault famously argued that the period 1660-1800 should be earmarked as the 'Great Confinement' throughout Europe. The 'mad' were rounded up with vagrants, criminals and beggars. Once in the asylum, workhouse or

Bastille, people were put to work. This confinement was implemented as a tool of social order by the bourgeoisie forces in order to 'police' the poor insane.<sup>8</sup>

From the 1800, there emerged a new form of control when Pinel struck chains off the insane inmates at a Parisian asylum. Foucault contends this new era of non-restraint was little more than a gigantic moral imprisonment imposed as a tool of social control. Within the asylum, madness was silenced through psychological terror and the insane were treated as children. Reason was restored through work and observation. Foucault epitomized this era of 'moral management' at the York retreat under the Tukes.

The partial suppression of physical constraint was the constitution of a "self constraint" in which the patients freedom was ceaselessly threatened by the recognition of guilt...one was in the grip of a positive operation that confined madness in a series of rewards and punishment and included in it the movement of moral consciousness.<sup>9</sup>

The asylum became a symbol of social control and the physician became the most important figure in the patient's incarceration, treatment and discharge.<sup>10</sup>

There are many obvious criticisms of Foucault's work that have been consistently pointed out by historians. Melling suggests that Foucault reduces psychiatric history to the work of only a few individuals and marginalises the various social classes, kinship networks and politics that shaped treatment and local developments.<sup>11</sup> Porter contests the factual accuracy of the 'Great Confinement'. Although conceding that the theory of confinement rings true of the Classical era in France, a 'Great Confinement' did not occur in Britain until Victorian era.<sup>12</sup> As to Foucault's assertion that the asylum was a method of policing the insane poor, Porter replies that this does not explain away the large numbers of middle and upper class people confined to institutional care.<sup>13</sup>

Foucault's text *Discipline and Punish* is relevant to the thesis. A theme of his history of discipline is the use of 'normalising judgement' in the disciplinary institution. Foucault argues that this theory aimed to reform the individual from within. Inmates were subjected to a series of graded rewards and punishments, where progression resulted from the inmate's good behaviour (naturally defined by the controlling powers).

The distribution according to ranks or grade has a double role: it marks the gaps, hierarchizes qualities, skills and aptitudes but it also rewards and punishes. It is the penal functioning of setting in order and the ordinal character of judging. Discipline awards simply by the play of rewards, thus making it possible to attain higher ranks and places, it punishes by reversing this process.<sup>14</sup>

In the prison, individuals were also subjected to constant observation, penalties for infraction, work and a structured day. As the prisoner reformed, they moved closer to a series of privileges that culminated in probation.

Both Foucault and Ignatieff are criticised for their generalisations. Counter-Revisionists contend that model prisons built in the 'panopticon' design were an ideal rather than a reflection of actual practice and did not necessarily filter down to local prison construction.<sup>15</sup> Ignatieff does concede that more emphasis should be placed on local decision making in the construction of institutions. However, he still attaches importance to the theory of the prison or asylum as a tool of social control and questions why the nineteenth century developed such an institutional solution to society's social problems.<sup>16</sup>

Despite the criticisms made of Andrew Scull's work, this man is commended as the first to take up the Foucauldian challenge.<sup>17</sup> Describing eighteenth century madhouses as cruel regimes and nineteenth century asylums as housing a mass of incurable cases,

Scull provided an equally pessimistic albeit more detailed historical account of the English asylum system between 1750 and 1900.<sup>18</sup> Scull also does not agree that the Classical era was one of a 'Great Confinement' and suggests that this era did not possess the economic means to confine the poor.<sup>19</sup>

The main focus of *Museums of Madness* is the social organisation of madness in nineteenth century industrialising England. In *Museums of Madness* the asylum is an instrument of social control where unwanted, difficult and dangerous members of society were confined. The family was influential in filling up the asylum with their relatives and this made the asylum a convenient dumping group for unwanted people. Scull argues that the late Victorian asylum was filled to the brim with incurable and hopeless cases. In order to control large numbers of people, the asylum became a 'custodial' institution whereby work was conducted for the benefit of the institution and in order to control large numbers of inmates.<sup>20</sup>

Scull also links the birth of the asylum to an emerging medical profession. In the early days, mad-doctors had come under attack from damaging parliamentary inquiries and in response, doctors turned to moral treatment in order to reinvent and monopolize their profession.<sup>21</sup> Scull argues that the psychiatric profession was one 'convinced of their biological degeneracy and inferiority' which used asylums to assert its dominance and authority in society.<sup>22</sup>

Scull has worked hard to refine his arguments. *Museums of Madness* was revised and reproduced as the *Most Solitary of Afflictions*. This text provides greater acknowledgement of the role of different players in asylum history and also provides a British rather than English perspective. However, Scull continued to refer to late



Victorian asylums as little more than warehouses that were devoid of cure.<sup>23</sup> With regard to the professionals, psychiatry had been reduced to 'quarantining the incurable rather than restoring sanity' and the nineteenth century psychiatric profession ended on a note of quiet desperation.<sup>24</sup> The English focus of the work is also problematic in the application of its arguments to Scottish asylum culture. Scull himself admits that there are fundamental differences in the organisation of the English and Scottish asylum system.<sup>25</sup>

Scull and Foucault's arguments have come under analysis since the publication of their texts. In the 1980s and early 1990s the pair were criticised for producing bold assumptions about past asylums based upon little data.<sup>26</sup> Quantitative historians have used extensive research with asylum registers of admission and casenotes to challenge Scull's argument that asylums were dumping grounds for long stay incurable patients. Among such critics are John Walton, Anne Digby and Lawrence Ray.<sup>27</sup> One drawback of quantitative history is its focus upon individual institutions. However, Digby's account of the York Retreat is highly relevant in its discussion of moral therapy and moral management.

More recent research moves its focus away from the medical profession's dominant role in organising and treating mental illness. Oonagh Walsh suggests that rather than simple medical dominance, power in the asylum was negotiated between physicians, patients and relatives as well as Poor Law commissioners, workhouse masters and the police.<sup>28</sup> Andrews also questions the extent to which the physician's power was absolute in the locality. He suggests that too little attention is currently paid to the views and strategies of local authorities in the mediation of Scottish pauper lunacy.<sup>29</sup>

Other scholars place emphasis on the importance of Poor Law ideology in both the admission and treatment of patients. By far the most extensive research undertaken on this subject is by Bartlett in his *Poor Law of Insanity* (1999).<sup>30</sup> Bartlett acknowledges that his research is not concerned with the professionalisation of medical superintendents, but alternatively, a study of the administration of pauper lunacy. His research suggests that the asylum should be understood in the context of the nineteenth century Poor Law and forwards the idea of the asylum as a Poor Law institution. Bartlett argues that the role of medical professionals is overplayed in the history of psychiatry in that the administrative and legal structures of the asylum were heavily influenced by the Poor Law.<sup>31</sup> Moreover, he suggests that asylum doctors had little say in deciding who was admitted to the asylum and how asylums should be constructed.<sup>32</sup>

A 1996 article by Forsythe et al considers the new Poor Law and the county pauper asylum system in Devon. Forsythe argues that the Guardians of the Poor Law played a central role in the experiences of the pauper lunatic.<sup>33</sup> In other words, the description of the pauper lunatic along with provisions made for management and treatment of the insane were heavily influenced by the ideology of the Poor Law and the practical measures taken by local officials.<sup>34</sup>

The importance of lay influence is the second theme defined as a reaction to the dominance of the medical profession in the historiography of psychiatry. An earlier initiator of this subject is Suzuki in his 1995 article on the non-restraint movement.<sup>35</sup> Up until Suzuki's publication, praise for the decline of restraint was placed with the medical profession and individuals such as Conolly and Pinel.<sup>36</sup> Suzuki suggests that outside influences had an impact on the promotion of the non-restraint movement. He argues this by highlighting how lay magistrates responded to the new Poor Law and

contemporary prison reform by promoting non-restraint long before the arrival of Conolly as medical superintendent.<sup>37</sup>

David Wright stresses the importance of the family as another lay influence in asylum culture. By separating the confinement of asylum patients from the history of psychiatry, Wright challenges the idea that the professionalising medical profession was central to admission of patients.<sup>38</sup> Alternatively, Wright believes that control over confinement was determined by the wishes of the family to control and look after insane relatives.<sup>39</sup>

Much of the existing literature deals primarily with English institutions. (This is with the exception of *Insanity and Institutions*, which does present a UK and an international focus especially through writers such as Oonagh Walsh, Lorraine Walsh and Jonathan Andrews). In Scotland, Jonathan Andrews and Allan Beveridge have led the way in documenting events. Much of Andrews' Scottish work focuses on developments in the West of the country. In his review of psychiatry in Glasgow, he provides discussion of District Asylums as well as outlining the development of mental pathology in the city.<sup>40</sup> His work on the Lunacy Commissioners is also useful in its account of the General Board's work and individual Commissioners involved in the asylum system post 1857.<sup>41</sup>

In the main, Scottish literature has generally focused upon individual histories of institutions. Although many accounts are only useful for background narrative, Andrews and Iain Smith's (ed) history of Gartnavel Royal Asylum in Glasgow is more analytical in scope.<sup>42</sup> Two other articles may be mentioned in connection with Scottish asylum history. Beveridge's study of patients at the Royal Edinburgh Asylum is a study

of a chartered institution.<sup>43</sup> Harriet Sturdy comments that the contribution of District Asylums has not received detailed assessment in the history of psychiatry.<sup>44</sup> To date, there has only been one study made of a Scottish District Asylum.<sup>45</sup> Although Beveridge and Doody's article provides interesting insights of an asylum population, they do not focus upon hospitalisation or external influences upon asylum life.

Overall accounts of the Scottish asylum system are generally Whiggish in outlook. This is with the exception of Frank Rice who provides a lucid account of the Scottish system after 1857.<sup>46</sup> One example is D.K. Henderson's *Evolution of Psychiatry* (1964). As a retired psychiatrist (and as the title of the book suggests), his views promote the idea of on-going progress in Scottish psychiatry. Tom Walmsley argues that modernisation did much to ensure the survival of Scottish asylums in the first decades of the twentieth century.<sup>47</sup> Also guilty of viewing Scottish psychiatry with rose tinted nostalgia is Drummond Hunter (another retired psychiatrist). Hunter describes hospitalisation as 'de-asyluming the asylum'.<sup>48</sup> He regards the 'open door' policy to be 'revolutionary'.<sup>49</sup> He views the appointment of trained hospital nurses and female nurses on male wards as a significant development in hospitalisation. He also believes that important advances were made in the training and education of mental nurses throughout the early twentieth century.<sup>50</sup>

There are no illusions in this thesis that hospitalisation was synonymous with progression. Yet, it *is* right to challenge the overtly negative attitudes of writers such as Andrew Scull. Relevant then is Harriet Sturdy's research of the boarding out policy of the insane. The General Board of Lunacy officially implemented the policy of boarding out harmless and chronic asylum patients in 1858, although boarding out was practised in the community long before this date. The topic of care in the community



has enjoyed extensive attention in recent years and is also outlined in the following chapter.<sup>51</sup> Of importance to this thesis is the impact that boarding out had upon hospitalisation. Sturdy argues that:

One important incentive to boarding out arose from the move towards hospitalisation of asylums, manifest in a determination to adopt, where possible, the methods employed in hospitals for investigating and treating disease...The extent to which boarding out created the opportunity for asylums to represent themselves as places of cure, rather than confinement, should be assessed further, particularly in view of Scull's insistence that the asylum in the nineteenth century was merely a 'dumping ground for a...mass of physical and mental wrecks'.<sup>52</sup>

Since the 1960s and 1970s, scholars have engaged in a varied and widespread effort to outline the varied story portrayed by psychiatry. Of particular interest is Foucault's theoretical outline of the disciplinarian institution and its relevance to asylum culture. Scull's continuing assertions of 'warehouses' should be tested in view of the variations between the English and Scottish asylum systems. The image of the 'total institution' is also considered in relation to Scottish asylums. Recent publications follow a common theme: the challenge of external influence to the domination of the medical profession. Such historiography is therefore highly relevant for this study in their attempt to look outside the asylum for influences upon treatment and care.

### Outline of Chapters

The thesis addresses the years between 1880 and 1914. Although 1914 is perhaps an obvious cut off point with the upheaval created by World War, the start decade of the 1880s should be clarified. It is throughout the 1880s and 1890s that the interest surrounding hospitalisation begins to emerge in the contemporary journals and newspapers. Doctors such as Thomas Clouston and George Robertson were

contributors to this debate.<sup>53</sup> It was also in the early 1880s that Craig House, a forerunner of the 'Asylum-Hospital' movement was constructed at the Royal Asylum in Edinburgh under the direction of Thomas Clouston.

Chapter two provides an overview of developments in related fields to mental health care, namely the Poor Law and public health, prison regimes and important medical and surgical developments. An overview of the moral and medical regimes in asylum culture prior to hospitalisation is provided and the meaning and context of hospitalisation clarified. Common areas identified in the chapter include the relationship of the asylum to the Poor Law, the increased role and responsibility of central government, the acceleration towards an institutional solution and impact of 'state' medicine in Scottish society.

Chapter three, 'moral management' and chapter four, 'liberty' document the continuation of moral approaches towards mental health care in the period 1880 to 1914. Chapter three examines the use of occupation as an intrinsic feature of asylum culture. The chapter questions whether patient employment was aligned more to traditional moral approaches in mental health care or if work was simply a method of institutional management that corresponded to the image of a 'total institution'. The chapter also suggests that the propagation of work for asylum patients could not be devoid from the wider context of Victorian social principles such as the work ethic.

Chapter four examines liberty as part of the distinctly Scottish approach to mental health care, which included the open door system and use of parole and probation. The chapter deals with the barriers placed on patient liberty in the asylum through the continuance of restraint and seclusion. The existence of voluntary patients within the

asylum system is briefly explored. This group (albeit in the minority) initially sits uncomfortably with Scull's perception of the Victorian asylum.

Moving away from traditional approaches to mental health care, chapters five and six deal with external influences, which impacted upon asylum culture. Chapter five 'Charitable Endeavours and the Poor Law' provides a case study of the Brabazon Employment Scheme that had some (albeit minimal) impact in the Glasgow asylums. The presence of the scheme is important because it was introduced to the asylums as a result of local enterprise rather than central policy. The ideology of the Poor Law coupled with the relationship of philanthropy to the Scottish asylum are both influential in explaining why the scheme spread to Scotland in the first place, and why the scheme's impact was subsequently minimal in Scottish asylum culture.

Chapter six 'The Open Air Rest Cure' highlights how asylum life could never be cut off from the outside world and thus shared social concerns such as the scourge of tuberculosis. Sanatorium treatment through rest in bed on verandahs was primarily implemented as a method of minimizing and treating the disease in the asylum. The use of open-air bed rest in the asylum is interesting in its extension to non-tuberculosis patients. In this context, the practice of outdoor bed rest is examined within the emergent debate over rest and exercise that was fuelled by the construction of hospital accommodation at asylums. The chapter documents how some doctors came to tack on outdoor bed rest as an alternative method of control, a move that was criticised by many other doctors and Commissioners.

Following this, the thesis moves onto discuss the practical attempts taken to hospitalize the asylum through scientific research, asylum nursing and architecture. Scientific

research covered in chapter seven highlights how the psychiatric profession aimed to emulate research developments that were present in the wider medical community. Efforts are therefore made to examine the input made by asylums outside Edinburgh and Glasgow. The financial constraints placed on research meant that few asylums employed qualified pathologists. As such, initiative was left up to individual doctors.

Chapter eight reviews psychiatry's move to imitate general hospital nursing through the employment of female nurses in male wards of asylums and the introduction of staff training. The implications of standards and qualification after the 1858 Medical Act and the move towards a hospitalised asylum environment, meant that asylum doctors required a more able and 'medicalised' staff. 'Professionalisation' was attempted from above in a bid to raise the status of psychiatry and asylum culture. As such, 'professionalisation' was not within the autonomy of the staff. Working conditions and pay for staff remained poor and the aims of the asylum doctors were out of tune with the rank and file staff. The chapter documents alternative strategies adopted by staff to improve their circumstances.

Finally, chapter nine 'architecture' deals with moves to hospitalize the asylum through the construction of hospital and admission wards and the increased classification of patients. Although the Commissioners urged the modernization of asylum buildings, local asylums were constrained by the willingness of district boards to fund change. The process of classification is examined in relation to both the wider medical context and the similarities that can be made with the prison regime. It is highlighted that despite the attempt to propagate a 'medicalised' asylum, architecture reflected the continued importance attached to moral approaches. Wider social problems and



medical opinions such as degeneration should also be taken into account in the move towards classification.

The thesis corresponds with recent historians (and also Scull) that the power over committal and treatment was shared between different factions in the asylum and community. The interface between local affairs and central power needs to be understood in terms of relations between the Commissioners in Lunacy, the District Boards and the individual medical superintendents. Certainly, the thesis shows that the Commissioners had an impact on local affairs *before* an asylum was built and were happy to advise on architectural change. However, while Commissioners could make recommendations about treatment and practice, they were unable to enforce their opinions unless there was evidence of malpractice.

Although the Poor Law did not control the Scottish asylum system in the late nineteenth century, it is important if only for the Poor Law's early link to mental health care and continuing relationship with patient admission. Chapter two outlines antagonisms between medical superintendents and the parochial board over asylum patients and rates. Some similarities are present between poorhouse practices and asylum life in the late nineteenth century. Parallels maybe drawn with poorhouse inmates and asylum patients in the prescription of work.

Although most doctors appeared to support hospitalisation, certain individuals pushed various strands of the policy to different degrees.<sup>54</sup> Within the asylum, the medical superintendent strove to maintain his control over treatment types and did not implement policies that they were opposed to. While the District Boards were usually content to give their superintendents a free reign in running the institution, it was an

uphill struggle to persuade Boards to finance architectural change and scientific research laboratories.

A thin line remains between the interface of therapy, care and control in the asylum. A willingness to work coupled with responsible behaviour was strongly linked to the perception of recovery. On the other hand, work therapy and the use of a reward-punishment system was both a practical and psychological method of control in line with Foucauldian thought. The classification of asylum accommodation created system of rewards and punishments for patients. Certainly, the patient's journey through the asylum was closely related to staff decision making and it would be dangerous to over emphasis the autonomy of asylum patients. However, there are examples where the individual asserted his/her independence in defiance of treatment and institutionalization.

The final theme is the implementation of the hospitalisation policy as a reaction to the failings of the nineteenth century asylum. By the late nineteenth century, the rising numbers of asylum admissions were frequently referred to in the annual reports of both the Commissioners and medical superintendents. Some indication of whether hospitalisation impacted on the ability of the asylum to cure is provided in the final conclusion to the thesis. Comparisons are made in admission, discharge and recovery rates to Scottish asylums between the periods 1857 and 1914.

### Choice of Asylums

As anticipated, much research work was conducted with the records and registers of Scottish asylum collections. The principal asylums researched were Argyll and Bute District Asylum, Lochgilphead (ABDA); Ayr District Asylum, Ayr (ADA); Bangour

Village Asylum Hospital, Edinburgh; Crichton Royal Institution, Dumfries (CRI); Gartloch Mental Hospital and Asylum, Glasgow; Perth District Asylum, Perth (PDA); and Woodilee District Asylum, Glasgow.

Over 20 District Asylums had opened in Scotland by 1914, which was in addition to the seven existing Royal Asylums. In choosing the aforementioned asylums' records for this research, it was important to provide a geographical spread of Scotland, and include a mixture of institutions in both urban and more rural locations (see Map 1). Bangour Village Asylum in Edinburgh and Woodilee District Asylum in Glasgow were chosen to represent Edinburgh and Glasgow's provisions for the mentally ill. Outside the main urban centres, asylums selected from the smaller Scottish towns included District Asylums in Ayr, Perth and Stirling. To contrast an institution catering primarily for a rural population, records of the ABDA in Lochgilphead were chosen. Crichton Royal Institution in Dumfries provided representation of a Royal Asylum population.

The second criterion rested upon the need to reflect various treatments and approaches discussed throughout the thesis. Gartloch Mental Asylum and Hospital in Glasgow was the first purpose built asylum-hospital and Bangour in Edinburgh was an apparent 'model' of the village asylum. Medical superintendents who supported hospitalisation were evidently more likely to implement the official hospitalisation policy than those medical superintendents who were disinterested or opposed to the process. George M Robertson was medical superintendent of both the Perth and Stirling District Asylums and pursued the hospitalisation policy there. The ADA under Easterbrook was of interest for the superintendent's extensive practice of open-air bed rest.

Research also considered traditional methods of treatment, namely moral management and work. A renowned advocate of moral approaches was Dr James Rutherford. Rutherford superintended the ABDA in Lochgilphead, Woodilee in Glasgow and the CRI in Dumfries throughout his career. Commissioners classed both the ABDA and Woodilee as models of early moral approaches in the apparent liberty given to patients and the institutions' use of work. These asylums were selected to highlight the practice of moral approaches and their adaptation to hospitalisation.



Map 1: Distribution of Selected Asylums



1. Argyll and Bute District Asylum, Lochgilphead
2. Ayr District Asylum, Ayr
3. Bangour Village Asylum, Edinburgh
4. Crichton Royal Institution, Dumfries
5. Gartloch Mental Hospital and Asylum, Glasgow
6. Perth District Asylum, Perth
7. Stirling District Asylum, Stirlingshire
8. Woodilee District asylum, Lenzie, Glasgow

*Source: Cartographic Centre, Stationery Office, J12187 5/9790*

Throughout the research, a number of other institutions emerged that were of particular interest. These include Gartnavel Royal Asylum, Glasgow where the principles of open-air bed rest were adopted under the superintendent Landel Oswald. Along with Bangour, Kingseat Village Asylum, Aberdeen was the one of the few asylums built from scratch as a village asylum. Both Stirling and Midlothian and Peebles District Asylums were of interest for their developments in female asylum nursing and hospital accommodation.

To give some indication of the diverse areas selected, an outline of three asylums is included that catered for a large urban population (Woodilee District Asylum, Glasgow); a semi rural/urban population (Perth District Asylum, Perth and a rural location (Argyll and Bute District Asylum). Reference is made to the populations of these institutions to demonstrate the contrasting sizes of Scottish asylums and the occupational backgrounds of patients for the period 1889 to 1908.

The Argyll and Bute District Asylum (ABDA) opened in 1863 and was the first opened under the 1857 Act. John Sibbald (later Commissioner) was appointed as superintendent in 1863 and succeeded by James Rutherford in 1870. In 1875, Rutherford moved to Woodilee in Glasgow and was followed by John Cameron who remained at the ABDA until the 1900s. In the first decade of opening, the ABDA was a model in its propagation of occupation and liberty. The ABDA was the smallest of the asylums under study, admitting an average of 36 male and 37 female patients per year between 1889 to 1908. The lowest number of admissions was 23 males (1906) and 26 females (1907). Numbers of admissions remained consistent throughout the period under study and there was an overall decline in admission figures. Cameron was superintendent for the majority of the period under study. During his

superintendence, Cameron and the District Board made few moves in the direction of hospitalisation.

Perth District Asylum (PDA) opened in 1864 with accommodation for approximately 200 patients. On average, the PDA admitted 39 males and 43 females per year. Although figures fluctuated, the asylum did not undergo an increase in admissions (although it was subject to periods of overcrowding). Dr W.C. McIntosh superintended the institution from 1863 to 1882 and was succeeded by Dr Colin MacIver Campbell (1882 to 1892). The PDA employed two main players in the hospitalisation movement. Dr George Robertson worked there as superintendent between 1894 and 1899 and was followed by Charles Lewis Bruce (1899 onwards). Both Robertson and Bruce made changes to the asylum's accommodation and research facilities.

Woodilee District Asylum in Glasgow opened in 1875 with accommodation for 400 patients. Its superintendents included James Rutherford (1875 - 1883), Robert Blair (1883 - 1902) and Hamilton C Marr from 1902 onwards. Marr was a supporter of hospitalisation and pressed the District Board to fund further scientific research. The asylum served the Barony parish that was plagued by high levels of urban and rural poverty.

When the asylum opened, many patients were transferred from the local Barony poorhouse. Unlike the rurally located PDA and ABDA, Woodilee underwent a dramatic upturn in population size. Its admission rates increased from 86 female and 85 male admissions in 1889 to an average of 150 admissions of each gender in the 1900s. In the wider social context, the industrialization and spiralling population size of Glasgow impacted on local asylums. A direct reason for the increased admission rate is

explained by David Yellowlees' decision to remove all pauper patients from his Glasgow Royal Asylum to the outlying district asylums from the 1870s.

The occupation of patients prior to admission was compiled from existing tables included in the three annual reports for the 20-year period 1889-1908. The compiled tables are divided between institution and gender and are included in appendix two. In the annual reports, the occupation titles were included in their original titles and had not been collated into occupational fields by the medical superintendent. The difficulties in coding occupational data are notorious and are well documented by historians.<sup>55</sup> In line with recommendations, no occupational titles were pre-coded prior to data entry.<sup>56</sup>

An important aim of collecting occupational data was to make comparisons between the asylum populations in patterns of occupational range. Schürer highlights that if due care is not taken in coding then data can be too easily compressed into too few fields.<sup>57</sup> An initial decision was taken to utilise Beveridge's table of occupational bands used in his study of the Royal Edinburgh Asylum population.<sup>58</sup> This would have allowed for comparison with another contemporary Scottish asylum. However, the bands used by Beveridge were too narrow for the rural PDA and ABDA populations. In order not to compress the numerous occupational titles into too few fields, Beveridge's table was abandoned and a wider table was devised.

Scull contends that the asylum became a holding place for society's unproductive, dangerous and inconvenient members.<sup>59</sup> Studies of individual asylum populations have consistently disputed this by arguing that the vast majority of patients were registered as employed on admission and that a proportion participated in skilled trades.<sup>60</sup> Such



studies also found that a high proportion of patients was employed in unskilled work, for example as labourers or in domestic service. Walton highlights that this simply reflects the local economy and the psychological and economic strains of the poor.<sup>61</sup>

The findings from all three asylums reflect that the institutions did not house the destitute and unemployed of local society. The largest single category of male occupations at the PDA and Woodilee asylums was labouring (Woodilee 22.2%, PDA 26.3%). The ABDA admitted a high number of labourers (18.1%), and the highest single category was agriculture and fishing (31.9%). This category included farmers, crofters and fishermen in addition to multiple occupations such as 'crofter and rabbit catcher' and 'crofter and roadman'. High numbers of male patients from the PDA worked in agriculture and fishing (16.8%). At the PDA, it was possible to see the presence of local industry and manufacturing (8.3%) including mill workers and textile weavers. Approximately one tenth of Woodilee males were employed in manufacturing and industry, including ironworking and the textile industry.

Male patients also came from skilled occupational backgrounds. Trade and craft accounted for almost 20% of admissions to Woodilee, 15% at PDA and one tenth of ABDA admissions. This band included tailors, joiners, printers, painters, shoemakers and blacksmiths. In Beveridge's study, 5% of paupers came from a clerical background.<sup>62</sup> This is similar to findings at Woodilee where the band accounted for 6.1% males. Clerical employment was less common in rural areas although the PDA also admitted 3.2% clerks or bookkeepers. All three asylums admitted a minority of patients from the professions including teachers, architects, solicitors, medical and divinity students and trainee teachers.

A pitfall of occupational analysis is the misleading nature of nineteenth century occupational titles. This data weakness frequently applies to female occupations. In all three asylum populations, domestic service and housewives were the most common occupational title for female admissions. However, the occupation title of housewife does not indicate if this group participated in part time, casual or home working. Domestic and personal service employed 36.1% of Woodilee females, 37.4% of the PDA and 44% of female admissions to the ABDA. Although housewives accounted for 38.9% of Woodilee females, the figures were lower in the more rurally located asylums. At the PDA this group accounted for 17.5% and 29.7% at the ABDA.

As such, there were higher numbers of female admissions in paid employment at the PDA. Manufacturing (mainly textile industries) accounted for 13.6% of PDA females compared to 8.6% at Woodilee. Similarly, 8.8% of PDA females were employed in labouring. There was a higher though not significant percentage of Woodilee females employed in retail and distribution industries, for example, dressmakers and shop girls. Only 2 females were registered as prostitutes and this was at Woodilee. A higher percentage of ABDA females participated in agriculture and fishing (5.5%).

In many ways, the pattern of occupation across the three asylums reflects occupation patterns in Scottish society as a whole. Occupations in the asylum corresponded with themes in regional employment as well as wider trends in society, such as the expansion of manufacturing and industry. For females, the key areas of occupation in society were agriculture, domestic service, textiles and clothing (although the percentage of women employed in these industries declined as the twentieth century approached).<sup>63</sup> These areas also show up as key types of occupation for women in the three asylums. It is also important to take into account the changing nature of



occupations in society across the nineteenth and twentieth centuries. There was a rise in clerical and retail positions in the late nineteenth century, which is also reflected in the urban population of Woodilee.

In Scotland, agriculture and fishing employed 19.12% of Scotland's male population in 1881.<sup>64</sup> This corresponded with the PDA where 16.8% of males were employed in this manner. At Woodilee, agriculture employed only 1.6% whereas it accounted for 31.9% of ADBA's asylum population. Again, this reflects local variation in employment type. Smout argues that Glasgow was dominated by the image of the skilled male craftsman and suggests that over 70% of the male employed workforce in this area could be described as skilled.<sup>65</sup> It is difficult to pinpoint the exact meaning of a skilled occupation, for example manufacturing was a dominant industry in Glasgow but was often characterised by unskilled monotonous tasks rather than skilled trade. The percentage of labourers and manufacturers far outstripped the numbers of craftsmen who were admitted to Woodilee.

Patterns in occupation at the three asylums cannot reflect the general distribution of occupation in Scottish society as a whole, because all three were district asylums and admitted predominately working class and lower middle class people. Royal asylums attracted the middle classes who could afford the rates and the upper class clientele. Both Glasgow and Perth had Royal asylums, and although Lochgilphead did not, the middle and upper classes would often travel out of the local area for treatment at Royal asylums.

In both male and female occupations, there were similarities between all three asylums in terms of occupational range and the findings challenge Scull's assumptions that

patients were destitute. The smaller size of the PDA and ABDA are hardly reflective of mammoth Victorian warehouses. However, the increased admissions to Woodilee do demonstrate the difficulties faced by urban institutions in terms of increased population and overcrowding.

### Sources and Methods

The records of all asylums in the thesis were researched at the following medical and hospital archives: Greater Glasgow Health Board Archive, Mitchell Library, Glasgow (GGHBA); Lothian Health Services Archive, Edinburgh University Library (LHSA); and the County Council Archives, Perth. Research was conducted at individual hospitals, including Argyll and Bute District Hospital, Lochgilphead; Bangour Village Hospital, Broxburn (West Lothian Health Care Trust); Crichton Royal Hospital, Dumfries (Dumfries and Galloway Health Board Archives); and Murray Royal Hospital, Perth.

Records held in local and medical archives have been meticulously catalogued and maintained. LHSA holds the annual reports of both Scottish asylums and the “Blue Books” of the Scottish Lunacy Commissioners. The Archive also preserves the extensive and diverse records of the REA. In addition to research of individual records, the archive was useful in supplementing missing asylum annual reports.

Likewise, the GGHBA retains a vast collection of hospital and asylum records, including the comprehensive records of Gartloch, Woodilee and Gartnavel hospitals. The survival rate of hospital records in both the Edinburgh and Glasgow archives is impressive. However, there are some gaps in the records (for example, Woodilee’s

annual reports are missing for the 1870s and 1880s). Yet such gaps in printed matter are filled for the most part by reference to the bound annual reports held at the LHSA.

It is important to point out the accessibility of larger collections. In contrast, the survival and maintenance of records held at individual hospitals is more sporadic. At Lochgilphead hospital for example, the majority of case notes had been destroyed. The annual reports of the asylum are available at the local town archive (situated in the council library). However, the remainder of records held at the asylum, such as the admissions register and small number of case notes are poorly catalogued and kept in a hospital cupboard. Likewise, although the Bangour records are fairly extensive and well maintained, with the imminent closure of the hospital, the future of the records is uncertain.

The closure of former asylums is of concern to those interested in the investigation of patient casenotes and asylum records. Already, many medical records have already been thrown out or damaged through neglect beyond repair. Andrew Scull has also recently made similar comments. As Scull suggests, it would be ironic if current research work on asylums was 'undercut by the demise of the institutions themselves, and with it, the destruction of the crucial records'.<sup>66</sup> (However, such issues must only be of recent concern to Scull as the majority of his past research has been based on printed annual reports and not unpublished material held in institutions).

Despite the future uncertainty of asylum sources, many hospitals maintained extensive collections. Perth District Asylum (PDA) records (held at Murray Royal Hospital, Perth and Perth County Council Archives), Ayr District Asylum (ADA), records kept at Ayrshire Archives and the Crichton Royal Institution (CRI) records held in the

hospital were both extensive and fully catalogued. The CRI records have come under scrutiny from researchers and are commonly assessed by both academics and family historians. However, both the former Ayr (ADA) and Perth District Asylums (PDA) have (like so many other smaller District Asylums) been pitifully under-researched. Both PDA and ADA archives hold extensive sets of case notes. The PDA is one of the only asylums to have maintained a daily casebook of patients in the nineteenth century. Moreover, the ADA holds (as far as it is known) the only existing bound volume of correspondence between the asylum and the General Board of Lunacy in Scotland. Whereas the often used asylum records of Scotland's two major cities are often scant in detail as a result of overcrowding and understaffing, the ADA and PDA record minute detail of patient treatment and care.

Early research in psychiatric history was primarily based upon asylum annual reports.<sup>67</sup> The source can hardly be avoided. The annual reports provide chronological (if somewhat basic) information of changes taking place at the institution. The reports also give excerpts (although edited to provide optimum praise for the asylum) from the Lunacy Commissioners "Blue Books". The reports include a variety of statistics relating to the asylum population and the accounts of the asylum farms. (The former statistics were of use in gauging economic benefits of asylum farming). Annual reports were a requirement set out by the 1857 Lunacy (Scotland) Act and every asylum head was obliged to write his yearly report of the institution.

The published source is evidently subject to bias in its opportunity for self-promotion of the institution and its staff. Of course, District Asylums did not use annual reports as propaganda to encourage private admissions. However, annual reports did allow medical superintendents the opportunity to 'show off their asylum' as so-called modern



centres of progressive treatment. This is particularly reflective in the promotion of the asylum 'nurse' to the outside world (discussed in chapter eight) as a trained hospital worker for the sick.

The quality of the annual report as a source is reliant upon its authorship. The scant details of some annual reports provide little but repetitive information that was regurgitated year after year. This is evident in reports written by superintendents Blair (Woodilee superintendent between 1883 and 1901) and Cameron (ABDA superintendent between 1875 and 1905). Although the brevity of reports may be demonstrative of the overworked medical staff, the lack of enthusiasm displayed was criticised by outsiders reading the reports. In consideration of Scottish asylum reports in the *Medical Press* (1886), it was reported that Cameron's report of the ABDA 'disappoints us by his brief reports'. Blair's report for the same year was dismissed as 'brief, stiff and almost barren in incident and interest'.<sup>68</sup>

Casenotes are a richer source for medical historians than annual reports. Andrews comments in his article on Gartnavel hospital casenotes that the new emphasis on researching history from the patient's viewpoint has placed even greater importance on casenotes as a source.<sup>69</sup> Casenotes outline the patient experience in the asylum and allow their journey to be traced through institutional life. Casenotes highlight medical attitudes towards treatments. The perceived link held by doctors between work therapy and recovery is evident in many notes.

Physicians had long kept their own journals as memoirs or as a method of highlighting an unusual case. From the nineteenth century casenotes came to be seen as method of extending the medical knowledge of insanity. Roy Porter documents the Manchester

Infirmary physician Thomas Percival's plea for the importance of keeping a regular journal in 1803. Percival recommended that the full particulars of each person be recorded, including 'age, occupation, sex, mode of life and if possible hereditary constitution.'<sup>70</sup>

Casenotes were maintained in order to illustrate the progress of a case with their symptoms and response to treatment. Risse and Warner highlight that although no hospital case record is identical in form or in length, they possess a number of features that have been relatively consistent across time and institution.<sup>71</sup> A hospital history typically begins with demographic information about the patient, for example name, age, religion, occupation and age. The date of admission and discharge would be included as well as information about the patient's past complaints, and the progress of the case. Although not written with the historian in mind, case records can illustrate the transition between traditional treatments and 'scientific' approaches towards hospital medicine in the eighteenth century.<sup>72</sup>

Andrews suggests that changes in asylum casenotes can be seen alongside attempts to 'hospitalise' the asylum.<sup>73</sup> Appendix three includes a selection of casenotes taken from the Crichton Royal Asylum, Gartloch and Woodilee District Asylums. The notes were selected to highlight variants in casenote keeping in different institutions as well as the combination of different treatment types. A case taken from Browne's CRI administration in the 1850s illustrates the mid nineteenth century format of the note (see Case A: Appendix three). Efforts were made to include adjuncts to the notes, such as letters written by relatives.



In England, asylums began to keep casebooks in the 1820s. An initiative for case note recording stemmed from the acquisition of medical knowledge of mental illness. Systematic note keeping was also a response to the increasing surveillance of asylums by commissions (for example the House of Commons Committee on Madhouses 1815-16).<sup>74</sup> In England, case note recording was made compulsory after the 1845 Lunacy Act. From this time onwards, commissioners insisted that case notes provide basic personal information, physical condition of the patient, nature and details of mental disorder, and the patient's history and additional hereditary details.

Similar to England's institutions, case note recording appeared on a more systematic basis from the 1820s at the 'Royals' in Scotland. Case A in Appendix three highlights the progress of patient W.Y. through the CRI in the 1850s. His notes denote a series of statements, which were taken from query sheets or written correspondence from the patient's relative or guardian. The questions refer to '*personal details*', '*cause, type and duration of illness*', '*pulmonary symptoms*', '*physical condition*', '*whether suicidal or dangerous*', '*presence of delusions*', '*epilepsy*', '*previous treatment*' and '*hereditary tendency to mental illness*'. Andrews' research has shown that this series of 'questioning' was common to most Scottish and English asylums of this period.<sup>75</sup>

Unlike England, there was no legal requirement to keep casenotes under the Lunacy (Scotland) Act of 1857. During the last decades of the nineteenth century however, emphasis on a more scientific approach to mental illness as well as access to printed forms led to recommended changes in case note keeping at asylums. Uniform printed case note recording originated from a *Medico Psychological Association (MPA)* committee (1869). The committee included David Skae and Thomas Clouston and suggested that a casenote keeping system be adopted throughout the asylums. Doctors were

encouraged to use the 'International Centre of Alienists' and Skae classification in order to record mental illness in their notes.<sup>76</sup> Clouston implemented the uniform, printed case note-recording schedule after taking up his post as REA medical superintendent in 1873.

Parallels may be drawn between this increased systematic clinical note keeping and Foucault's work on disciplinary institutions. In *Discipline and Punish*, he suggests that specific techniques were used to subjugate the body through which the individual was under constant and minute surveillance.

...the penitentiary Panopticon was also a system of individualizing and permanent documentation...the system of moral accounting was made compulsory: an individual report of a uniform kind in every prison, on which the governor or head-warder, the chaplain and the instructor had to fill in their observations on each inmate.<sup>77</sup>

In the context of the asylum, Wright argues that Foucault is correct in thinking that these new sanitised and professional procedures saw the individual as a 'case' and aimed to subject him/her to a rigorous examination and scrutiny.<sup>78</sup>

However, there was medical opposition to uniform case note keeping as some doctors felt that the individuality of data would be lost through standardised forms. Bartlett also suggests that case note keeping was not consistent and did not adhere to this 'clinical and professional gaze' espoused by Foucault.<sup>79</sup> This is also true of Scottish asylums. The maintenance of notes varied between asylums and medical superintendents into the twentieth century.

The CRI introduced uniform printed forms in the 1880s under Dr Rutherford (see Cases B and C in Appendix three). The schedule for the CRI formed the first two

pages of the notes and closely followed Clouston's form at the REA. It first asked for the patient's name, date of admission, age, sex, level of education, religion, private or pauper status, marital status, origin of referral and occupation. The next section was called 'history' and included questions about the patient's habits and disposition, previous attacks, hereditary history, duration of attack, description of symptoms and if the patient was suicidal or dangerous. A section was then provided for the patient's medical certificates to be transcribed. The following section asked for details of the state on admission under a variety of headings: exaltation, excitement, depression, enfeeblement, memory, coherence, delusions, abnormalities and whether the patient could answer questions.

The schedule asked for physical condition of the patient including a physical examination, nervous system and bodily health. In line with the MPA recommendations, the schedule requested the nature of 'disease' and Skae's classification. A table was also provided for the 'predominant features' of the case (i.e. delirium and incoherence, hallucinations or enfeeblement) followed by the progression of the patient. Little to no change was made to the form of the case notes at the CRI between the 1880s and 1910. The only additional information required from the 1890s was the patient's weight and temperature throughout their duration of stay. As Case H in Appendix three shows, this was not consistently recorded.

Gartloch (a model 'asylum-hospital') did not introduce printed forms until 1913. The Gartloch case notes form did record similar information to the CRI although not in as minute detail. The notes become more detailed under Dr Parker and developed subsections such as 'information from relative', 'physical examination', 'circulatory, respiratory and digestive system,' 'urine' and 'nervous system' (see Case F: Appendix

three). The notes for J.K. (Case D: Appendix three) admitted to Woodilee are not a standardised printed pro-forma under Blair. Hamilton C. Marr did introduce printed casenotes when he became medical superintendent of Woodilee in the 1902 (see Case G, Appendix three). It is likely that Marr was influenced by Rutherford's practice when he worked under him at the CRI.

The quality of case notes begs the obvious question: who wrote them? For the most part, assistant doctors and clerks compiled the case notes.<sup>80</sup> In this context, case notes do not provide a true version of history from the patient's voice but put across attitudes of medical staff. Casenotes varied in length and quality. A family member might not provide a full case history of the patient or the medical clerk may not have the time to fill out the details on a regular basis. Whereas some casenotes were completed consistently, larger institutions like Woodilee and Gartloch often lapsed in months between some patient's entries. The entries of notes for Case G in Appendix three run for years without comment and give no indication as to where the patient was transferred after release.

Scottish asylum law allowed staff to read patient correspondence and consequently, many letters were not posted and retained. Recent historians have used correspondence from relatives and friends as a source. In 1991, Roy Porter published *Stories of the Insane: A Social History of Madness*. In this, Porter examined the history of insanity through memoirs written by patients. More recently, Allan Beveridge researched the letters of more than 400 patients at the Royal Edinburgh Asylum between 1873 and 1908.<sup>81</sup> Beveridge has collaborated with Morag Williams to provide a detailed history of the CRI patient John Gilmore.<sup>82</sup> The case of J.K. included in Case D in appendix three, contains a letter written by the patient's father that highlights the



son's breakdown after the death of his brother. A letter written by the CRI patient H.A.'s doctor and presumably passed on to the CRI doctors is enclosed in Case H of Appendix three. However, the retention of letters depended upon the interest of the individual doctor involved. Keeping correspondence was not always the first priority of overworked staff.

An interesting adjunct to the Woodilee casenotes is the inclusion of patient photographs from 1906. These were taken to show the patient's front and side profile and is reminiscent of a prison 'mugshot'. It is likely that these were included as a means to identify patients and the images highlight the decline of these larger district asylums into primarily custodial institutions. The inclusion of photographs varied between institutions. The Ayr District Asylum case notes contains patient photographs after 1902 (under Charles Easterbrook) and serves as an interesting illustration of the asylum's use of verandah treatment.

The method of compiling casenotes varied between the institutions. In the main, case notes were divided into gender and bound in chronological admission order. One exception is Bangour Village, Broxburn. Although the notes are divided into male and female volumes, the notes are arranged into bound volumes of "patient discharge" or "death". There is also no obvious chronological order to the volumes. This means that no volume is given a year or time span (i.e. 1906 or 1906-1908). Alternatively, patient entries in the volumes can range between years and decades. It is therefore not possible to provide a date or catalogue number when referring to Bangour records.

Quantification is a further methodology that broadens the basis of research in the history of psychiatry. In the past, writers such as Scull and Foucault constructed large



hypotheses about asylums on the basis of little solid data. As previously noted in the literature review, Scull asserted that asylums were filled to the brim with long stay incurable patients. The literature review also pointed to the attempt by 'quantitative historians' (for example, Anne Digby) to deconstruct these hypotheses. Historians like Digby used case notes and asylum registers to construct large databases of patient populations. These were used to disprove the assertions made by Scull and Foucault. Admission registers were also researched in order to discuss topics of gender, age, marital status, geographical origin and the disease of asylum patients.

While the thesis does not aim to provide overviews of asylum populations, quantitative methods are adopted with certain asylum registers. 1) Registers of restraint and seclusion; 2) pass and probation; 3) accidents and escape. These registers have been examined as part of the discussion of patient liberty. Registers of restraint and seclusion have survived at the ADA and CRI. Again, registers of pass and probation are available at the ADA and CRI. The registers of accidents and escape are useful in gauging consequences of patient liberty, which was allegedly extended by the open door system.

There are drawbacks in using these registers as a historical source. Digby points out that medical staffs were under pressure to provide a favourable set of statistics in their annual reports and registers in order to propagate a progressive image.<sup>83</sup> It was often common then that instances of restraint or seclusion went unrecorded. Drummond Hunter utilises the printed statistics in the 56<sup>th</sup> Annual Report of the Scottish Lunacy Commissioners (1913) to suggest a 'progressive diminution' in the use of restraint and seclusion in Scottish asylums between 1896 and 1911.<sup>84</sup> The propagandist nature of

these statistics should be borne in mind and only reference to individual registers provides a more realistic image of restraint and seclusion at the time.

Moving away from specific asylum sources, the “Blue Books” (or Annual Reports) of the Lunacy Commissioners detail their twice yearly visits to Scottish asylums. The books also include official reports of current issues and statistical data relating to Scotland’s mentally ill. Although the reports provide useful factual information and draw the reader’s attention to official contemporary concerns, they are a printed and published source. This means that they are subjected to the same bias and propagandist drawbacks as any annual report. Andrews’ survey of the Scottish Lunacy Commissioners in the nineteenth century draws attention to the “self-justifying” aspect of the reports.

Constituting very much “the official version” of Commissioners activities, these sources are strongly prejudiced towards a self-justifying view. The cases publicised in the annual reports were selected largely for polemical purposes, to justify the commissioners’ own peculiar prejudices, strategies and ethos, when it came to dealing with the mentally disordered.<sup>85</sup>

The best way to counter bias in sources is to use them in conjunction with other evidence. A further source relating to the Commissioners is their minute books, which are held at the Mental Welfare Commission Archive, West Register House, Edinburgh. However, these only include snippets of information in minute form relating to the Commissioners activities, and do not include written correspondence.

Andrews suggests that in order to combat deficiencies, Commissioner “Blue Books” and Minutes should be used alongside the records of other groups who dealt with the Commissioners (such as the District Boards and Inspectors of Poor). It is therefore useful to point out the existence of a bound book of correspondence between the

Commissioners and the Ayr District Asylum (1869 – 1951). The bound volume contains letters, reports and memoranda to the asylum and copies of letters sent to the Commissioners. Topics of interest here include the issue of animal testing as part of scientific research work and the tuberculosis problem at the asylum. The drawback of this source is that it only includes correspondence with the ADA. It is a fascinating insight however into the relationship between the General Board of Lunacy and a Scottish District Asylum in the nineteenth and twentieth centuries.

The relationship between the asylum and the parochial boards is given insight through surviving correspondence belonging to Cameron, the Inspector of Poor for Lismore and Appin. The letters were written to and from various community members including the local medical superintendent.<sup>86</sup> Lismore and Appin was the largest district from where the Argyll and Bute District Asylum (ABDA) received its patients. The unpublished correspondence that relates to mentally ill people includes letters concerning boarded-out and asylum patients, recommendations or refusals from the medical superintendent about a patient's release and letters from persons recommending friends or relatives for committal to the asylum. The correspondence denotes the strained relationship between Cameron and James Rutherford, Medical Superintendent of the ABDA between 1870 to 1875. Occasional letters give some indication of Rutherford's perceptions of boarding out and his unpublished view of asylum treatment.

Moving away from asylum and official sources are medical journals and newspapers. The most renowned nineteenth century psychiatric journal is the *Journal of Mental Science*. The *JMS* was the 'official' journal of the *Medico Psychological Association* and as such, the journal provides the opinions of *MPA* members, minutes of *MPA* meetings,

a 'Notes and News' section and 'Occasional' pieces. Reviewing the general medical journals such as the *BMJ*, the *Lancet*, the *Edinburgh Medical Journal*, the *Glasgow Medical Journal* and the *Scottish Medical and Surgical Journal* can combat the often self-congratulatory air of the *JMS*. The medical journals are all helpful in their coverage of developments in mental pathological research work in Scotland. In particular, the *SMSJ* published the annual reports of the Scottish Conjoint Asylums Laboratory Scheme (SCALS). These pathological reports have not survived in their original format.

The *American Journal of Insanity* provides an American perspective of developments. The Journal is particularly useful for its coverage of trips made by American doctors to Scottish asylums in the late nineteenth century. The *Review of Neurology and Psychiatry* contains much published research work and is an indicator of the extent that Scotland's asylum doctors contributed to the scientific research community.

Newspapers especially the regional press such as the *Edinburgh Evening News*, *Glasgow Herald*, and *Scotsman* report local reaction to asylum building and care. The interest surrounding the open door system at Woodilee in the 1880s generated a local outcry in the papers when a female patient escaped from the asylum and was killed by a train on the Edinburgh – Glasgow track.

In discussing newspapers and journals as a source, the Press Cutting Books of the REA must not be overlooked. These volumes contain a vast collection of local, national and international newspaper clippings and journal articles relating to mental illness and asylum care. The volumes were compiled by the successive REA medical



superintendents Thomas Clouston, George Robertson, and then by a press agency. There are 9 volumes in total spanning nearly a complete century from 1862 to 1958.<sup>87</sup>

Whatever caught the medical superintendent's eye at the time is included in the collection of clippings and the volumes prove an invaluable reflection of contemporary issues and debates surrounding mental illness and asylum care. A transatlantic slant is placed on the volumes, possibly a result of Clouston's American wife sending newspaper cuttings on her trips to the States. A diverse number of topics can be found in the volumes, ranging from medico-legal cases to the force feeding of asylum patients. Of particular use in this thesis is the attention given to female asylum nurses, architectural developments and research work. The collection helps identify the discrepancies between the image and reality of asylum nursing and the discontent expressed by asylum staff.

Like any source, there is an inevitable bias attached to the Press Cutting Books. Only articles that were deemed of importance or of interest enough to the compiler were included. In this context, there is a great deal of material on alcoholic insanity, a topic with which Thomas Clouston was absorbed. George Robertson's interest in female nursing in male wards is also well represented. The compilation of the press cuttings by the individual doctors makes it possible that issues that doctors disagreed with might be brushed over. Nonetheless, the Press Cutting Books are a fascinating source and much remains to be done with the Press Cutting Books in their own right.

The remainder of sources used is less easy to categorise. This section comprises of topics whose sources were tantamount to constructing a 'jigsaw' in order to gain any understanding of the subject. In order to consider the influence of philanthropy and



the Poor Law (in particular the Brabazon Employment Society), it was not possible to rely on asylum records. Case notes and annual reports provided some information. Case notes made occasional reference to the BES as a form of treatment and annual reports repetitively drew attention to the 'useful work' carried out by Brabazon volunteers. Research of the Mental After Care Association (MACA) archives in London (the BES's closest philanthropic relative) was also of little use for Scottish philanthropy. Although the MACA archives were extensive, they dealt primarily with England and Wales. Trawling through the Internet accessible National Register of Archives (NRA) catalogue only brought up reference to the records of English based Brabazon societies. Although useful for a study of the BES in its own right, the records provided little help for the BES as a part of the history of psychiatry.

Many of the sources for the BES were gleaned from detailed minute books of Glasgow poorhouses (where the BES had its Scottish origins), District Board minutes of asylums, the BES annual reports (included in Glasgow parish record collections) and autobiographical sources. These collections of sources if individually utilised were certainly far from ideal. The propagandist element of the annual reports and memoirs and biographical accounts of those involved made such sources fraught with bias. When used in conjunction with the other sources, the drawbacks were lessened.

There are a small number of additional sources that should briefly be referred to. Minute books of the Royal College of Physicians, Edinburgh were of use in studying the origins of the Conjoint Laboratory Scheme of Scottish Asylums. In the discussion of tuberculosis within asylums, it was felt useful to make comparisons with a tuberculosis hospital. The example used for this comparison was the Royal Victoria Hospital for Consumption, Edinburgh.

In conclusion, a diverse selection of sources was sought in order to provide a rounded approach to the thesis. These included more typical sources for the history of psychiatry such as asylum registers and records. The changes made in asylum case notes record moves towards these sources' medicalisation, although this was not consistent across institutions. By looking outside the hospital, at sources unconnected to psychiatric history, it is possible to gain a more varied perspective on social influences upon the asylum environment.

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<sup>1</sup> G.M. Robertson, 'The Employment of Female Nurses in the Male Wards of Mental Hospitals in Scotland', *Edinburgh Medical Journal*, (1916), p.194.

<sup>2</sup> This quote refers to John Sibbald, Commissioner in Lunacy between 1883 and 1905. See J. Andrews, '*They're in the Trade... of Lunacy They 'cannot interfere' - they say*': *The Scottish Lunacy Commissioners and Lunacy Reform in Nineteenth-Century Scotland*, (Occasional Publications, The Wellcome Trust, 1998), p.19; Andrews, 'The Evolution of Psychiatry in Glasgow in the nineteenth and twentieth centuries', in G.E. Berrios & H. Freeman (ed), *150 years of British Psychiatry 1841 - 1991*, (Gaskell, 1991), p.321; Andrews, 'A Failure to Flourish: David Yellowlees and the Glasgow school of Psychiatry part 2', *History of Psychiatry*, 8 (1997), p.347-49 and Andrews, 'Raising the Tone of Asylumdom' in J. Melling & B. Forsythe (ed), *Insanity, Institutions and Society 1880 - 1914: A Social History of Madness in Comparative Perspective*, (Routledge, 1999), p.213.

<sup>3</sup> Termed by Joseph Melling to describe a recent tendency to view psychiatric history through 'rose tinted' glasses. Melling & Forsythe, *Insanity, Institutions and Society*, p.312.

<sup>4</sup> With regard to Scotland see D.K. Henderson, *The Evolution of Psychiatry in Scotland*, (E & S Livingstone, 1964) and C.C. Easterbrook, *A History of the Crichton Royal Institution*, (Dumfries Press, 1945).

<sup>5</sup> G. Mclachlan (ed), *Improving the Common Weal: Aspects of Scottish Health Services 1900-1984*, (Edinburgh University Press, 1987), p.335.

<sup>6</sup> E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*, (Penguin, 1961), p.16-17.

<sup>7</sup> M. Ignatieff, *A Just Measure of Pain: The Penitentiary in the Industrial Revolution 1750 - 1850*, (Pantheon, 1978), p.214.

<sup>8</sup> M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, (Routledge, 1961), see particularly p.38-68.

<sup>9</sup> *Ibidem*, p.250.

<sup>10</sup> *Ibid.*, p.270.

<sup>11</sup> Melling & Forsythe, *Insanity, Institutions and Society*, p.2.

<sup>12</sup> R. Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency*, (Penguin, 1987), p.7-8.

<sup>13</sup> *Ibid.*, p.9.

<sup>14</sup> M. Foucault, *Discipline and Punish: The Birth of the Prison*, (Penguin, 1977), p.181.

<sup>15</sup> S. Cohen & A. Scull (ed), *Social Control and the State*, (Basil Blackwell Ltd, 1983), p.82.

<sup>16</sup> *Ibid.*, p.83.

<sup>17</sup> Melling and Forsythe, *Insanity, Institutions and Society*, p.3.

<sup>18</sup> A. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England*, (Penguin, 1979), p.63 & 194.

<sup>19</sup> Cohen & Scull, *Social Control and the State*, p.150.

<sup>20</sup> Scull, *Museums of Madness*, p.201.

<sup>21</sup> Cohen & Scull, *Social Control and the State*, p.154.

<sup>22</sup> Scull in Melling and Forsythe, *Insanity, Institutions and Society*, p.313.

<sup>23</sup> Scull, *The Most Solitary of Afflictions: Madness and Society 1700 -1900*, (Yale University Press, 1993), p.370.

<sup>24</sup> Scull, 'Museums of madness revisited', *Social History of Medicine*, 6/1, (1993), p.22.



- <sup>25</sup> Melling and Forsythe, *Insanity, Institutions and Society*, p.308.
- <sup>26</sup> R. Porter & A. Wear (ed), *Problems and Methods in the History of Medicine*, (Croom Helm, 1987), p.154.
- <sup>27</sup> A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat 1796 - 1914*, (Cambridge University Press, 1985); L. Ray, 'Models of Madness in Victorian Asylum Practice', *European Journal of Sociology*, 22 (1981) and J. Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire 1848-50', *Journal of Social History*, 13/1 (1979).
- <sup>28</sup> O. Walsh, 'Lunatics and criminal alliances in nineteenth-century Ireland', in P. Bartlett & D. Wright, *Outside the walls of the asylum: Historical perspectives on 'care in the community' in modern Britain and Ireland*, (Althone, 1999), p.132.
- <sup>29</sup> J. Andrews, 'Raising the Tone of Asylumdom', p.217.
- <sup>30</sup> Also refer to Bartlett's chapter 'The Asylum and the Poor Law: the productive alliance' in Melling and Forsythe, *Insanity, Institutions and Society*, p.48-67.
- <sup>31</sup> *Ibid.*, p.49.
- <sup>32</sup> Bartlett, *The Poor Law of Insanity: The administration of pauper lunatics in mid-nineteenth century England*, (Leicester University Press, 1999), p.2.
- <sup>33</sup> B. Forsythe, J. Melling and R. Adair, 'The New Poor Law and the County Pauper Lunatic Asylum – The Devon Experience', *Social History of Medicine*, 9/3 (1996), p.335.
- <sup>34</sup> *Ibid.*, p.336.
- <sup>35</sup> A. Suzuki, 'The Politics and Ideology of Non-Restraint: the Case of the Hanwell Asylum', *Medical History*, 39 (1995).
- <sup>36</sup> R. Hunter and I. Macalpine, *Three Hundred Years of Psychiatry*, (Oxford University Press, 1963), p. 887.
- <sup>37</sup> Suzuki, 'The Politics and Ideology of Non-Restraint', (1995), p.2.
- <sup>38</sup> D. Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, 10/1 (1997), p.138.
- <sup>39</sup> *Ibid.*, p.139.
- <sup>40</sup> J. Andrews, 'A failure to flourish?'
- <sup>41</sup> Andrews, *'They're in the Trade...of Lunacy'*.
- <sup>42</sup> J. Andrews & I. Smith (ed), *Let There be Light Again: A History of Gartnavel Royal Hospital from its Beginnings to the Present Day*, (Gartnavel Royal Press, 1993).
- <sup>43</sup> A. Beveridge, 'Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873 – 1908 Part I and II,' *History of Psychiatry*, 6 (1997).
- <sup>44</sup> H. Sturdy & W. Parry-Jones, 'Boarding out insane patients: the significance of the Scottish system 1857-1913' in Bartlett and Wright, *Outside the walls of the asylum*, p.86.
- <sup>45</sup> *Ibid.*
- <sup>46</sup> G.A. Doody, A. Beveridge and E.C. Johnstone, 'Poor and Mad: a study of patients admitted to the Fife and Kinross District Asylum between 1874 and 1899', *Psychological Medicine*, 26 (1996).
- <sup>47</sup> F. Rice, 'The Origins of an Organisation of Insanity in Scotland', *Scottish Economic and Social History*, 5 (1985).
- <sup>48</sup> T. Walmsley, 'Psychiatry in Scotland' in Berrios and Freeman, *150 Years of British Psychiatry 1841-1891*, p.303.
- <sup>49</sup> D. Mclachlan (ed), *Improving the Common Weal*, (Edinburgh University Press, 1987), p.335.
- <sup>50</sup> *Ibid.*, p.334.
- <sup>51</sup> *Ibid.*, p.337.
- <sup>52</sup> Bartlett and Wright, *Outside the Walls of the Asylum*, (1999).
- <sup>53</sup> *Ibid.*, p.104 & 111.
- <sup>54</sup> An early article by Clouston is 'Medical Treatment of Insanity', *Journal of Mental Science*, 16 (1870-71). See also G.M. Robertson, 'Hospital Ideals in the Care of the Insane: a statement of certain methods in use at the Stirling District Asylum', *JMS*, 48 (1902). Although published in the 1900s, this article outlines the evolution of hospital practices at the asylum in earlier years.
- <sup>55</sup> Appendix one includes brief biographies of medical superintendents who are frequently referred to throughout the thesis. The appendix is intended to reflect the individual interests of doctors as well as their shared characteristics.
- <sup>56</sup> R.J. Morris, 'Occupational Coding: principles and examples', *Historical Social Research*, 15/1 (1990); K. Schürer, 'The Historical Researcher and Codes: Master and Slave or Slave and Master' in E. Mawdsley et al (ed.), *History and Computing 3: Historians, Computing and Data*, (Manchester University Press, 1993) and W.A. Armstrong, 'The use of information about occupation', in E.A. Wrigley, *Nineteenth Century Society: Essays in the use of quantitative methods for the study of social data*, (Cambridge University Press, 1972).
- <sup>57</sup> Morris, 'Occupational Coding', p.4.
- <sup>58</sup> Schürer, 'The Historical Researcher and Codes', p.74.
- <sup>59</sup> A. Beveridge, 'Madness in Victorian Edinburgh Part 1'

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- <sup>59</sup> Scull, *Most Solitary of Afflictions*, p.370.
- <sup>60</sup> Beveridge, 'Madness in Victorian Edinburgh part 1', p.48; Doody, 'Poor and mad', p.892 and Walton, 'Lunacy in the Industrial Revolution', p.10.
- <sup>61</sup> Walton, 'Lunacy in the Industrial Revolution', p.10.
- <sup>62</sup> Beveridge, 'Madness in Victorian Edinburgh', p.30.
- <sup>63</sup> E. Gordon, 'Women's spheres' in W.H.F. Fraser and R.J. Morris, 'People and Society in Scotland, Volume 2, (John Donald, 1990), p.209.
- <sup>64</sup> J.H. Treble, 'The occupied male labour force' in *Ibid.*, p.195.
- <sup>65</sup> T.C. Smout, *A century of the Scottish people 1830-1950*, (HarperCollins, 1997), p.87.
- <sup>66</sup> Melling and Forsythe, *Insanity, Institutions and Society*, p.313.
- <sup>67</sup> Scull's *Most Solitary of Afflictions* is criticised for its reliance upon annual reports. See J. Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11/2 (1998), p.256.
- <sup>68</sup> *Medical Press*, (3/2/86) in *Presscuttings Book 1885-1889*, LHB17/12/3.
- <sup>69</sup> Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity', p.255.
- <sup>70</sup> Porter, *Mind-Forg'd Manacles*, p.211.
- <sup>71</sup> G.B. Risse & J.H. Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *SHOM*, 5 (1992), p.185-6.
- <sup>72</sup> H. Dingwall, *A History of Scottish Medicine Themes and Influences*, (Edinburgh University Press Ltd, 2003), p.132.
- <sup>73</sup> Andrews, 'Case Notes, Case Histories and the Patient's experience', p.261-2.
- <sup>74</sup> *Ibid.*, p.256.
- <sup>75</sup> *Ibid.*, p.262.
- <sup>76</sup> See Beveridge for an outline of the two systems in 'Madness in Victorian Edinburgh part 1', p.27.
- <sup>77</sup> Foucault, *Discipline and Punish*, p.250.
- <sup>78</sup> Bartlett, *The Poor Law of Insanity*, p.163.
- <sup>79</sup> *Ibid.*, p.165.
- <sup>80</sup> In effect, assistant doctors were today's junior doctors. Their working conditions were characterised by long hours and arduous tasks. Assistant doctors carried out the daily medical and administrative responsibilities at institutions.
- <sup>81</sup> A. Beveridge, 'Life in the Asylum; patient letters from Morningside, 1873-1908', *History of Psychiatry*, 9 (1998).
- <sup>82</sup> A. Beveridge & M. Williams, 'Inside "The Lunatic Manufacturing Company": the persecuted world of John Gilmour', *History of Psychiatry*, 13 (2002).
- <sup>83</sup> Porter and Wear, *Problems and Methods in the History of Medicine*, p.163.
- <sup>84</sup> McLachlan, *Improving the Common Weal*, p.335.
- <sup>85</sup> Andrews, *'They're in the Trade...of Lunacy*, p.65.
- <sup>86</sup> Correspondence of the Inspector of Poor for Lismore and Appin, Box 1 – 7, (1860 – 1882. Letters are missing for the period 1876 – 1879), CO6/30/30/1 – 7.
- <sup>87</sup> The 9 volumes span the following years: 1862-1881, 1882-1885, 1885-1889, 1889-1893, 1893-1903, 1903-1917, 1918-1927, 1927-1938, and 1954-1958.

## Chapter Two Hospitalisation in Context

### Introduction

Research findings can fall prey to the 'vacuum effect' when they are not viewed in the context of wider social developments. Drawing parallels with what is going on around prevents 'isolation' and assists in understanding historical research within a broader framework. With this in mind, the chapter provides an outline of developments in related fields to mental health: namely, the Poor Law and public health, prison regimes and general medicine. The background of mental health care in Scotland up until the period of hospitalisation is documented and the context of hospitalisation outlined. A number of interlinked themes are identifiable in these topics and provide a backdrop in which mental health care between 1880 and 1914 can be understood.

By the late nineteenth century, central government had increased its formal presence in society. The amended Poor Law of 1845 marked the advent of central government intervention in the lives of the poor. With the Poor Law came a statutory right to care for physically and mentally ill paupers. Prison system underwent reform and by the late nineteenth century Scottish prisons were under the Board of Control. Medicine and public health underwent increased legislation. Mental health care followed a similar pattern with the 1857 Lunacy (Scotland) Act.

Parallels may be drawn between developments in general medicine and asylum practice. After all, attempts to hospitalise the asylum should be understood in relation to the earlier medicalisation of the hospital. Broad themes in general medicine and psychiatry are comparable, such as the advance of medico-scientific research, institutional growth, and development of treatment and diagnosis. Hospitals became medicalised by the



removal of control from lay persons to the medical profession, the changes in case note taking (discussed in the methodology) and branching out by the medical profession into specialist fields that included mental health. In the nineteenth century, advances were made in clinical procedures and scientific knowledge as well as surgery.

Numerous institutions in the form of poorhouses, prisons, hospitals and asylums were strewn across the Scottish landscape by the twentieth century. The age-old practice of boarding out mentally ill people was mostly replaced by an asylum solution. Scholars have referred to nineteenth century prisons, asylums and poorhouses as 'total institutions' that were instruments of social restraint, sharing similar control tactics and architectural features. Although similarities may be drawn between these institutions, the concept of a 'total institution' does not take into account the diversity of Scottish practice. Similarly, the chapter shows that in all areas of discussion, including poor relief, prison regimes and the medical and psychiatric profession, hospital types and medical treatment, events were far from homogeneous.

### Poor Relief and Public Health

#### *Poor Law*

The Scottish Poor Law system differed in content and timing from its English counterpart. Unlike Scotland, England provided relief for its able-bodied unemployed and also adopted compulsory poor rates. Well documented by historians, the desire for Poor Law reform in England arose out of economic necessity but also to curb the rising cost of poor relief.<sup>1</sup> Digby suggests that a by-product of Poor Law reform was the social control of the poor as a response to the Swing Riots of the 1830s.<sup>2</sup>

Relief in England was based upon the principle of 'less eligibility'. The Royal Commission believed that outdoor relief subsidised wages, thus bringing down wage levels and bringing on pauperism. In reality, poverty was caused by under-employment in rural areas and under employment and cyclical employment in the growing towns.<sup>3</sup> Although some outdoor relief was administered in the home, the workhouse was often used to discourage pauperism. Crowther suggests that the law was based on the premise that anyone who accepted relief inside the workhouse lacked the moral fibre to survive outside.<sup>4</sup> Although work in the workhouse was not initially intended as deterrence, occupation declined into monotonous routine in a bid to halt the tide of relief.

The newly amended English Poor Law created resentment as the traditional right of the poor to parish assistance in their own homes had been removed.<sup>5</sup> Likewise the replacement of local informal poorhouses with the psychological cruelty of the new workhouses led to their labeling as the 'Bastille'. The Scottish Poor Law did not work on the principle of 'less eligibility' and as such did not share the taint of the English workhouse. Nevertheless, this did not mean that the Scottish Poor Law was any more successful in tackling poverty. After all, no statutory right was provided to able-bodied unemployed males in Scotland.

Before the Scottish Poor Law Amendment Act of 1845, each parish in Scotland was responsible for their poor, the right to belong to a parish being determined by their length of settlement in the parish. Voluntary relief was raised through church collections and miscellaneous service fees such as the use of the mortcloth. These funds were administered through the Kirk, which was the local body of the Church of Scotland. Kirk sessions were reluctant to resort to institutional provisions, preferring

to provide outdoor relief in the recipient's own home. Helen MacDonald argues that the boarding out of children in the community was an intrinsic feature of the Scottish welfare system.<sup>6</sup> Boarding out people with a mental illness with a Guardian or family member was also common and is outlined later in the chapter.

Rosalind Mitchison argues that the voluntary nature of relief and its control by the church arose partly from the Protestant desire to establish a well ordered society along with the influence of the evangelical movement that emphasised personal dependency.<sup>7</sup> The church also retained control of relief simply because there was no other body in Scotland that had an effective system of local government. Houston suggests that the church was in principle a central element in people's lives not only for religious guidance but also in time of education and economic need.<sup>8</sup>

By the early nineteenth century, population effects of an industrialising Scotland placed tremendous strains on the administration of the Scottish Poor Law. Consequently, some parishes had offered unemployed able-bodied men discretionary poor relief. Poverty levels coupled with inadequate voluntary relief forced many Scottish parishes to adopt the unpopular policy of assessment by the 1830s. Assessment was the forcible levying of rates on those who could afford to pay. Assessment in larger towns led to a break in tradition where control of poor relief was passed from the Kirk to Town Council.

The crisis of poor relief was brought to a head by the Disruption of 1843, which made it impossible for the Church to continue administering relief to a population of different practising faiths. A Royal Commission was formed in 1843, which resulted in the Poor Law Amendment Act of 1845. In Scotland, the Poor Law Amendment Act

of 1845 changed the administrative structure of poor relief. The Act created a Board of Supervision in Edinburgh although relief continued to be administered at a parochial level. Each parochial board appointed an Inspector of the Poor to oversee relief. The Board of Supervision possessed little more than persuasive powers over its parochial boards and was hampered by a shortage of funds and staff. Although there was no compulsory levying of rates, the Act demanded that adequate funds were provided for relief and an immediate effect was the increase in assessed parishes.<sup>9</sup>

Scotland continued to be dominated by locality in its administration of poor relief. Paterson argues that the Board of Supervision actively encouraged diversity in relief and that often, applicants were treated according to circumstance and local tradition.<sup>10</sup> Parishes varied significantly between levels of population, size and industry and as such, relief varied according to local provisions and customs.

Poor relief was provided in cash or kind on an outdoor basis. Relief continued to be denied to the able-bodied although until a court decision of 1859, discretionary relief was provided. Provisions were also made for the construction of poorhouses and their numbers doubled between 1850 - 1868 from 21 to 50. By 1894 there were 66 poorhouses with accommodation for 15,000 paupers. The provision of poorhouses varied between parish. Although parishes could join together to build a poorhouse, parishes in Scotland also realised that it was cheaper to run lodging houses for those requiring indoor relief. Paterson argued that parishes were tempted to take this avenue because without a poorhouse, parishes were subjected to less central rigours and interference.<sup>11</sup>



The Scottish Poor Law made no provision for a work test. Although work was provided, no one could theoretically be compelled to work. English workhouses operated on a system of less eligibility that aimed to deter the able bodied unemployed from seeking relief. In Scotland, this group was not entitled to relief and as such, deterrence in the poorhouse was usually not necessary. Although work could not be forced in the poorhouse, people capable of working were expected to participate. Appendix four provides a copy of the poorhouse admission form for the rural Lismore and Appin district in Scotland. The form asks if the relief recipient was capable of work. In larger urban poorhouses work was an important part of the poorhouse discipline. Paterson highlights that as inmates could not be forced to work, a system of inducements operated where inmates received rewards for good behaviour and for participating in work.<sup>12</sup> Such a system also operated in Scottish district asylums in order to encourage activity.

The Scottish Poor Law included a statutory right to medical relief for the physically and mentally ill paupers. Authorities received government grants in order to help provide for the physically ill. A similar governmental grant was provided for mentally ill paupers after 1875. Most poorhouses offered rudimentary care by the late nineteenth century, although provisions were scarce in the distant rural areas. Glasgow for example was reasonably well serviced with medical services by the end of the nineteenth century.<sup>13</sup> Poorhouse positions were unattractive posts for doctors and the Board of Supervision found it difficult to encourage doctors to take on parochial work in rural areas.

As Scotland had relatively few poorhouses until the late nineteenth century, the mentally ill paupers were often sent to the Royal asylums in Scotland. Lorraine Walsh



highlights that the greatest part of funding for the Dundee Royal Asylum up until 1850 came from the admission of pauper mentally ill patients.<sup>14</sup> Royal asylums were not keen to encourage the admission of paupers as it lessened the status of their institutions. Royal asylums increasingly catered for a private clientele (particularly with the construction of district asylums after 1857 and transfer of many pauper patients to these institutions). With the rising number of poorhouses after 1845, mentally ill paupers were increasingly sent to the lunatic wards of these institutions. When Woodilee asylum in Glasgow opened in 1875, a high number of admissions were transferred from the lunatic ward at Barnhill poorhouse that served the Barony parish. Mentally ill paupers were also boarded out with family or community members, particularly in the more remote areas of Scotland. Conditions for the mentally ill poor, particularly in the Royal asylums and poorhouse lunatic wards were far from ideal and were influential in the recommendations for lunacy reform in the 1850s.

The reform of the traditional Poor Law was a step towards the centralisation of Scotland's lunacy policy.<sup>15</sup> With the creation of the General Board of Lunacy in 1857, the control of mental illness was transferred from the Board of Supervision to the newly established General Board of Lunacy. Hostilities were present between the newly created Board and the existing Board of Supervision and its Inspectors of the Poor.

Parochial boards resented the increased interference of a central authority in their affairs. Andrews argued that the Lunacy (Scotland) Act not only led to increased expenses for the parochial boards but also resulted in increased interference in local affairs.<sup>16</sup> Appendix five transcribes a distinctly frosty letter from James Rutherford, (Medical Superintendent of the Argyll and Bute District Asylum 1870-1875) to Angus

Cameron, (Inspector of Poor for Lismore and Appin). Rutherford had sent a nurse (without the Inspector) to collect a patient from Perth District Asylum. However, the Inspector had been incensed that Rutherford's act was of 'mindless interference' with his duty. The case is an example of the parochial board's reluctance to maintain paupers not chargeable to their parish as this resulted in the transfer of the patient to the ABDA. Contention also arose between parishes and the General Board over the 1875 lunacy grant. The government grant was given to local authorities as an incentive for improving lunacy provisions. However, the Board of Supervision was given responsibility for controlling the grant whereas the General Board retained the duty of deciding entitlement.

By the 1890s, changing attitudes, especially towards the 'deserving' poor meant that the Poor Law was rapidly becoming outdated. Levitt argues that the growing body of social knowledge coupled with increased interest from the medical profession and philanthropists began to undermine the feasibility of traditional Poor Law practice.<sup>17</sup> In 1894, the Board of Supervision was replaced with a Central Board of Control. In 1898 the parochial boards were also replaced new democratic councils. The new Board was more dynamic than its predecessor was. It sought to improve standards of relief and from 1901 employed a medical inspector. However, historians agree that the new Board, like its predecessor exerted little control or influence over the localities and up until the 1920s, central government continued to have little presence at a local level.<sup>18</sup>

### *Public Health*

In Scotland, worsening social conditions fuelled by urbanisation meant that society could no longer rely on local initiatives to tackle issues. Urbanisation in Scotland increased steadily between the 1830s and early twentieth century. In this period, the

percentage of people living in settlements of over 5,000 in Scotland had nearly doubled from 31.2 to 58.6 %. In 1851, one in five of Scottish people lived in the main cities of Glasgow, Edinburgh, Dundee and Aberdeen. By 1911, this had risen to one in three. In turn, this generated problems of overcrowding, sanitation problems and disease.

The Board of Supervision had some powers in the combat of public health problems. The Board of Supervision (which controlled the Poor Law in Scotland) was given sanitary and health functions in 1856. As their Poor Law record highlights, the Board of Supervision did not enjoy or want extensive authority over localities and was understaffed with only three public health inspectors (who possessed no experience in sanitary matters). In terms of legal powers, the Nuisance Act of 1856 gave the Board of Supervision the right to enforce sanitary measures in times of emergency.

The Public Health (Scotland) Act was eventually passed in 1867, 12 year later than the English counterpart. This act provided a consolidation of previous legislation relating to nuisances, sewers, water supplies, common lodging houses and the prevention of disease. Although the Act gave Scottish towns the power to levy a general rate for public health purposes, this was limited to burghs with a population over 10,000.

The Act also gave increased powers to the Medical Officers of Health. Crowther argues that these men provided the impetus for reform by leading the battle for cleanliness, drainage, parks and housing.<sup>19</sup> Men such as Littlejohn in Edinburgh, Gairdner and Russell in Glasgow and McVail in Stirling devoted much time to the collection of health and social statistics as well as making recommendations for health improvements.

Improvements in public health at a local level tended to use the local and national legislation available. Under the 1866 City of Glasgow Improvements Act, 88 acres of central Glasgow were cleared or remodelled. Under this Act, powers were extended to ticket overcrowded tenements. This process was spread to Edinburgh and Glasgow through local acts. Between 1875 and 1899, Scottish authorities borrowed over £2 million for sanitary improvements.

The institutional nature of the asylum that accommodated hundreds of people meant that the cross over of infectious disease from society to the asylum was inevitable. The impact of tuberculosis in the asylum led to public health measures in asylums that were in line with nineteenth century disease prevention. For example, the construction of infectious disease wards and sanatoria at asylums for the isolation of patients with tuberculosis is discussed in chapter six.

By the late nineteenth century there was awareness that increased central government intervention was necessary. The social and health problems of the urban areas such as Glasgow were of particular concern. Additionally, the physical capabilities of the working classes were highlighted by the poor physical conditions of Boer war army recruits. The future health of the nation was a priority in the bulk of infant and education related legislation. The provision of free school meals in 1906 and school medical inspection from 1907 resulted from the findings of a 1904 Interdepartmental Committee on Physical Deterioration.

Concerns over the state of the nation's health also tied in with contemporary fears surrounding the apparent rise of mental illness and 'mental deficiency' in society. Concepts of degeneration linked mental illness to environment, and suggested that



conditions such as alcoholism were passed down by and worsened throughout generations. This link between mental illness and environment fuelled the push for temperance and public health reform. Eugenists also picked up on concepts of degeneration to support their push for interventions such as the sterilisation of people with learning disabilities. Degeneration was propagated in the late nineteenth century to segregate people with learning disabilities away from society.

Governments also responded to political motivation and industrial unrest, which were fuelled by urbanisation and poverty. The Scottish Labour Party was founded in 1888 and in 1894 merged with the Independent Labour Party. For most workers involved, socialism was less an ideological stance than a simple will to use any means possible to combat poverty.<sup>20</sup> Although as a whole trade unionism membership in Scotland remained relatively low in the 1890s, this did not prevent official concerns about levels of industrial militancy. Worker unrest also spread to hospital and asylums and chapter eight documents the growing discontent with attendants' and nurses' working conditions in the early twentieth century.

### Prison Regimes

Similar to the asylum system, the British prison system was expanded throughout the nineteenth century. The Penitentiary Act of 1779 was followed by the General Prison Act of 1791 and Peel's Prison Act 1823. Traditionally, transportation or hanging was used as a form of punishment for serious offences whereas local gaols and houses of correction were utilised for minor offences (i.e. begging or vagrancy). These acts favoured the increased reliance on penal servitude as punishment. In the late eighteenth century transportation was made difficult by the American War of Independence. In 1853, transportation to Australia was suspended after protest from



the Australian government. In 1877, the whole prison system was put under Home Office control.

Coupled with the changing views on punishment were reform campaigners such as John Howard and Jonas Hanaway. Howard favoured improved conditions in prisons and Hanaway championed solitary confinement. In the nineteenth century, model prisons emerged practising solitary confinement and penal servitude. Famous examples are the models of 'Millbank (1816) and Pentonville (1842). Pentonville was the epitome of the reformer's dreams in its systematised use of solitary confinement. Pentonville was an 'ideal' regime of solitude, hard labour and religious indoctrination and was the model for other national penal servitude prisons and country prisons. Although initially intended as a place of reform before transportation, its use shifted to a long-term solution in the nineteenth century.

The 'model' prison experience was subjected a series of stages. Firstly, solitary confinement was intended to reconcile the prisoner with their crime and encourage repentance. Ignatieff suggests that solitary confinement epitomised the liberal utopia of a punishment 'so rational that offenders would punish themselves in the silent anguish of their own minds'.<sup>21</sup> The only reading material allowed to those in confinement was religious and confinement could last up to nine months. Prison visitors came to preach religious fervour and help the convict repent. Work such as mat making or sewing was also provided as it could be conducted in confinement.

Following confinement, prisoners were subjected to hard labour, such as the treadmill for men or sewing and mat making for females. Early moral philosophy intended prison labour to be reformatory, in that it could teach the inmates new trades.

However, hard labour came only to be used as punishment and characterised by images such as the treadmill, breaking rocks or picking oakum.<sup>22</sup> Dietary was made as unappealing as possible and was deliberately meagre. As Morris and Rothman suggest, the effects of starving people who were already hungry (and may have often come from the streets) were both cruel and destructive.<sup>23</sup>

The final stage of the penitentiary was the 'ticket of leave' (later probation). The ticket of leave was first used in Australia in order to ease public expenditure on the flood of new transported convicts. Instead of bond labour, convicts could make their own living although they could be recalled to bond labour for any misdemeanours. The ticket was not initially given on the basis of good behaviour but according to the convict's chance of self-sufficiency.<sup>24</sup>

In Britain, the ticket of leave was the final process of the prisoner's penal servitude. After imprisonment, the convict was released on a 'ticket of leave' and was required to report to the police at regular intervals, maintain a steady job and avoid association with other offenders. Tickets were revoked for failing to report to the police or for association with undesirables. Further means of controlling ticketed prisoners was introduced in the late nineteenth century. Photography of inmates was introduced in the 1860s and fingerprinting from the 1890s.<sup>25</sup>

Traditionally, the history of the prison has been written as one of reform, which was fuelled by non-conformist philanthropists such as John Howard in the eighteenth century. In the past decades, Revisionists such as Rothman, Foucault and Ignatieff attacked the humanitarian reform of the prison, arguing that prisons practised psychological control, and were elements of social control and order for the propertied

and powerful classes. Rothman argues that rather than their philanthropic motives being humanitarian, reformers aimed to re-establish a sense of discipline.<sup>26</sup> Similarly, Foucault argued that physical punishment was replaced with confinement that attacked the soul and mind.<sup>27</sup>

Revisionists are criticised for their generalisation. Certainly it is important to bear in mind that what so often was 'model' or central policy, did not stretch down to local practice. For example, Royle suggests that the ideals of many 'model' prisons such as Pentonville were not necessarily practiced in the local gaols and that historical reality is more complex than Revisionists assumed.<sup>28</sup> It is also likely that even the 'model' prisons varied in their practice. The earlier historiographical review discusses Revisionist arguments and the concept of the 'total institution' in relation to the Scottish asylum.

### Scottish Medicine in Context

#### *Medical Profession*

In pre-industrial British society, the medical 'profession' was divided into three strands: physicians, surgeons and apothecaries. In this period emerged a new group of general practitioners, who were fuelled by economic and educational opportunities of the Enlightenment. This group of doctors typically received training by combining apprenticeships with classes attended at Edinburgh University, extramural classes or private London schools.<sup>29</sup> The period of the Napoleonic Wars provided opportunities for such practitioners in the army or navy. However, the economic depression that followed 1815 led to fierce competition for work. While the elite profession treated the rich patients, the rank and file competed with alternative practitioners and druggists

for the middle class. This new group of doctors aimed to develop a closed profession and pressed for this by lobbying parliament and forming medical societies.

Traditionally, there was more cohesion in Scotland's medical 'profession' than in England. Whereas the three orders of physicians, surgeons and apothecaries were stratified in England, Scotland could boast of some interaction. In Glasgow, physicians and surgeons belonged to the same medical faculty in Glasgow from the late 16<sup>th</sup> century. In Edinburgh, the 1650s achieved fusion of apothecaries and surgeons. Jacqueline Jenkinson argues that due to this increased unity, a more cohesive medical profession emerged earlier in Scotland than the rest of Britain.<sup>30</sup>

Divisions were not so clear cut as the split between the elite and this new medical profession who demanded a meritocratic system. Within this new group, doctors were unsure as to the best means of achieve professional recognition.<sup>31</sup> The different types of medical practice among doctors were diverse and the nineteenth century witnessed new drug therapy and medical electricity that not all doctors supported. There were agreements that bonded most doctors. The vast majority shared the view that orthodox medicine should be the legitimate healer and that this required a qualification and hospital experience.

The first major stepping stone towards regulation of medicine in Britain was the Apothecaries Act of 1815. The Act was the outcome of agitation by provincial general practitioners in England who were unprotected by any medical body and believed that their livelihoods were threatened by untrained 'druggists' or 'quacks'.<sup>32</sup> Although the Apothecaries Act did not cover Scotland, the regulations of the Act held significant implications for Scottish medicine. Many MDs or surgeon apothecaries who trained in



Scotland went to England in order to practise. However, Scottish qualifications were not recognised by the English Apothecary Act. Opposition by the London College of Surgeons to Scottish qualifications was based on the premise that training in Scotland was too short and sporadic.<sup>33</sup> Hamilton argues that this disregard for Scottish qualifications fuelled the desire for medical reform.<sup>34</sup>

The Medical Act (1858) set up a General Council of Medical Education and registration and applied to England, Wales, Ireland and Scotland. The Act established a register of all approved practitioners who would be eligible for public employment. Branch councils of the General Council were set up in Ireland and Scotland. Helen Dingwall questions if the GMC and British wide registration went some way towards ending the focus of Scottish medicine as a separate sphere.<sup>35</sup>

Pressure for the 1858 Act came from the medical profession and the government. By mid nineteenth century, the medical profession was dominated by general practitioners who possessed a degree from Edinburgh, Glasgow or London. However, the Apothecaries Act did not provide general practitioners with their own governing body.<sup>36</sup> General practitioners therefore wanted recognition that separated them from unqualified healers. Increasingly, medical men were also working in public arenas as factory and medical inspectors, prison doctors, medical officers of health, Poor Law medical officers and asylum doctors. With legislation and increased state intervention in the nineteenth century fields of lunacy, education and prisons, the authorities required a benchmark of 'qualification' for their employees.



### *Hospital growth*

Many Scottish towns built their own infirmaries in the Georgian period. By the early nineteenth century, Scotland could boast of voluntary hospitals constructed in Edinburgh, Aberdeen, Glasgow, Dumfries, Paisley, Inverness, Perth and Montrose. Porter argues that enlightened philanthropy was influential in construction as a means of promoting the gratitude of the poor to their benefactors.<sup>37</sup> Further impetus for hospital construction was linked to developments in medical education, which saw doctors training in hospital wards. Porter argues that because patients were receiving treatment for free, they could hardly complain when they were displayed to students on standard ward rounds.<sup>38</sup>

Hospitals only slowly medicalised before the nineteenth century. This should be remembered when considering the asylum's attempt to hospitalise. More often than not, lay persons or religious orders that provided the finance controlled hospitals. Porter argues that only with developments in new medical approaches and research from the 1800s could the hospital become truly medicalised.<sup>39</sup> The link between infirmaries and the city's medical schools (such as Edinburgh) assisted in transforming the hospital into a medically dominated institution.

Both Crowther and Walsh suggest that the foundation of institutions such as infirmaries was a symbol of the town's civic pride.<sup>40</sup> The voluntary hospitals catered for poor (but not pauper) patients and were funded by public subscription. Medical posts within the voluntary infirmaries were eagerly sought after and eminent doctors worked in these institutions for no fee. Such employment was done more for personal gain than charitable impulse as the posts brought doctors in contact with hospital managers

(and therefore lucrative private paying patients). The voluntary hospitals operated on a strict admissions policy in order to retain their status. Terminally and chronically ill patients were not admitted and paupers were left for the poor relief system. Not all cases were deemed appropriate for admission, such as pregnant women or those with venereal or infectious disease.

After the 1845 Poor Law Amendment Act, hospital care in Scotland was stratified between the traditional voluntary hospitals and the Poor Law system. The Poor Law hospitals and sick wards of poorhouses were left to deal with the majority of poor, infectious, chronically and terminally ill patients. This had obvious implications for these institutions' status, and parochial jobs did not offer the same level of status as the voluntary hospitals. Posts in the Poor Law infirmaries generally attracted the newly qualified doctors.<sup>41</sup>

Although standards and provisions varied between parishes, Poor Law hospitals and wards shared similar characteristics. Rona Gaffney argues that the strict economy of Poor Law managers had a negative impact on parochial medical care.<sup>42</sup> As such, Poor Law hospitals trailed behind the voluntary system in the introduction of new medical techniques such as antiseptic practice or even rudimentary basics like the provision of separate operating rooms. Scotland contrasted with England where the large workhouse infirmaries had typically been turned into modern hospitals by the late nineteenth century. By the 1900s, Scotland witnessed the construction of new infirmaries, such as Stobhill and the Western and Victoria Infirmaries in Glasgow. However, these new hospitals were in urban areas and provisions continued to vary according to locality.

Alongside the main developments in hospital care was the evolution of specialist hospitals. Granshaw argues that specialist hospitals emerged due to the new theory and practice of medicine that emerged from Paris in the early nineteenth century. This thinking shifted the focus away from the body as a whole to emphasis on particular organs as the seats of disease.<sup>43</sup> The template for other specialist hospitals was John Cunningham Saunders' 'London Dispensary for the Relief of the Poor Afflicted with Ear and Eye Diseases'. In Glasgow William Mackenzie established the Eye Infirmary in 1824. In Edinburgh, the Ear, Eye and Throat Infirmary opened in 1830. Another popular specialist institution was the lying in or maternity hospital that appeared in major towns and cities.

Specialist hospitals were a means for doctors to medicalise hospitals by removing them from lay control. As Porter argues, specialist hospitals became 'medicalised' earlier than general hospitals with doctors controlling admissions, appointments and hospital policy.<sup>44</sup> Lawrence argues that specialist hospitals were also founded in order to promote a doctor's advancement.<sup>45</sup> In this context, the presence of specialised hospitals exposed further conflict within the medical profession. The medical profession's elite felt threatened because the specialist hospitals took away interesting cases from the Infirmary's medical teaching rounds. General practitioners were disgruntled because the specialist hospitals removed potential clients.<sup>46</sup>

Attempts to hospitalise the asylum should be understood in relation to these earlier efforts to medicalise the hospital. There is no direct link between the evolution of specialist hospitals and the process of establishing hospitals in asylums. More analogy can be made between specialist hospitals and the growth of a psychiatric profession and asylums in the eighteenth century. However, comparison can be seen between

specialist hospitals and hospitalisation in that doctors used an association with a specialist hospital as a source of professional leverage.<sup>47</sup> Asylum doctors also sought to enhance their professional standing and propagate an image of medical modernity by linking the asylum with general medicine.

### *Surgery*

A characteristic shared by any hospital in this period whether voluntary or Poor Law funded was the threat of disease and inability in combating high mortality rates. 'Hospitalism' was the collective term for blood poisoning, skin infection and gangrene, all of which occurred when surgical wounds turned septic.<sup>48</sup> Concerns voiced regarding the cleanliness of hospitals and threat of disease had been raised from the eighteenth century. Since the 1750s, ventilation and cleanliness were advocated to combat disease and in Edinburgh's infirmary, a high priority was proper air circulation.<sup>49</sup> Such thinking arose from the general acceptance of the environmental miasma where the root of infection was thought to be miasma discharged by the earth and other non-human sources.

As is well documented, advances in surgery were made through anaesthetics and antiseptics in the nineteenth century. Certainly, anesthetics had an ancient tradition and opium, hashish and alcohol were all used to lessen the sensations (or inebriate patients during) basic surgery. The Bristol physician Thomas Beddoes is the first documented anaesthetic attempt with nitrous oxide. The breakthrough came with William E Clarke in Rochester, New York. In 1842, Clarke extracted a tooth using ether. Ether was first used in London in 1846 by the surgeon Robert Liston who amputated the thigh of a patient. In Edinburgh, James Yong Simpson's use of chloroform in 1847 led to chloroform becoming widely used to ease child labour.



The process of anaesthetics generated more adventurous and exploratory surgery. Yet putting patients to sleep did nothing to prevent the risks of surgical disease and mortality. By far the most documented practitioner of antiseptic procedures is Joseph Lister.<sup>50</sup> Lister's first trial of antiseptic surgery was on the 11-year-old James Greenlees in 1865 at Glasgow Royal Infirmary.

The emergence of Lister's antiseptic illustrates the conflicts and hostilities underpinning medicine at the time. One criticism of Lister arose from the old tradition of 'laudable pus', whereby infection was regarded to be a necessary process in healing. However, as Lister argued that infection was an abnormal process, this meant that the success of antiseptics rested on the total acceptance of the germ theory. Lister created conflict by not publishing statistics of surgical mortality or providing substantial publications of his work. Doctors also argued that the success of surgery was due to more widespread improvements in sanitary measures, diet, nursing and architectural reforms.<sup>51</sup>

The advent of antiseptic surgery and anaesthetics gave surgeons the confidence to operate in new anatomical areas. The late nineteenth century saw abdominal surgery, cancer (particularly mastectomies), appendectomies, the removal of gallstones and the removal of tonsils become routine. Developments were also made in surgical procedures for tuberculosis. A never before explored surgical field was brain surgery, especially in the treatment of epilepsy. John Rickman Godlee (Lister's nephew) was a pioneer in this area. Although the profile of surgery increased throughout the late nineteenth century, surgical procedures remained highly experimental and subject to high levels of patient mortality. Likewise procedures such as brain surgery were far



removed from Scotland's Poor Law infirmaries (and voluntary hospitals) where staff were only starting to come to terms with the necessity of a separate operating theatre by the late nineteenth century.

### *Scientific Developments*

The nineteenth century is regarded as crucial period for medico-scientific advance. In this era, European governments and universities funded science and it became an important strand of medical teaching. Although the British medical profession lacked systematic funding for research, a research culture based on scientific medicine had been established by the late nineteenth century in Britain. Moreover, inventions were made in diagnostic tools and laboratory based medicine. However, the medical profession was widely disjointed. Whereas some doctors favoured scientific advance in clinical practice, there was also hostility. Lawrence argues that many British doctors used science-based vocabulary and research in order to bolster their own profession, but in reality ascribed science only a minor role in clinical practice.<sup>52</sup>

Germany was at the forefront of laboratory medicine and research. Laboratory medicine did date back the seventeenth century, but the nineteenth century witnessed a distinct scientific medicine based on microscopy, vivisection, and chemical investigations within a laboratory environment.<sup>53</sup> A crucial aid to laboratory medicine was the development of the microscope. Although early beginnings in microscopy had been made in the seventeenth century, the microscope was improved from the 1830s. This led to obvious progress in the study of histology and cytology. Further inventions included the fixing of cell tissues in 1870, colour staining in 1880 and formaldehyde in 1890s. Possibly the most dramatic and intrusive tool invented for anatomical exploration in the late nineteenth century was the x-ray. The principle of X rays were

invented by Karl Wilhelm Rontgen in 1895 and soon after, its diagnostic potential was in use.

Technical advances ran parallel with individual achievements in laboratory experimentation. To name a few, Virchow in Germany argued that all cells came from cells and projected an internal concept of disease. Virchow is known for his research into cancer and his theory that cancer arose from abnormal changes within cells that multiplied out of control. Pasteur was first to show that particular microbes caused disease and his research into disease led to new vaccines such as the anthrax vaccine. Koch gave microbial theory of disease theoretical solidarity with his Koch postulates. Koch's discoveries included the tuberculosis bacillae and cholera bacillae.

Historians commonly suggest that Great Britain lagged behind Europe in laboratory medicine. One reason for Britain's trailing research record was the lack of state funding for research in Britain enjoyed by French and German universities. This does not mean that Britain did not engage in research in its medical community. Chapter seven outlines how a research culture had emerged by the late nineteenth century. This was through the growth of journals, medical societies and the inclusion of increasingly science based subjects in the medical school curricula.

A barrier to physiological research was the antivivisection lobby in late nineteenth century Britain. Bynum argues that it was in Britain where the anti vivisection campaign was most vocal and powerful.<sup>54</sup> Physiology and animal physiology was fast becoming part of the curriculum in the nineteenth century. A textbook published by London University in the 1870s gave detailed accounts of animal physiology conducted in its medical school. Public opposition to such practice led to demonstrations and the

establishment of a Royal Commission in 1875 to investigate vivisection. The commission's report resulted in the 1876 Cruelty to Animals Act. This permitted qualified medics to conduct vivisection experiments only under license and in strictly stipulated conditions.

France is widely regarded as the starting point for clinical practice. Pierre Louis and his text *Essay on Clinical Instruction* (1834) held that symptoms were second in clinical value to signs of disease. This thinking had a major impact in the identification of disease, making prognoses and if possible, devising cures. This new clinical medicine was also closely linked to practical inventions for assessing bodily functions. The key diagnostic invention of the nineteenth century was the stethoscope, invented by Rene Laennec in 1816.

The nineteenth century witnessed a number of other inventions to aid diagnosis. The kymograph (designed to measure body alterations) appeared in 1846. The spirometer also appeared in this year and was designed to measure the quantity of air breathed. Attempts to measure the pulse resulted in the sphygmomanometer in 1835, which displayed the pulse beat. This was refined in the 1860s by Etienne-Jules Marey as a sphygmograph, used to monitor the pulse. A diagnostic aid to measuring blood pressure was designed in the 1890s by Scipione Riva Rocci and led to blood pressure becoming an acceptable practice by the early twentieth century. Although the invention of the thermometer dated back to Gabriel Daniel Fahrenheit in the seventeenth century, it was refined in the mid nineteenth century by Carl Wunderlich.

This new scientific approach to clinical medicine had an impact on the practice of clinical and laboratory medicine. Hardy argues that the intrusion of science on clinical

practice widened the knowledge gap between the medical profession and the public.<sup>55</sup> Alternatively, Lawrence points out the attitude of the doctor to technology was also dominated by their private patients, who retained control over what they might permit the doctor to do.<sup>56</sup>

Medicine also encompassed a high number of traditionalists who were disinterested in changing old practices. However, the new scientific approach of clinical medicine did broaden university teaching and from the mid-late nineteenth century, histology, clinical physiology, chemistry and bacteriology as well as instruction in scientific instruments became an important part of the curriculum. In this context, the new generation trained in diagnostic aids was keen to put these techniques into practice.

### *Drug Therapies*

While scientific and technological developments helped advance in physiology, they possessed little therapeutic impact. Pharmaceutical advance was one area that combined scientific advance with therapeutic value. The use of drugs in medicine such as cannabis and alcohol was age old. Again, France and Germany led the way in this field. Porter suggests that although drug therapy made slow progress, the study of materia medica transformed into laboratory based pharmacy.<sup>57</sup> Advances were made at Edinburgh University, which had a history of courses in materia medica.<sup>58</sup> In this period, common plant drugs were subjected to chemical analysis and produced drugs such as codeine, nicotine, caffeine, morphine and cocaine.

The nineteenth century also saw a rise in the use of drugs in asylums, although the use of drugs for mental illness was age old. An ancient theory was that purges helped relieve mental illness. Laxatives were still in vogue in the nineteenth century and



croton oil (a substance causing diarrhoea) was still in use in the late nineteenth century. Croton oil was used for the patient E.B in the 1880s (see Case B, Appendix three). Opium had been popular for centuries and was a constant theme throughout the nineteenth. The case notes for W.Y. highlight that the doctor used opium to relieve W.Y.'s symptoms of mania in the 1850s (see case A, Appendix three). Later in the century, opium was combined with lead as a cure for diarrhoea, again referred to in E.B.'s notes (Case B, Appendix three).

Drug therapy emerged as a method of temporary symptom relief in the nineteenth century. The invention of the hypodermic needle led to drug use (and abuse) in and out of the asylum. One form of drug used in asylums was alkaloid-derived drugs such as morphine (which had been isolated from opium in 1806). Another popular alkaloid was hyoscyamus, used primarily as a sedative. Chloral became immensely popular for the relief of common psychiatric symptoms and was favoured by middle class women as a 'home remedy'.<sup>59</sup> Bromine gained immense popularity in asylums and like other sedatives was highly addictive. E. B. was an alcoholic who also craved drugs such as chloral, bromine and chloral. In March 1885 it was noted that 'she purloined some lead and opium pills which another patient was taking for diarrhoea, knowing them to contain morphia' (Case B, Appendix three).

Other nineteenth century asylum drugs included paraldehyde, strychnine and sulfonal. All were sedatives although strychnine (a highly poisonous alkaloid) was used only in very extreme cases. Sulfonal appeared in 1888 and was used as a sleeping draught. The drug was deemed to have little effect on E.M., admitted to Gartloch in 1901 (see Case E, Appendix three). J.K. admitted to Woodilee Asylum in 1898 was given a draught of paraldehyde to induce sleep and was also administered a 'hypodermic

injection of Lij Strych[nine]' (see Case D, Appendix three). In a recent published book on psychiatry at Bedlam, the authors emphasise that although Bethlem Hospital casenotes gave little information about chemical treatments applied to individual patients, this did not mean that they were never employed.<sup>60</sup> Psychiatry never pretended that drugs offered anything more than a short-term cure.

It was not until the twentieth century that pharmaceutical means became fully systematised and developed as aids to cure. One early twentieth century example was the treatment of general paralysis of the 'insane' (or later neurosyphilis). If the disease affected the brain, psychiatric symptoms came first, followed by dementia and paralysis. Traditional methods of treating syphilis included the painful treatment of mercury. H.A., admitted to the CRI in 1911 had undergone a 'long course of mercury' for syphilis while working as a doctor in India (see Case H, Appendix three). In 1910, Paul Ehrlich announced that the compound "Salvaran" blocked the development of primary and secondary syphilis. However, to be successful the treatment had to be administered at an early stage (before the onset of symptoms). By the time patients were admitted to an asylum, the symptoms were typically advanced and treatment was too late.

### Medical Regimes and Therapies in Asylums Prior to Hospitalisation

#### *Eighteenth century Perceptions and Therapies*

Historians such as Roy Porter and R A Houston have respectively provided excellent histories of madness in eighteenth century England and Scotland.<sup>61</sup> Although it is unnecessary to reiterate eighteenth century perceptions and treatment of madness at length here, a brief synopsis is provided. In the eighteenth century, madness was seen as a result of divine intervention or demonic possession. Similar to general medicine,

those who could afford to pay would seek treatment for madness from physicians who treated madness as a sideline to regular medicine. For the vast majority, most people would have sought assistance from non-medical quarters, including healers, wise women, witches, 'quacks' or even clergymen.<sup>62</sup> Methods of traditional treatment include herbal remedies, purges, bloodletting and folk wisdom.

In line with developments in general medicine and science, medicine began to make an impact on mental illness through the eighteenth century. Rice argues that in light of the general support for science at the time, doctors were in a stronger situation to propose that madness was more of a bodily malfunction rather than a demonic defect.<sup>63</sup> As such, doctors were also in a good position to impose their authority on the treatment and 'cure' of madness. Whereas traditionally, doctors dealt with mental illness as a sideline, the eighteenth century saw the emergence of private madhouses run by doctors specialising in the treatment of the mad. This new 'trade in lunacy' was the first major step towards institutionalisation of the mentally ill.

New modes of treatment ran parallel with this new group of emerging mad-doctors. A number of new 'medical and scientific' treatments were attempted in the eighteenth century. As the last section highlighted, drugs had long been utilised in both general medicine and as a treatment for mental illness. Medical electricity also came into vogue as another popular method of treatment. Despite this new wave of medical influence, mad doctors remained reliant on a number of traditional treatments such as bloodletting, blistering and purges.

*Moral Management and Moral Therapy*

Rice argues it is ironic that in an age where medicine and science was fast emerging, moral not medical methods became the most popular and documented method of treating the mentally ill.<sup>64</sup> Moral management in the eighteenth century was practised by individual doctors and involved concentrated interaction between the doctor and his patient. Although physical punishment was only utilised as a final resort, any other means such as work, rest and exercise were adopted in order to promote discipline and sanity. William Battie's *Treatise on Madness* (1758) was the standard textbook for this moral doctrine and he promoted the use of humane management to regulate sanity.<sup>65</sup>

Porter suggests that this early moral management was systematised into institutional moral therapy.<sup>66</sup> Moral therapy meant the practice of psychological methods to treat mental illness in a regulated institutional environment. In England, the most stereotypical image of moral therapy is the York Retreat. The Quaker William Tuke opened the York Retreat in 1796. It was modelled on the idea of domestic life and encouraged self-control (and recovery) through a system of rewards and punishment coupled with pastimes and pleasant activities.<sup>67</sup> Although medical therapies had been attempted in the Retreat's early years, the Tukes believed moral rather than medical means had a far better effect on recovery.<sup>68</sup> Traditionally, the Retreat's therapy was regarded by Whig historians to be the essence of kindness and humanity.<sup>69</sup> However, in a more recent assessment of the Retreat, Digby argues that its therapy was both repressive and rehabilitative.<sup>70</sup>

The nature of moral therapy is hotly debated by historians and is discussed in the historiographical section. Whig historians regarded moral treatment as a humane enlightenment in the treatment of the mentally ill. Another publicised Whig hero in



moral therapy was Phillippe Pinel, who pioneered moral therapy in revolutionary France and apparently struck the chains off mentally ill patients in the Salpêtrière and Bicêtre asylums in Paris. The link of moral treatment with kindness and enlightenment has generated criticism from Revisionists such as Michel Foucault and Andrew Scull. In particular, Foucault argues that moral treatment was akin to a gigantic moral imprisonment and went hand in hand with the incarceration of society's other 'undesirables' (such as the poor and criminals) in a mass institutional roundup.<sup>71</sup> These theories were discussed in the review of literature. What is relevant to the thesis at this point is not the reasoning behind moral therapy but the actual process of change. As Porter highlights whatever the thinking behind moral therapy, it does not detract from the fact that the introduction of moral therapy at institutions such as the Retreat marked a radically new technique of management in the new asylums.<sup>72</sup>

### *Scottish Developments*

What was taking place in Scotland at the time? Before the Lunacy Act of 1857 there was no legal requirement to construct asylums in Scotland. In discussion of the Scottish Poor Law, Lorraine Walsh suggests that this official reluctance to build asylums was part and parcel of the Scottish unwillingness to accept institutional solutions for society's 'problem' groups.<sup>73</sup> Certainly, care of lunatics in Scotland often meant the boarding out of harmless and incurable patients with family members or non related guardians in the community. Yet from the late eighteenth century, institutional accommodation for the mentally ill was utilised in Scotland and featured as an important means of housing Scotland's mentally ill. By the 1857 Act, which provided compulsory construction of asylums, Scotland's mentally ill were accommodated in poorhouse lunacy wards, private madhouses and Royal Asylums (see table 1).

Table 1: Accommodation of Mental Illness in Scotland (1858)

	Private	%	Pauper	%	Total	%
In public institutions (Royal Asylums)	786	77.7	1594	33.7	2380	41.4
In private institutions	219	21.7	526	11	745	13
In poorhouses	6	0.6	833	17.6	839	14.6
In private houses	..	..	1784	37.7	1784	31
Total	1011	100	4737	100	5748	100

Source: 56<sup>th</sup> Report of the General Board of Lunacy for Scotland (1913), GD17/5/24.

By 1857, there were 26 private madhouses in Edinburgh, Glasgow and the surrounding areas. After the Poor Law Amendment Act, 17 lunacy wards had been established in these institutions. Finally, 8 asylums with philanthropic origin had been established in Scotland by 1857.

As table 1 shows, 41% of pauper and private patients were housed in the seven public asylums of Montrose, Aberdeen, Edinburgh, Glasgow, Dundee, Perth, Elgin and Dumfries in 1858. (Although founded in the 1830s, Elgin was not a Royal Asylum but had philanthropic origins). As these institutions consolidated the largest number of patients in one setting, it is natural that any focus upon institutional treatments considers the regimes of the Royals. Walsh argues that while English asylums were dominated by medical men in the early nineteenth century, the charitable roots of the Scottish Royal Asylums, coupled with the lack of lunacy legislation in Scotland meant that the asylum system remained dominated by lay thinking for longer.<sup>74</sup> Both Smith and Swann suggest that the histories of the Scottish Royals highlight the conflict between socio-psychological (moral) and physical treatments (medical) in institutions.<sup>75</sup>

The Royal Asylums appeared to adhere to popular moral treatment and management. This should hardly be regarded as surprising. In 1858, nearly 80% of Scotland's registered private patients were accommodated in the Royal institutions. If these

institutions and their directors were to attract the fees of this clientele, then it was necessary for the superintendent in charge to adhere to the popular treatments of the time. In the case of the Crichton Royal institution in Dumfries, its director, Lady Crichton performed a coup for her new institution by inviting WAF Browne (Scotland's then most famous propagandist of moral treatment) to take up the post of medical superintendent. Browne accepted, and the CRI was able to generate a 'client' base from the whole of Britain and overseas.

Moral treatment was an important method of treatment at Glasgow Royal Asylum (opened in 1814). Patients were strictly classified according to class and sex and were encouraged to entertain their minds in work, entertainment and religion. Occupations listed at the asylum included tailoring, bookbinding, joinery, sewing and joinery. The institution also worked on a system of 'rewards and punishment', which was an intrinsic working of moral management's practice. Disruptive behaviour was threatened with the removal of privileges and well-behaved patients were encouraged to 'look after' the more disruptive.<sup>76</sup>

Despite this strong propagation of moral treatment, case notes suggest that traditional treatments persisted and doctors also utilised 'medical' methods routinely. Rice, Swann and Smith demonstrate that Gartnavel Royal consistently used physical and medical treatments throughout the institution's history. Rice highlights that this resulted from the development of a more somatic approach to insanity advocated by figureheads such as David Skae, Medical Superintendent of the Edinburgh Royal Asylum 1846-1873. In particular, somatic approaches emphasised the distinction between the different stages of insanity and the necessity of prescribing treatment for each stage.

Whereas medical means were most suitable early on, moral treatment was utilised in the remainder of the case.

Aside from these new modern medical methods, it is clear that doctors found it difficult to give up the traditional 'medical' recourses of the eighteenth century. At Gartnavel there was evidence of bloodletting, blistering, purges and evacuants well into the nineteenth century as well as the use of leeches and poultices. The nineteenth century also saw a rise in the use of narcotics such as opium, cannabis indica and alcohol.<sup>77</sup> Perhaps most contradictory from moral treatment was the persistent use of mechanical treatment and restraint. As well as more traditional methods (i.e. the camisole or straitjacket), the rotating or whirling chair was introduced in the early nineteenth century. Certainly effective as a deterrent, Swann and Smith suggest that any improvement in behaviour was probably due to the chair's power of intimidation.<sup>78</sup>

Although the 'Royals' were dominated by the directors' and managers' desire to attract a clientele of paying patients, the lack of statutory power over these institutions also meant that medical superintendents could impose their ideals upon their asylum and its patients. William Alexander Francis Browne is possibly one of the most widely known asylum doctors of the pre 1857 era in Scotland. His influential text *What Asylums Were, Are And Ought to Be* (1837) was not only important as a piece of propaganda for asylum doctors but was also a blueprint of how an 'ideal' asylum should be run in the age of moral treatment.

#### *WAF Browne and Moral Therapy*

Browne studied at Edinburgh University and was influenced by continental medicine, having visited hospitals and asylums in Italy, Belgium and France. Such a period of



study on the continent was not uncommon for medical students of this period. After concluding study and travels, Browne's first appointment was as medical superintendent of Montrose Royal asylum in 1834. It was here that Browne first implemented his system of moral treatment and in 1836 presented a course of public lectures, which embodied the text of *What Asylums Were...*. As highlighted earlier, the notoriety of his text led to his appointment as medical superintendent of the Crichton Royal, Dumfries in 1839. Browne remained as medical superintendent there until 1857. Thereafter, he was appointed as the first Commissioner in Lunacy for Scotland.

Browne's 1836 work described the horrors of the traditional asylum system by using two well-publicised Commission reports into British lunacy provisions held in 1807 and 1815-6. Although focusing primarily upon English provisions, the reports heavily criticised conditions in the whole of Britain. The reports proposed the creation of a system of public asylums that would be rigorously inspected. Scull points out that this was a blow to medical men who were simultaneously trying to maintain a monopoly on asylum provisions and did not want control to pass to magistrates.<sup>79</sup> Browne's text was therefore an effective piece of propaganda for doctors. As well as admitting the horrors of the system, Browne also proposed a realistic and popular solution that could be effected by medical men for reform.

The ideology of Browne's text suggested that asylum care was a moral system whereby the mind was strengthened and reason restored. The restoration of reason was achieved in a number of ways. The asylum and its surrounds should be made as pleasant as possible and within the asylum, the classification of gender, class, disease and behaviour was of utmost importance.

Classification may proceed on various principles. There is first the very obvious ground for separation, the rates of board...the pauper could not appreciate, nor prize, nor derive benefit from the refinement and delicacies essential to the comfort, and instrumental in the recovery of the affluent...the second principle to be recognised is the stage of disease...the third principle ...is that these classes [of disease] should be subdivided according to the character of the malady and of the dispositions of each individual.<sup>80</sup>

The doctor in charge of the asylum must also be intellectual and of high moral calibre.<sup>81</sup>

Patients were also expected to participate in activities and were subjected to a system of rewards and punishment according to behaviour.

I may, with all reverence, compare the employment [of patients] to that of any other medicine. It must be regulated by the idiosyncrasies of the patients, by the symptoms, the duration and the complications of the disease.<sup>82</sup>

Either better diet and clothing are given, certain coveted luxuries are awarded to the industrious patient, to which as a pauper he has no right, and which his board, if in a higher class could not purchase.<sup>83</sup>

Andrew Scull questions how far Browne's ideology was practised in the CRI while Browne was superintendent.<sup>84</sup> Annual reports show that a variety of activities were utilised as treatment in a structured and organised regime. These ranged from leisure pursuits such as sport, dances and evening parties to trips into the local community, such as the races, walks and the theatre. The CRI newspaper *New Moon* was brought into being by Browne and was written and produced by patients. Occupations were also promoted and included gentle work and exercise, public readings and lectures. The extract of the CRI annual report is useful in outlining the various activities of the asylum (see extract 1 on the following page). It should be remembered however that

such a report would be utilised as propaganda to attract patients to the institution. W.Y., admitted to the CRI in 1852 under Browne, received opium as the first mode of treatment and was then prescribed work therapy in order to reduce his 'ambitious views' and delusions.<sup>85</sup> This patient did not enjoy any of the attractions and activities listed below.

Extract 1: CRI Annual Report (1840)

Amusements	No. of patients participating	Remarks
Backgammon	4	
Battledoor and Shuttlecock	6	A patient and Attenant performed the feat of keeping up the Shuttlecock 1300 times.
Billiards	3	
Cards	10	
Christmas and New Years-day dinner	all	
Concert and Theatre		
Dances	2	
Drafts	50	
Drawing	15	There are two players who could challenge the county.
Drives-ordinary	2	
Fancy work	31	
Grace, La,	9	
Music	2	
Picnics to Newabbey	4	One patient has driven 1465 miles.
Carlaverock	6	
Lochmaben	5	
Annan	1	
Iringray	1	
Quoits	8	
Races		
Regatta	9	
Skittles	1	
Singing school	7	
Visits to Camera		
Horticultural Exhibit	16	
Menagerie	2	
Walks	5	
Writing and school	30	
Reading	15	
	24	One patient has walked 405 miles.

*Source M. Williams, History of Crichton Royal Hospital 1839-1989, (Dumfries & Galloway Health Board, 1989), p.22.*

On the eve of lunacy reform in 1857, Scotland possessed a variety of settings in which to treat the mentally ill. Institutionally, the 'Royals' were by far the most utilised arena of treatment and admitted both private and pauper patients. The 'Royals' provided a

mix of medical and moral treatment and also resorted to eighteenth century remedies such as blood letting. The most influential treatment was moral based and advocated by medical heads such as Browne. For pauper patients, treatment meant boarding out in the community or incarceration in the 'Royals' and private madhouses (a system wide open to abuse). Although the 1845 Act provided a statutory right to care, it was not until the 1850s that a system of public asylums was enacted.

*Aftermath of the Lunacy (Scotland) Act (1857)*

In 1855 a Scottish Lunacy Commission was formed to inquire into provisions for this group in Scotland. There is a general consensus that the Commission was called through the intervention of the American social reformer Dorothea Dix. Dix, who visited Scotland in the 1850s, was appalled at the conditions for the mentally ill in Scotland.<sup>86</sup> The findings of the 1855-57 Commission paved the way for the 1857 Lunacy (Scotland) Act and the establishment of the General Board of Lunacy for Scotland.

Practical developments after 1857 are well documented by historians and it is unnecessary to regurgitate these events at length here.<sup>87</sup> The earlier section on the Poor Law explained how the control of provisions for the mentally ill was removed from the Board of Supervision and placed in the hands of the General Board. Jonathan Andrews provides a lucid account of the General Board and its Commissioners.<sup>88</sup> In brief, the establishment of the Board included an unpaid chairman, two paid Medical Commissioners and three other unpaid legal Commissioners. The powers of the Board included visitation of institutions housing the mentally ill and the regulation of all matters relating to such establishments.



The 1857 Act also required local authorities to construct asylums for the mentally ill. As already highlighted the formal institutional provision for Scotland's mentally ill was in the eight public asylums. By 1913, Scotland had its Royal Asylums but 20 District and Parochial Asylums (see table 2). In 1886, there were 1130 patients in district asylums. By 1912, this figure had risen to 10,350.

Table 2:  
District and Parochial Asylums opened by 1913

*Name (Year of Opening)*

Argyll and Bute District Asylum, Lochgilphead (1863)  
 Ayr District Asylum, Ayr (1869)  
 Banff District Asylum, Ladysbridge and Woodpark (1864)  
 Bangour Village Asylum, Edinburgh (1904)  
 Dundee District Asylum (1903)  
 Dykebar District Asylum, Renfrewshire (1909)  
 Elgin District Asylum (1834)  
 Fife and Kinross District Asylum, Cupar (1866)  
 Gartloch Asylum and Hospital, Glasgow (1896)  
 Glasgow District Asylum, Woodilee, Lenzie (1875)  
 Glasgow Kirklands Asylum (1881)  
 Govan District Asylum, Paisley (1873)  
 Greenock Parochial Asylum (1879)  
 Haddington District Asylum (1866)  
 Inverness District Asylum (1864)  
 Kingseat Village Asylum, (1906)  
 Lanark District Asylum, Hartwood, Shotts (1895)  
 Midlothian and Peebles District Asylum, Roslin Castle (1874)  
 Paisley Burgh Parochial Asylum Riccartonbar (1876)  
 Perth District Asylum, Murthly (1864)  
 Roxburgh, Berwick and Selkirk District Asylum, Melrose (1872)  
 Stirling District Asylum, Larbert (1869)

The construction of asylums is the most visible consequence of the 1857 Act. Although the institutions were not geographically well spread, a network of institutions coupled with improved transport facilities had evolved by the late nineteenth century.

*Features of the Scottish Asylum System*

The 1857 Act provided a springboard for the Commissioners to impose their ideas and aspirations on the new district asylum system. With the employment of figureheads such as Browne as Commissioners, it is unsurprising that moral means were initially

pushed as the way forward. As such, there emerged a number of distinct features in the Scottish lunacy system. Initially, these included patient employment on asylum farms, the removal of prison like features and the boarding out of patients. Later policies included the open door system and hospitalisation.

An important feature of the new district asylums was the use of occupation as therapy for patients. Emphasis was placed on the possession of asylum farmlands after 1857 although purse clutching district boards were often unwilling to foot the bill for additional farmlands. Commissioners advocated the necessity of land not just for economic means but also as a means of occupying the mind. The use of work as part of moral management is discussed fully in chapter three.

Commissioners and doctors alike promoted the policy of non-restraint through the removal of the “prison like” aspects of asylum accommodation.<sup>89</sup> Asylums were traditionally constructed with airing courts for patient exercise and surrounded by high boundary walls. The Lochgilphead asylum in Argyll and Bute was regarded as a pet asylum of the Commissioners. It was not only the first district asylum to open after 1857, but also led the way in work and liberty.

This is one of the pet asylums of the Scotch Commissioners. All the favourite ideas of the Scotch Board have been carried out; airing court walls have been pulled down, and all the patients have been turned out to work on the farm.<sup>90</sup>

The abolition of airing courts was also linked to the wider movement towards the increased liberty of patients and was a forerunner of the open door system introduced to Scottish asylums from the 1870s. It can be suggested that the last three decades of the nineteenth century witnessed an apparent movement towards the increased liberty of patients through open doors and then the villa system of the early twentieth century.

Patient liberty was not curbed by hospitalisation in that liberty in asylum practice (i.e. the 'open door' policy, non-restraint and probation and parole) was dependent upon the attitudes of individual medical superintendents. Asylums that practised hospitalisation continued to use liberty in their rewards system for patients (i.e. parole for good 'behaviour' and 'open door villas'). This use of rewards was evident in the villa system of accommodation by the 1900s (see chapter nine).

Another feature of the Scottish asylum system was the boarding out of patients. As the earlier section on the Poor Law showed, children and the mentally ill were boarded out with friends, family or guardians under the Poor Law. From 1858, the General Board of Lunacy officially implemented the policy of boarding out. Patients deemed to be either incurable or harmless could be cared for in a private dwelling, outside the walls of the asylum. Patients were either accommodated in a relative's houses or with an unrelated Guardian. Andrews highlights that boarding out was carried out for economic, communal and humane reasons rather than for therapy.<sup>91</sup> This certainly seems likely as patients selected for boarding out were typically deemed incurable cases. Boarding out was a cheaper option than asylum care and also allowed medical superintendents to free up space in over crowded institutions. The boarding out of incurable cases continued throughout the second half of the nineteenth century and up to 25% of registered pauper and private patients were accommodated in this manner.<sup>92</sup>

The boarding out policy highlights continuing tensions between medical superintendents and parochial boards. Although parish officials favoured boarding out on economic grounds, some medical superintendents were reluctant to board out patients to untrained guardians. A case of mistaken identity at the Argyll and Bute District asylum highlights medical superintendent James Rutherford's views of

boarding out. In August 1870 Rutherford wrote to Angus Cameron, Inspector of Poor, (Lismore and Appin recommending that F.M. could be boarded out to friends (see letter one, Appendix six). Rutherford highlighting that a mistake had been made in the patient's identity then wrote two subsequent letters.

Flora C. or M. is a very different case from the one regarding which I wrote on Saturday. She is yet capable of further improvement and I would not say that she was incurable.<sup>93</sup>

The events show Rutherford's belief that patients should only be boarded out when there was no further hope for cure. Eventually, the patient who was deemed capable of further improvement was sent home to her husband in September 1871 (see letter four, Appendix six).

An important incentive to boarding out in the late nineteenth century was the move towards 'hospitalisation' of the asylum. Sturdy argues that the progress towards hospitalisation was hampered by the concentration of incurable cases in asylums. Boarding out provided a partial solution in that it promoted the asylum as an institution of cure rather than refuge.<sup>94</sup> It is unclear if boarding out had an effect on hospitalisation. Levels of patient recovery during the period of hospitalisation will be outlined at the end of the thesis. It is perhaps more accurate to suggest that the biggest impact of boarding out in asylums was the relief of overcrowded wards.

### Hospitalisation and the Perceived Role of the Asylum

The movement to hospitalise asylum culture came in the 1880s and gained popularity in the 1890s. Hospitalisation was heralded at the time and since as a distinct feature of the Scottish asylum system and one of the most important changes made to lunacy administration.<sup>95</sup> The term 'hospitalisation' was introduced in the late nineteenth century to describe the introduction of medical and general hospital features into



asylums. As such the process of hospitalisation encompassed a number of characteristics. These were:

- The creation of hospital wings at asylums and observation wards for newly admitted patients
- Provision of smaller and segregated buildings as accommodation
- Provision of facilities for medical research and treatment
- Aspirations to develop the nursing standards of general hospitals through the employment of female nurses on male psychiatric wards
- A system of assistant nurses, who were employed from the ranks of general hospital trained nurses.
- Co-operation with general hospitals and the establishment of psychiatric units at general hospitals.

Hospitalisation should naturally be regarded in the context of the changing nature of care in hospitals. Likewise, hospitalisation needs to be seen within contemporary developments in psychiatry. In the longer term, lunacy doctors and administrators were concerned with the apparent increased levels of insanity in Scotland and levels of overcrowding in their institutions. In hindsight, the increased number of admissions in the late nineteenth century can be attributed to factors such as the lunacy grant of 1875 and the construction of district asylums in areas where there had formerly been no institutional provision along with improved transport facilities.

However, faced with increased admissions and an apparent inability to cure their charges, Harriet Sturdy argues that contemporary asylum doctors and administrators were in a dilemma as to the appropriate role of the asylum.<sup>96</sup> As the previous section highlighted, the new district and parochial asylums built after 1857 were typically

constructed as rural institutions that emphasised the use of agricultural employment for patients, coupled with an extension of liberty through the open door system and disuse of airing courts. A typical example of an institution favoured by the General Board is Woodilee, Lenzie, Glasgow (opened in 1875). By the 1890s, the shift in thinking led to asylums built with hospital features. Gartloch Hospital and Asylum in Glasgow opened 22 years after Woodilee and whilst retaining a policy of agricultural employment and patient labour, also provided a hospital building with observation wards and a laboratory. By the 1900s, asylums were constructed not only with separate hospital buildings, but also adhered to the principles of segregation and classification such as Bangour Village Asylum opened in 1904.

Scottish developments in hospitalisation should also be paralleled with English developments. Scottish Commissioners boasted that hospitalisation was part of the distinctly Scottish approach to mental health care. However, not dissimilar developments were occurring in the English asylum system. Debate surrounding the changing nature of asylum care led to changes in asylum architecture in England and encouraged provisions of hospital buildings for acute patients in asylum sites. The planning of new asylums in England from the 1890s promoted the inclusion of a separate hospital, such as West Riding at Wakefield, Napsbury, Middlesex and Hellingley in Middlesex.

England's asylums led to way in medico-scientific research. As chapter seven shows, the large county asylums constructed laboratories for research work. A laboratory scheme run by the London County Council provided impetus for the Scottish Conjoint laboratory scheme. It is arguable that Scotland was influenced by developments in research work in England. Researchers in London certainly had a better track record

(for example Fredrick Mott, pathologist to the London Scheme). However, English county asylums trailed behind Scotland in the use of female nurses on male wards.

A report by the London County Council into a proposed new hospital for the mentally ill in London (1889) provided short-term impetus for Scottish hospitalisation. The London report was highly critical of the progress made by psychiatry throughout the nineteenth century and proposed that a hospital should be constructed.<sup>97</sup> The main recommendations of the report were for a 100-bed hospital in the centre of London that had strong links with medical teaching and visiting consultants. However, many English medical superintendents opposed the new hospital, perhaps fearing a take-over of psychiatry by general medicine. The Committee sided with the opposing medical superintendents and the proposal was rejected. However, the topical debate surrounding medical *v.* moral treatment and London's hospital fuelled a Commission into action to review the issue. Scottish members of the committee included Thomas Clouston, David Yellowlees and John Urquhart.

Commissioners in Lunacy pursued hospitalisation as an official policy. An important figure was John Sibbald who became a Commissioner in 1883. Sibbald started his career at Edinburgh Royal Infirmary, before working at Edinburgh Maternity Hospital, Perth Hospital and Brompton Consumption hospital. He was then appointed assistant physician to the Royal Edinburgh Asylum. In 1862, Sibbald became the medical superintendent to the Argyll and Bute District Asylum, Lochgilphead. Andrews suggests that Sibbald's belief in hospitalisation stemmed from his early background in general medicine.<sup>98</sup> Sibbald was heavily involved in promoting the village style asylum in Scotland. John Macpherson replaced Sibbald as Commissioner in 1899. Macpherson too was a vocal supporter of hospitalisation before attaining this position.

Macpherson worked at Stirling District Asylum where he remodelled the asylum to include extensive hospital features.<sup>99</sup>

Although the hospitalisation policy was part of the General Board's specifications in asylum construction by the 1890s, the impetus for hospitalisation arose from debate between individual doctors. Thomas Clouston, medical superintendent of the Royal Edinburgh Asylum is acknowledged as the leader of the hospitalisation movement. Clouston was responsible for introducing the Scottish Conjoint Asylums Laboratory Scheme in 1890s. Although Yellowlees (Clouston's Glaswegian counterpart) supported hospitalisation, Andrews argues that Yellowlees complacency about his position at Gartnavel Royal led to little clinical incentive at the site.<sup>100</sup> John Batty Tuke, superintendent of the Fife and Kinross District Asylum and then the private Saughton Hall Asylum in Edinburgh was particularly aware of psychiatry's limitations. Other medical superintendents supportive of the hospitalisation movement included George M Robertson (Clouston's successor at the Royal Edinburgh Asylum), Lewis Charles Bruce, Charles Easterbrook, John Urquhart and Hamilton C Marr.

There were no outspoken opponents to the process of hospitalisation. Andrews argues that although some doctors were dubious as to the superiority of hospitalisation over moral methods, doctors were also happy to promote their institutions as 'brain infirmaries'.<sup>101</sup> There were asylums that did virtually nothing to embrace hospitalisation and institutions such as the Argyll and Bute District Asylum, Lochgilphead came under criticism from Commissioners and other doctors. Yet those who supported hospitalisation did not reject moral methods in treatment. Both doctors and commissioners regarded the ideal in treatment to be a combination of moral treatment and hospitalisation.



## Conclusion

Official central government intervention in society through legislation was widespread by the late nineteenth century. With the increased interference in the lives of the poor, mentally ill and physically sick created by the Poor Law, this opened the doorway for further legislation. Without the reform of the Poor Law and subsequent right to care for the mentally ill, it is unlikely that the lunacy reform of the 1850s would have occurred. The culmination of legislation was linked to the growth of institutionalisation. With the creation of medical posts in the Poor Law hospitals and asylums, a benchmark of standards was required for the profession. Parallels in lunacy and prison reform may also be drawn and highlight a trend towards institutionalisation fuelled by moral reformers. This chapter suggests that pressures for intervention varied and included responses to urbanisation, increasing poverty, social reformers, Victorian morality and the medical profession.

Like asylum care, barriers and diversity in practice were part and parcel of general medicine. Medical provisions differed between the type of hospital and locality. The difficulties faced by general medicine in developing a thriving research culture are identifiable in the later attempts to conduct medico-scientific research in asylums. History can regard advances made in medicine as progressive developments supported by the whole medical profession. However, this ignores the hostilities between doctors such as over Lister's practice and opposition to new clinical methods. Although doctors may have killed less people in general medicine by the late nineteenth century this did not mean that cure was any more effective. Like the asylum, general medicine utilised drug therapies as a short-term relief of symptoms and as a method of enhancing their own standing.

The concept of the asylum as a 'total institution' is discussed in the thesis as some similarities may be paralleled between asylums, prisons and poorhouses. Yet the Scottish poorhouse was different from the English system as it did not practice 'less eligibility'. Yet although inmates were not forced to work, participation in activity was expected. Traditionally, Scottish society favoured a non-institutional solution, for example the boarding out of the mentally ill or children. The concept of the 'total institution' is therefore problematic in Scottish society and does not take into account the variance of practice.

Although Poor Law administration was not controlled by the Church after 1845, the Board of Supervision still encouraged a local response in poor relief. Unsurprisingly then, the control of Scotland's public health by the same Board meant that improvements resulted from local initiative rather than central intervention. Changing attitudes to poverty in the late nineteenth century, the abandonment of the Board of Supervision and impact of urbanisation marked increased intervention in local affairs. The medical profession and hospital provision was also heterogeneous in terms of status and clinical practice.

By the late nineteenth century, lunacy care was centralised in its removal from the Board of Supervision and dominance by the all-reforming General Board of Lunacy. Within localities, the place of treatment typically occurred in the local asylum. However, links (and hostilities) remained between parochial boards and asylum superintendents who respectively had different priorities in economy. The growth of the asylum solution for mental illness did not signify that asylum care was standardised across the Scottish localities and profession. Ultimately, the confusion felt by late nineteenth century medical superintendents between moral and medical approaches to

mental illness that preceded and continued in the era of hospitalisation appeared to echo the disparities between moral and medical therapies one hundred years earlier.

<sup>1</sup> Comprehensive coverage of the English Poor Law system is provided in M.A. Crowther, *The Workhouse System 1834-1929 The History of an English Social Institution*, (Batsford Academic and Educational Ltd, 1981), A. Digby, *British Welfare Policy Workhouse to Workfare*, (Faber & Faber, 1989), and D. Englander, *Poverty and Poor Law Reform in 19<sup>th</sup> century Britain from Chadwick to Booth 1834 – 1914*, (Longman 1988).

<sup>2</sup> Digby, *British Welfare Policy*, p.38.

<sup>3</sup> E. Royle, *Modern Britain A Social History 1750-1997*, (2<sup>nd</sup> ed. Arnold, 1987), p.183.

<sup>4</sup> Crowther, *The Workhouse System*, p.3.

<sup>5</sup> *Ibidem*, p.125.

<sup>6</sup> H. Macdonald, 'Boarding Out and the Scottish Poor Law, 1845-1914', *Scottish Historical Review*, 125/2: No. 200, (Oct.1996).

<sup>7</sup> R. Mitchison, *The Old Poor Law in Scotland The Experience of Poverty 1574 – 1845*, (Edinburgh University Press, 2000), p.1.

<sup>8</sup> RAB Houston & I.D. Whyte, *Scottish Society*, (Cambridge University Press, 1989), p.30.

<sup>9</sup> Englander, *Poverty and Poor Law Reform*, p.49.

<sup>10</sup> Paterson, 'The Poor Law in Nineteenth-Century Scotland', in D. Fraser (ed), *The New Poor Law in the 19<sup>th</sup> Century*, (Macmillan, 1976), p.180.

<sup>11</sup> *Ibid.*, p.187.

<sup>12</sup> *Ibid.*

<sup>13</sup> S. Blackden, 'The Poor Law and Health: A Survey of Parochial Medical Aid in Glasgow, 1845-1900' in T.C. Smout, *The Search for Wealth and Stability*, (Macmillan, 1979), p. 262.

<sup>14</sup> L. Walsh, 'The Property of the Whole Community', in Melling and Forsythe, *Insanity, Institutions and Society 1880 – 1914*, p.189-90.

<sup>15</sup> J. Andrews, 'Raising the Tone of Asylundom', in J. Melling and B. Forsythe (ed), *Insanity, Institutions and Society 1880 – 1914: A Social History of Madness in Comparative Perspective*, (Routledge, 1999), p.202.

<sup>16</sup> Andrews, '*They're in the Trade...of Lunacy They 'cannot interfere' – they say*': *The Scottish Lunacy Commissioners and Lunacy Reform in Nineteenth-Century Scotland*, (Occasional Publications, The Wellcome Trust, 1998), p.17.

<sup>17</sup> I. Levitt, *Poverty and Welfare in Scotland 1890-1948*, (Edinburgh University Press, 1988), p.48.

<sup>18</sup> Crowther, 'Poverty, Health and Welfare', in W.H. Fraser and R.J. Morris, *People and Society in Scotland, vol. 2 1830 - 1914*, (John Donald Publishers Ltd, 1990), p.273 and R.A.B. Houston & W.W.J. Knox (ed), *The New Penguin History of Scotland From the Earliest Times to the Present Day*, (Penguin, 2002), p.435.

<sup>19</sup> *Ibid.*

<sup>20</sup> Houston & Knox, *The New Penguin History of Scotland*, p.406.

<sup>21</sup> M. Ignatieff, *A Just Measure of Pain The Penitentiary in the Industrial Revolution 1750-1859*, (Columbia University Press, 1980), p.124.

<sup>22</sup> P. Priestley, *Victorian Prison Lives. English Prison Biography 1830-1914*, (Pimlico, 1999), p.123.

<sup>23</sup> N. Morris & D.J. Rothman, *The Oxford History of the Prison*, (Open University Press, 1995), p.149.

<sup>24</sup> *Ibid.*, p.271.

<sup>25</sup> Ignatieff, *A Just Measure of Pain*, p.204.

<sup>26</sup> D.O. Phillips, 'The Revisionist History of Crime' in S Cohen and A Scull (ed), *Social Control and the State*, (Basil Blackwell Ltd, 1985), p.60.

<sup>27</sup> P. Rabinov, *The Foucault Reader: An Introduction to Foucault's thought*, (Penguin, 1984), p.215.

<sup>28</sup> Royle, *Modern Britain*, p.226; and Ignatieff, 'State, Society and "Total Institutions" in Cohen and Scull, *Social Control and the State*, p.78.

<sup>29</sup> C. Lawrence, *Medicine in the Making of Modern Britain 1700 – 1920*, (Routledge, 1994), p.28.

<sup>30</sup> J. Jenkinson, *Scottish Medical Societies 1731-1939: Their History and Records*, (Edinburgh University Press, 1993), p.54.

<sup>31</sup> Lawrence, *Medicine in the Making of Modern Britain*, p.33.

<sup>32</sup> R. Porter, *Disease, Medicine and Society in England 1550-1860*, (Macmillan, 1987), p.49.

<sup>33</sup> Hamilton, *The Healers A History of Medicine in Scotland*, (Canongate, 1981), p.116.

<sup>34</sup> *Ibid.*, p.167.

<sup>35</sup> H. Dingwall, *A History of Scottish Medicine Themes and Influences*, (Edinburgh University Press Ltd, 2003), p.197.

<sup>36</sup> Porter, *Disease, Medicine and Society in England*, p.49.



- <sup>37</sup> Porter, *The Greatest Benefit to Mankind A Medical History of Humanity from the Antiquity to the Present*, (HarperCollins, 1997), p.298.
- <sup>38</sup> Porter, *Blood and Guts A Short History of Medicine*, (Allan Lane, Penguin, 2002), p.144.
- <sup>39</sup> *Ibid.*, p.144.
- <sup>40</sup> Crowther, 'Poverty, Health and Welfare', p.276 and Walsh, 'The Property of the Whole Community', p.182.
- <sup>41</sup> R. Gaffney, 'Poor Law Hospitals 1845-1914' in O. Checkland & M. Lamb (ed), *Health care as a Social History The Glasgow Case*, (Aberdeen University Press, 1982), p.55.
- <sup>42</sup> *Ibid.*, p.47.
- <sup>43</sup> L. Granshaw, 'Fame and Fortune by means of bricks and mortar': the medical profession and specialist hospitals in Britain, 1800-1948' in L. Granshaw & R. Porter (ed), *The Hospital in History*, (Routledge, 1989), p.199.
- <sup>44</sup> Porter, *The Greatest Benefit to Mankind*, p.387.
- <sup>45</sup> Lawrence, *Medicine in the Making of Modern Britain*, p.34.
- <sup>46</sup> Granshaw, 'Fame and Fortune by means of bricks and mortar', p.206.
- <sup>47</sup> Porter, *Blood and Guts*, p.144.
- <sup>48</sup> M. Goldman, *Lister ward*, (Adam Hilger, 1987), p.1.
- <sup>49</sup> G. Risse, *Mending Bodies. Saving Souls A History of Hospitals*, (Open University Press, 1999), p.366.
- <sup>50</sup> See J. Jenkinson, M. Ross & I. Russell, *The Royal: 200 Years of Glasgow Royal Infirmary*, (Glasgow Royal Infirmary NHS Trust, 1994).
- <sup>51</sup> Risse, *Mending Bodies. Saving Souls*, p.377.
- <sup>52</sup> C. Lawrence, 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914', *Journal of Contemporary History*, 20 (1985), p.504-505.
- <sup>53</sup> Porter, *Cambridge Illustrated History of Medicine*, (Cambridge University Press, 1996), p.320.
- <sup>54</sup> W.F. Bynum, *Science and the practice of medicine in the nineteenth century*, (Cambridge University Press, 1994), p.169.
- <sup>55</sup> *Ibid.*, p.22.
- <sup>56</sup> Lawrence, 'Incommunicable Knowledge', p.514.
- <sup>57</sup> R. Porter, *Blood and Guts*, p.102.
- <sup>58</sup> M. Weatherall, 'Drug Therapies', in W.F. Bynum & R. Porter (ed), *Companion Encyclopedia of the History of Medicine Volume 2*, (Routledge, 1993), p.921.
- <sup>59</sup> E. Shorter, *A History of Psychiatry From the Era of the Asylum to the Age of Prozac*, (John Wiley & sons, 1997), p.199.
- <sup>60</sup> C. Gale & R. Howard, *Presumed Curable: An Illustrated Casebook of Victorian Psychiatric Patients in Bethlem Hospital*, (Wrightson Biomedical Publishing Ltd, 2003).
- <sup>61</sup> R. Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency*, (Penguin, 1987) and R.A. Houston, *Madness and Society in Eighteenth Century Scotland*, (Clarendon Press, 2000).
- <sup>62</sup> Porter, *Mind-Forg'd Manacles*, p.173.
- <sup>63</sup> F. Rice, 'Care and treatment of the Mentally Ill' in Checkland & Lamb, *Health care as a Social History*, p.60.
- <sup>64</sup> *Ibid.*
- <sup>65</sup> Porter, *Mind-Forg'd Manacles*, p.206.
- <sup>66</sup> *Ibid.*, p.222.
- <sup>67</sup> see A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat 1796-1914*, (Cambridge University Press, 1985).
- <sup>68</sup> S. Tuke, *Description of the Retreat, an Institution near York*, (1813).
- <sup>69</sup> Digby, *Madness, Morality and Medicine*, p.57.
- <sup>70</sup> *Ibid.*, p.85.
- <sup>71</sup> M. Foucault, *Madness and Civilisation. A History of Insanity in the Age of Reason*, (Routledge, 1961).
- <sup>72</sup> Porter, *Mind-Forg'd Manacles*, p.225.
- <sup>73</sup> Walsh, 'The Property of the Whole Community', p.181.
- <sup>74</sup> *Ibid.*, p.185.
- <sup>75</sup> J. Andrews & I. Smith (ed), *Let There be Light Again: A History of Gartnavel Royal Hospital from its Beginnings to the Present Day*, (Gartnavel Royal Press, 1993), p.52.
- <sup>76</sup> *Ibid.*, p.56.
- <sup>77</sup> Rice, 'Care and treatment of the mentally ill', p.71.
- <sup>78</sup> *Ibid.*
- <sup>79</sup> A. Scull, C. Mackenzie & N. Hervey, *Masters of Bedlam The Transformation of the Mad-doctoring trade*, (Princeton University Press, 1996), p.96.



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- <sup>80</sup> WAF Browne, *What Asylums Were, Are and Ought to be*, (1837) reprinted in A. Scull, *The Asylum as Utopia*, (Routledge, 1991), p.199-200.
- <sup>81</sup> *Ibid.*, p.179.
- <sup>82</sup> *Ibid.*, p.207.
- <sup>83</sup> *Ibid.*, p.197.
- <sup>84</sup> Scull et al, *Masters of Bedlam*, p.110.
- <sup>85</sup> See Case A, Appendix three.
- <sup>86</sup> Andrews, *'They're in the Trade...of Lunacy'*, p.6.
- <sup>87</sup> Andrews, *'They're in the Trade...of Lunacy'* and F.J Rice, 'The Organisation of Insanity in Scotland', *Scottish Economic and Social History*, 5 (1985).
- <sup>88</sup> Andrews, *'They're in the Trade...of Lunacy'*.
- <sup>89</sup> *Ibid.*, p.51.
- <sup>90</sup> *Asylum Journal*, 21 (1875-6).
- <sup>91</sup> Andrews, *'They're in the Trade...of Lunacy'*, p.40.
- <sup>92</sup> H. Sturdy & W. Parry-Jones, 'Boarding out insane patients: the significance of the Scottish system 1857-1913' in P. Bartlett (ed), *Outside the walls of the asylum: Historical perspectives on 'care in the community' in modern Britain and Ireland*, (Althone, 1999), p.86.
- <sup>93</sup> See Letters two (15 Aug. 1870) and three (20 Aug. 1870), Appendix six.
- <sup>94</sup> H. Sturdy, 'Boarding Out the Insane, 1857-1913: A Study of the Scottish System', Ph.D. diss., *University of Glasgow*, 1996, p.201.
- <sup>95</sup> See for example, J. Macpherson, 'The Hospital Treatment of the Insane in Asylums', *Journal of Mental Science*, 42 (1896), G.M. Robertson, 'Hospital ideals in the Care of the Insane: a statement of certain methods in use at Stirling District asylum, Larbert', *JMS* 48 (1902), GM Robertson, 'The Hospitalisation of the Scottish Asylum System' *Presidential Address JMS* 68 (1922) and T. Walmsley, 'Psychiatry in Scotland' in G.E. Berrios and H. Freeman (ed), *150 Years of British Psychiatry 1841-1891*, (Gaskell, 1991).
- <sup>96</sup> H. Sturdy, 'Boarding Out the Insane, 1857-1913', p.203.
- <sup>97</sup> 'Proposed Hospital for the Insane of London', *Occasional Notes of the Quarter, JMS* 36 (1890), p.77-80.
- <sup>98</sup> Andrews, *'They're in the Trade...of Lunacy'*, p.19.
- <sup>99</sup> see Appendix one for details of medical superintendents' careers
- <sup>100</sup> Andrews, 'A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry: Part 2', *History of Psychiatry* 8 (1997), p.349.
- <sup>101</sup> Andrews, 'Raising the Tone of Asylumdom', p.213.

## Chapter Three Moral Management

There is always hope in the man who actually and earnestly works.

In idleness alone there is perpetual despair.<sup>1</sup>

### Introduction

The use of work is age old in the treatment of mental ill health and was an important feature of early nineteenth century moral therapy. Moral approaches adopted psychological methods and occupation in the attempt to regulate reason and restore sanity. In the asylum, the willingness of a patient to work well and without duress was linked to recovery and was indication of the patient's returning sanity. With the growth of district and county asylums, the personal prescription of moral treatment declined and was replaced by moral management. Although work remained linked to recovery in asylums, occupation was also used to control large numbers of asylum patients.

The custodial perception of occupation in the asylum denotes similarities with the prison and workhouse regime. Goffman argues that such institutions brought people together, in order to perform similar tasks under a single discipline.<sup>2</sup> Work in the English workhouse assumed a penal character in its nature of deterrence. Although early model prison reformers intended occupation to rehabilitate it became easier to provide work that was punitive and required little supervision.

Kathleen Jones also argues that work in the asylum was organised for the economic benefit of the institution rather than for the patients' therapy.<sup>3</sup> However, Scottish asylums varied in size and whereas larger urban institutions did use work as a form of custodial control, smaller institutions were able to retain some moral and individual approaches.

The Commissioners' support for occupation was a characteristic of the Scottish asylum system. One explanation is that participation in work might meet the objection that working class patients would become lazy and unproductive in the asylum. Although this might ring true for the rate aided district asylums, it does not explain the attempt to engage private patients in occupations throughout the same period. Although private and pauper patients were prescribed different types of occupations, the failure of people to participate in any form of activity was equally criticised, whatever the patient's class.

In this context, the prevailing Victorian climate of industriousness and respectability should be considered in the continuance of work in asylum treatment. Victorian society promoted the view that all who were able should work. Even though the Scottish poorhouse did not provide employment as deterrence there was still an expectation that inmates should be active. Parallels can therefore be drawn between the asylum and poorhouse in their use of rewards in order to encourage activity.

### 'Useful Work' and Victorian Respectability

The Victorian period propagated the dignity of labour and saw it as less of a necessity than a duty. Distinction between respectable and non-respectable was marked out through lifestyles and attitudes towards work and occupation.<sup>4</sup> A vital strand was the maintenance of personal independence in that it was immoral for an individual to depend on charity or poor relief unless absolutely necessary.<sup>5</sup>

The expectation that patients should contribute to the upkeep of their institution is certainly reflective of Victorian attitudes towards self-help and responsibility. In an unpublished paper, Mike Barfoot suggests that by the late nineteenth century, patients worked in order to support the economy of the Scottish district asylum that had been put under tremendous strain by large intakes of paupers.<sup>6</sup>

However, accounts of English institutions tend to place great stress on the financial profitability made by English asylums and their patient workforce. Jones states that in practice, patient occupation was organised for the benefit of the institution, and not the patients.<sup>7</sup> The maintenance of large farms and the employment of patients thereon appear to coincide with the asylum's financial interests.<sup>8</sup>

The productivity of asylum patients could help reduce running costs by providing the institution with fresh produce. In a case-study of the Woodilee District Asylum for the decade 1890 to 1899 it was found that its farms supplied patients with around one third of their diet (see table 3).



Table 3 Ratio of Woodilee Patient Food Provisions, (1890-99)

	From Farm	Bought Provision	Total	Ratio
	£	£	£	%
1890	2900	5036	7936	37
1891	3038	5145	8183	37
1892	3033	5387	8420	36
1893	2966	5359	8325	36
1894	2820	5198	8018	35
1895	2962	5481	8443	35
1896	2947	5822	8769	34
1897	3371	6362	9733	35
1898	3911	7025	10936	36
1899	3371	7081	10452	32
Total	31319	57896	89215	35

Whether profitability was a major impetus for employing patients is debatable. In Scotland, the smaller size of the Scottish asylums meant that they could not match the profitability and 'workforce' aspect of the vast English institutions. Of the 25 asylums that were open in 1900, the average patient population was 405 patients. Of these 25 institutions, 8 accommodated less than 300. Only one Scottish district asylum (namely Woodilee with 748 patients) exceeded 700 patients. The two largest asylums with over 800 patients each were Royal asylums. In comparison, some English asylums were built for up to 2,000 patients. Findings speculate that as Woodilee was the largest of the Scottish District Asylums (see table 4) the institution was unique in its profit levels.

Table 4 Patient Numbers in Scottish Asylums, (1900)

Asylums	Average No. of Patients
Aberdeen Royal	873
Aberdeen District*	...
Argyll District	440
Ayr District	508
Banff District	165
Dumfries Royal	733
Dundee Royal	405
Dundee District**	...
Edinburgh Royal	915
Edinburgh District*	...
Elgin District	160
Fife District	525

Glasgow Royal	421
Glasgow (Gartloch)	485
Glasgow (Woodilee)	748
Govan District	486
Haddington District	142
Inverness District	569
Kirklands District	202
Lanark District	669
Midlothian District	253
Montrose Royal	659
Paisley District**	...
Perth Royal	125
Perth District	366
Renfrew District*	...
Roxburgh District	293
Stirling District	641
Greenock District	227
TOTAL	11,010

*Source: 56<sup>th</sup> Annual Report of the Lunacy Commissioners for Scotland, (1913), GD17/5/24*

\* These asylums were not opened until after 1900

\*\* These asylums were not district asylums in 1900

As the small size of district asylums did not permit them to act as significant profit making institutions, it is likely that participation in useful or productive work was more important than if the asylum was able to be economically self-sufficient. This perception of work adhered to contemporary Victorian values of respectability. Discussions of economic management should realistically be placed on hold until a fuller investigation of Scottish asylum accounts and records is made. For the most part, the true nature of economic management in district asylums is no more than speculative. As yet, no real research has been conducted on the role that economic management played in smaller district asylums.

### Asylum Occupations

With the appointment of W.A.F. Browne to the position of Commissioner in Lunacy after 1857, moral theories had an impact upon the new district asylums. Moral therapy was the practice of psychological methods of treatment such as work and a rewards system within a 'domesticated' albeit institutional environment.<sup>9</sup>

Male and female asylum patients participated in occupations deemed appropriate to their perceived gender spheres. Male patients were encouraged to involve themselves in outdoor occupations such as farming, manual labour and gardening. Fresh air and occupation were regarded as integral features of treatment for both body and mind. In the period 1890 – 1899, outdoor work in the farm and gardens accounted for over half of male occupations at Woodilee, Glasgow. At the Ayr District Asylum (ADA), Commissioners observed in 1909 that ‘the number of men working in the gardens and grounds has been largely increased...this is the most suitable and most beneficial work in men who are mentally abnormal ...can be engaged.’<sup>10</sup>

Occasionally, efforts were made to match the patient’s previous occupation in the asylum. Appendix two provides information relating to patient occupation prior to admission. The highest single occupation for male admissions was labouring and for females domestic service or housewifery. In the asylum patients typically participated in manual, outdoor or domestic chores. Some patients were matched to their skilled trades. J.S., a private male shoemaker admitted in 1885 to the CRI was tried out in this work.

12/11/85            This shoemaker still refuses to work at his trade or at ordinary garden work. For the sake of exercise he will polish a floor or help to beat a carpet.<sup>11</sup>

The tailor R.F. was admitted to Gartloch in 1899.

29/11/00            Now very much improved and working in the tailors shop.<sup>12</sup>

R.P. was also a cabinetmaker admitted to Gartloch in 1899.

28/4/99            Is demented. Has been sent to the asylum from the observation ward. In a few days he will be tried in the joiner’s shop to see if he will now start work.

13/5/99            There is little change in this man’s condition. He has been tried in the joiner’s shop but is of little use. He is listless and unenergetic and needs constant supervision to keep him at work.<sup>13</sup>

Usually, such opportunities were uncommon and most people were expected to comply with the standard occupation offered by the institution.

The emphasis placed upon outdoor or physical work created difficulties in occupying female patients. At Woodilee no female was occupied in this way. Like many of Scotland's asylums, a significant proportion of Woodilee's female patients knitted or sewed as their daily occupation. Laundry work was an obvious occupation for females. Elaine Showalter suggests in her review of female insanity that 'this aggressive activity of pounding the wet clothes, wringing them was thought to be a useful and effective outlet for their superfluous nervous energy'.<sup>14</sup> Certainly, Commissioners and doctors supported the use of laundry work to rid excessive energy. Unrest on the female side of an asylum was often mentioned as a consequence of the non-active occupations such as sewing and knitting. After a tour of Woodilee in June 1882, Mitchell commented in his Commissioners report that 'it is largely due to the want of active work that the female side of all asylums are less tranquil than the male side'.<sup>15</sup>

From the 1890s, outdoor occupations were developed for female patients in asylums. The 'Asylum-Hospital' of Gartloch in Glasgow (Gartloch) regularly employed its female patients in the gardens and grounds. A further female occupation was fruit picking in the summer months. At the Stirling District Asylum (SDA), females picked fruit in addition to weeding.

A beginning was also made in fruit culture, and about an acre of strawberries and rasps was planted. ...they are...useful in this way that they supply outdoor labour of a suitable and attractive kind to the female patients.<sup>16</sup>

Developments in outdoor occupations for female patients should be placed in the context of contemporary thinking. As chapter six on open-air rest points out, tremendous emphasis was placed in society upon the benefits of fresh air and exercise



for all. With the developments made in open-air rest therapy in asylum culture, it appears unsurprising that fresh air treatment was extended to the female sphere.

### Custodial v. Moral Approaches

Scull suggests that occupation was used as a method of control in large English nineteenth century asylums.<sup>17</sup> Work was not provided because it was of therapeutic value but because it was a convenient method of discipline. In the 'total institution', all aspects of life were supposedly conducted in the same place, each phase of daily activity was conducted in the company of others and all phases of the day's activity were planned and prearranged.<sup>18</sup>

Many aspects of Goffman's argument correlate with late nineteenth century asylums like Woodilee, whose population verged on a thousand by the twentieth century. Daily life at Woodilee by the 1880s was systematised in order to maintain discipline at the institution. In a tour of Scottish asylums in 1882, an American physician anonymously described the operation of a full working day for patients, which he witnessed in his visit to Woodilee.

The patients and attendants rise at half-past five. All are house cleaners until the breakfast hour, which is half-past seven. At half-past eight all go to chapel...At nine o'clock the various working parties are arranged and inspected by medical officers, after which they go to work. At one o'clock all return to dinner...At two o'clock all leave the hall...resume their work as in the morning...At 6 o'clock all return for tea.<sup>19</sup>

The then superintendent James Rutherford appeared emphatic in his implementation of a full working day. Rutherford noted, 'it is more satisfactory to keep the hours that working men are accustomed to, as it makes the work more natural and real'.<sup>20</sup> This

strict daily routine would have made it far easier to control large numbers of patients, especially in an asylum practising 'open doors' (discussed in the following chapter).

Although Woodilee's population size de-personalised life in this institution, Rutherford was previously proactive in this approach. The case of the Argyll and Bute District Asylum patient C.M. is outlined in unpublished letters between Rutherford and the Parochial Board of Lismore and Appin in appendix seven. In letter five of the appendix, James Rutherford makes reference to the 'moral treatment of the asylum' and references are also made in letters three and four to the use of liberty as a test of sanity. His knowledge of individual patients is additionally highlighted in the letters about ABDA patients that are included in appendix six. Foucault argues that the power of the doctor in the asylum was ultimate.<sup>21</sup> However, the variance between Rutherford's practice at Woodilee and the ABDA denotes that the doctor could be constrained by events and influences outside his powers.

Even in the larger asylums, there were discrepancies in the treatment of patients. This was particularly the use of 'trusties' [trusted patients paid for their work] in the asylum. The payment of inmates coupled with the hierarchy created among patients sat uncomfortably with the 'total institution' such as the workhouse or asylum. Crowther highlights that in the workhouse, the central Commissioners opposed the payment of some inmates for participation in special work. However, local Guardians went against the central authority and continued payment of small sums or in kind (i.e. beer or tea and snuff), as it was more economic to use inmate labour.<sup>22</sup>

A similar practice persisted in many asylums and some superintendents openly favoured the payment of patients employed in more responsible positions. At Woodilee,

trustworthy patients accompanied the night attendants on rounds, assisting them in taking up patients, watching the suicidal and epileptic patients and helping in the care of sick patients.<sup>23</sup> For such assistance, patients received a few shillings per month. John Macpherson commented in the Stirling District Asylum Report of 1892 that 'many patients complain that they are obliged to work for nothing'.<sup>24</sup> In the same report he suggested the benefits of giving remuneration in order to retain the patient's respectability and independence on release.

Not all superintendents favoured this practice of payment for 'trusties'. Rutherford himself admitted that the issue was contentious and that 'the remuneration of patients in an asylum...may be regarded still as unsolved'.<sup>25</sup> A request by a patient to remain employed at the Perth District Asylum was rejected by the superintendent, George Robertson. The patient had been a 'trustie' for some time prior to his recommended discharge.

The parish council of Mourlin had before them yesterday the case of Archibald Stewart, lunatic pauper, Murthly Asylum. Stewart was for many years postmaster in Pitlochery and is a man of superior education and intelligence. He gave way to drink to which there is a hereditary tendency in his family and became insane some years ago and has been an inmate of the asylum ever since. For the last 2 years he has been acting as Assistant House Steward at Murthly Asylum and is I believe of considerable assistance in the asylum. The medical officer has intimated that Stewart may be removed if he can be placed in a situation where supervision can be exercised over him. This is a very difficult situation to get and Stewart would himself like to remain in the employment of the Lunacy Board if it were found feasible.<sup>26</sup>

Dr Robertson highlighted that 'there were other patients who could give and would be glad of the opportunity of giving assistance... and he was afraid that it would just be creating an office and bad precedent'.<sup>27</sup> The case shows how the parish and asylum

might clash over a patient's accommodation. The case also denotes the decline of mental health due to alcoholism. Although the patient was not given employment, the request had been made because the patient was known as a local postmaster 'of superior education and intelligence'. It is unlikely that this level of intervention would have occurred in a larger urban institution.

While the PDA head Robertson did not support payment for patient occupation, he was favourable to moral approaches. In the 1890s, Robertson established a school for patients. The parallel between education and the treatment of mental illness is linked to the perception of the insane as children. Foucault argues that life at the York Retreat was organised so that the insane were regarded as children and subjected to re-education.<sup>28</sup>

At the PDA, lessons were provided in all subjects and a weekly lecture was given to patients. An anonymous account of the school in 1895 was written in the *Murthly Magazine* in the Perth District Board of Lunacy's minute books.

*'The School - 1895'*

School is held in the library and as we enter, one of the pupils (A.S.) never omits to bid us welcome with a hearty "Good Evening Sir". Seated on either side of a table, the women are busy with their pens while the men are struggling with the arithmetic of their earlier years...here again, is a very regular scholar (M.L.) busy with his copy book instead of slate. To this son of the Emerald isle the pen is mightier than the slate pen. A few years ago, the outside world and friends were far away, but now this has become a great pleasure to himself and others...<sup>29</sup>

Of course, the school might have provided positive implications for patients in an educative role and is likely to have broken monotony of asylum life in its provision of evening lectures and classes. However, the description of the school above coupled



with the following quote by George Robertson is suggestive of the Foucauldian perception of the insane as children.

When I see a patient who has ruined his constitution and wasted his life in drinking bouts...playing a game of football with the zest of a school boy...

I feel that he at least is better off here in our innocent and "healthy" pursuits.<sup>30</sup>

The Perth school is not a reflective of provisions made by all Scottish asylums. In turn though, the school does show the example of the medical superintendent's individual impact upon on asylum culture.

In *Discipline and Punish*, Foucault suggests that the prison practised a system of 'moral accounting' where the offender becomes 'an individual to know'.<sup>31</sup> Detailed notes were maintained of the offender that would assist in his reform. A feature of early moral therapy was the close relationship between the patient and doctor. Typically, this relationship was lost with the growth of asylum populations. However, the Robertson's predecessor Dr W.C. McIntosh maintained a daily casebook of patients between 1868 and 1888. A selection of entries taken from the Perth Daily Casebook in November and December 1885 are included below.

*28 November 1885*

Elizabeth D. has been very quiet and easily managed of late; appears industriously inclined.

*30 November 1885*

J. M. has improved considerably of late. She is now fairly cheerful and assists well in the sewing room.

C.K. No change has taken place in the mental condition of this case. She is very idle and untidy.

*1 December 1885*

J. W. is rather better in his physical condition than usual. He goes to the tailor's shop daily but is quite idle.

3 December 1885

C.J. has improved again. [She] is industrious in the sewing room.

10 December 1885

Alex W. was discharged today and left in excellent mental and bodily condition. He has been very industrious of late and has worked on parole and done any little bits of mason work.

15 December 1885

W. B. was sent out with the working party this morning against his inclinations. He worked at a window this noon and broke several panes and the woodwork, slightly cutting himself. After the wound was dressed and a sedative administered, he was sent out again.<sup>32</sup>

The examples denote the link between recovery and work, discussed further in the next section. Again, this individual recording at the PDA was not common practice at most asylums. This is the only existing series of daily casebooks of record in district asylums. It is unlikely that larger institutions maintained similar observations. At Woodilee or Gartloch, weeks or months could pass between entries in patient casenotes.

### Occupation and Recovery

The engagement of patients in work was linked to the individual's recovery and discharge. In an assessment of nineteenth century asylums in Ireland, Mark Finnane argues that the process of work was regarded to be both a therapeutic agent and as a sign of recovery.<sup>33</sup> Namely, the process of work and willingness to partake in it was considered a sign of mental improvement, as was a diligent worker a sign of impending recovery.

Unwilling participation in work was seen as a sign of inadequate recovery or improvement. In June 1885, the CRI male patient A.K. was 'induced to do some work

outside, but this has not made any mental improvement.<sup>34</sup> In July 1883, the PDA patient A.H. started work as a plumber's assistant. The daily case notes highlight that he 'is not a great success as a plumber's assistant and is being sent back to the working party again'.<sup>35</sup> Force of example was utilised to generate enthusiasm for 'it is held that unless this interest can be aroused and kept up, the value of work done by the patients as a means of treatment is greatly reduced'.<sup>36</sup>

The force of example was used to encourage participants to take an interest in the work conducted. Woodilee attendants both directed and participated in working parties.

All attendants who are with working parties, join in the work, whatever it is, with as much energy and interest as if they were paid for results...The patients are led to follow example rather than precept, and it was manifest that a large number of them were as much interested in the progress of the work in which they were engaged as any labourers or artisans could be.<sup>37</sup>

At the Ayr District Asylum (ADA) in 1909, Visiting Commissioners praised the increased numbers of male patients employed in the grounds, 'the credit for this improvement largely belongs to the head attendant for the way he inspires both his staff and patients'. At the PDA it was reported in the annual report that 'constant pressure and persuasion is used to engage all in some kind of work or occupation even if it should be unproductive or useless'.<sup>38</sup>

The importance of work is evident in the treatment of private patients and highlights the continuation of moral treatment for this group. In the 1880s at the CRI, James Rutherford systematised gardening parties for the Institution's private male patients. To begin with, the scheme was not an unqualified success and varying degrees of achievement were recorded. C.C. was one of the private patients that the CRI doctors tried to make work.

18 February 1886           An attempt to get him to work with the gardening party has utterly failed. He went out with them unwillingly but would not work, stood looking on with his hands in his pockets.

14 September 1886       He is very idle. The hope of getting him to work in the garden proved vain and he is not asked to go out with the party...<sup>39</sup>

The force of example and compulsion of regular habit and occupation were vital components of the moral management of private patients.

...almost every able bodied young man goes out and engages in such work.

This has been brought about by the force of example and habit, than which nothing has greater influence on the Insane and weak minded.<sup>40</sup>

If private male patients participated in a morning's work, they would receive small payments and could pursue leisure activities in the afternoon.

Patient casenotes for private and pauper patients made consistent references to the ability and willingness of an individual to work. This is perhaps an unsurprising attitude in relation to the rate aided pauper patients. However, the expectation that private patients should also be active denotes the relationship of good mental health and recovery through occupation.

An asylum being what it was, no one could theoretically be forced to work.<sup>41</sup> This is true in that patients were encouraged to participate by force of example and those, who were sent out against their will, could not be physically coerced into working. Parallels are therefore evident between the attempt to get poorhouse and asylum inmates to work. Paterson argues that in order to encourage activity, Poor Law Guardians used bribes and incentive to work.<sup>42</sup>

Although Robertson had drawn the line at paying patients at the PDA, he used incentives to engage patients in work.



They are [patients] are...encouraged to occupy themselves usefully, the men  
by the offer of tobacco and the women of tea.<sup>43</sup>

Publicly, some superintendents such as James Rutherford opposed the reward system in terms of tobacco, snuff, beer and extra food. Rutherford believed that such luxuries should not be given according to the work conducted. Yet as this chapter highlights, even Rutherford resorted to the reward-punishment system in his superintendence at the CRI and had consistently paid 'trusties' to work as pauper nurses.

In the asylum, privileges were removed if patients did not comply with the occupation and obedience expected of them. As Digby points out, this link between patient attitude and recovery continued well into the twentieth century.<sup>44</sup>

That the indulgences and rewards extended to the orderly and industrious inmates of an asylum should be withheld from those who will not use what self control remains to them is entirely right and is a valuable means of inducing them to amend their ways.<sup>45</sup>

To remove luxuries or privileges from patients who had not 'earned' them was an integral practice in moral management.

Bribery and coercion also existed in the treatment of private paying patients. At the CRI, the private patient B.P. was threatened with removal from a probationary house because she would not occupy herself.

1 Jan 1887      Miss P. is intensely lazy and is always complaining of symptoms, which are nothing more than a result of her want of activity.

1 June 1887      She is now at Maryfield and is made to sew. The condition that if she works she remains at Maryfield.<sup>46</sup>

Activity was encouraged through more radical measures. Shock therapies such as cold baths, batteries (i.e. an electrical charge) and blistering were deemed to lessen listlessness

and discourage bad behaviour. In March 1886, A.A. was admitted to the CRI. Her notes suggest unsatisfactory progress and refusal to work.

June 1885        This patient who has not been progressing satisfactorily has been ordered a cold bath...and application of the Voltaire current for five minutes every day.

27 July 1885     There has been a marked improvement in this patient since the above treatment was commenced. This morning she was knitting and said she would knit and sew if she were allowed to escape the bath.<sup>47</sup>

Soon after admission to Gartloch in 1899, R. F. was ordered outdoor work as treatment.

March 1900       Patient...is very mindless and listless and takes no interest in anything. Occasionally he works outside but his mental condition is becoming much worse.

April 1900       He is very dull and apathetic and does not interest himself in anything...is rousing up somewhat under the batteries.

By November 1900, the patient was deemed to be 'very much improved and working in the tailor's shop' and the 'battery treatment stopped'.<sup>48</sup>

Work could also be employed as a form of punishment. Occupation in unappealing work was a means by which unacceptable behaviour could be corrected. At Bangour Village Asylum in 1906, C.C. was 'seen yesterday kicking a fellow patient, an imbecile, who was not interfering with him in the least'. As punishment, the patient was 'sent out with the working squad'.<sup>49</sup> The patient A.G.S. caused problems for CRI medical staff in his refusal to bow to the institution's authority (see Case C, Appendix three). When sent out to work in a garden party, he threw stones at the medical attendant. The patient 'was sent to the second house where he will have harder work with the pauper squad'. Yet, this had little effect and he continued to display violent behaviour. A few days later, 'while in the second house Mr S. wore the pauper clothes and worked all day at the barrows. The discipline has done him good, he is quiet though still sullen and has a less exaggerated idea of his importance'.

Case notes demonstrate a number of persistent cases who 'shied away' from the work ethic. Oonagh Walsh also highlights that it is surprising how disobedient or disruptive the patient could be in refusing to work or by spoiling events organised by the asylum staff.<sup>50</sup> Case notes from various asylums highlight the 'laziness', 'idleness' and 'indolence' of patients who would not work. W.S., a pauper male patient at the CRI was considered 'very lazy' because of his refusal to work and that he 'grumbles a great deal but refuses to go and work for himself'. J.S. admitted to Woodilee in 1897 was recorded to be dull and melancholy and that he 'is frequently complaining that he cannot work – he is really lazy however'.<sup>51</sup> It was recorded of the pauper female C.C. in 1906 that 'she still refuses to do any work of any kind: when asked if she would try to help the others in different kinds of work she answers that she won't - her expression being slightly sullen and stubborn'.<sup>52</sup>

The same criticism was equally made of the private patients. T.G., a CRI private patient admitted in 1895 'so far cannot be got to work, although he came from Gartnavel [Royal Asylum] with the reputation of being a good worker'.<sup>53</sup> The following examples are taken from the casenotes of CRI patient M.P.

31/12/87 M.P. cannot be made to work. She sits idly on the sofa and believes that she is too weak to do anything.

10/4/88 She is as lazy and hypochondriac as ever. She maintains that she is too weak to do any work and spends her time in absolute idleness, sitting at the fireside or lying on the sofa.<sup>54</sup>

Similarly the private male patient CC was deemed 'very idle' in 1887.

The hope of getting him to work in the garden proved vain and he is not asked to go out with the party...He will take a bat a cricket but in a lazy and half hearted fashion and he will not field'.<sup>55</sup>

M.A. a private voluntary patient was 'indolent and will not work but he occasionally plays football but not in a very energetic manner'.<sup>56</sup>

Yet casenotes occasionally highlight when patients actively sought out work. R.C. a pauper male patient admitted to the CRI in 1885, 'asked to be allowed to go out to work and was put on the barrow party where he did well'.<sup>57</sup> J.L. a 69 year old pauper patient at the CRI also requested work.

9/6/85            In the morning he asked for something to do and was put to chop wood as an outlet for the energy of his destructive tendencies. He worked hard all day and expressed his intention of presenting several people with the price of a cartload of sticks..<sup>58</sup>

In view of the Victorian emphasis placed upon respectability and independence, the willingness of people to work is perhaps not that surprising. Crowther proposes that it was possible find workhouse inmates who would work without compulsion in order to retain any shred of independence.<sup>59</sup> Similarly, occupation in the asylum provided some patients with an outlet for their monotony and retention of dignity in daily life.

### Conclusion

Occupation in the asylum must be placed within psychiatric treatment's history. In the smaller institutions such as the PDA, elements of early moral treatment remained. This included the role of education and the individual recording of patients through the daily casebooks. This chapter drew upon Woodilee to highlight how daily life in the larger asylums paralleled the custodial monotony of many late nineteenth century English asylums. In these larger institutions, work was utilised as a means of controlling large numbers of patients through working parties that were part of a tightly scheduled day.



Occupation was important for those who supported hospitalisation and those in favour of more traditional methods. Despite George Robertson's strong support for hospitalisation, his continued support for moralistic approaches to the mentally ill is also reflected at the PDA. James Rutherford clearly favoured the use of work as part of a moral approach to treatment. Although work became custodial during his time at the large Woodilee asylum, his subsequent CRI post reflects his application of moral approaches through the use of occupation for all and a rewards system. As such this denotes the impact of factors on treatment methods that were outwith the asylum doctors control.

Evidently, work in the asylum should be understood in the context of other Victorian institutions as well as wider society. Parallels were present through the expectation that all should participate in work. As such, activity was encouraged through persuasion in both the asylum and poorhouse. In line with Crowther and Walsh's arguments, as much as people were expected to work, there were a number who rebelled against their incarceration by refusing to fit in with the discipline of the institution.

It is likely that the support and continuation of occupations within the asylum was a combination of a traditional moral doctrine and the influence of contemporary society. In promoting the asylum to wider society, Commissioners could also propagate the asylum's inclusion of useful work. In turn this helped justify the costly growth of asylum construction that sat uncomfortably with Scottish principles of non-institutionalisation.

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<sup>1</sup> Quoted in G. Alder-Blumer, 'The Medical and Material Aspects of Industrial Employment for the Insane', *American Journal of Insanity*, 54 (1897), p.157.

<sup>2</sup> E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*, (Penguin, 1961), p.16-17.

<sup>3</sup> K. Jones, *Asylums and After: A Revised History of the Mental Health Services from the Early Eighteenth Century to the 1920s*, (The Althone Press, 1993), p.120.

<sup>4</sup> T.C. Smout, *A Century of the Scottish People 1830-1950*, (Fontana press, 1997), p.89.

<sup>5</sup> G. Best, *Mid-Victorian Britain 1851-75*, (Fontana Press, 1985), p.280.

- <sup>6</sup> M. Barfoot, 'Love Labours Lost: The Work, Exercise and Health of Pauper Inmates of Nineteenth Century Scottish Asylums', *Unpublished Paper, Scottish Labour History Conference, Edinburgh* (1997) and *Diet, Disease and Death Group*, University of Aberdeen, (1997).
- <sup>7</sup> Jones, *Asylums and After*, (1993), p.120.
- <sup>8</sup> M. Finnane, *Insanity and the Insane in Post Famine Ireland*, (Redwood Burn Ltd, 1985), p.196.
- <sup>9</sup> R. Porter, *Mind-For'd Manacles A History of Madness in England from the Restoration to the Regency*, (Penguin, 1987), p.222.
- <sup>10</sup> *Minutes of the Ayr District Lunacy Board*, (1909), AA17/4/7.
- <sup>11</sup> *CRI Casebook of Male Admissions*, (1885), DUM.CR1989.138.
- <sup>12</sup> *Gartloch Casebook of Male Admissions*, (1899), HB1/14/4.
- <sup>13</sup> *Ibid*.
- <sup>14</sup> E. Showalter, *The Female Malady. Women, Madness and English Culture 1830 - 1980*, (Virago Press, 1987), p.83.
- <sup>15</sup> *Woodilee Patient Books (containing Twice Yearly Reports by HM Commissioners in Lunacy)*, (1882), HB10/2/1.
- <sup>16</sup> *30<sup>th</sup> Annual Report of Stirling District Asylum*, (1899-1900), GD17/1/36.
- <sup>17</sup> A. Scull, 'Museums of Madness Revisited', *Social History of Medicine*, 6/1 (1993), p.11.
- <sup>18</sup> Goffman, *Asylums*, p.16-17.
- <sup>19</sup> *Notes on British Asylums*, *AJI*, 39 (1882-1883), p.279.
- <sup>20</sup> *Notes and News*, *JMS*, 27 (1882), p.478.
- <sup>21</sup> M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, (Routledge, 1961), p.270.
- <sup>22</sup> M.A. Crowther, *The Workhouse System 1834-1929 The History of an English Social Institution*, (Batsford Academic and Educational Ltd, 1981), p.197.
- <sup>23</sup> *Notes on British Asylums*, *AJI*, 39 (1882-1883), p.281.
- <sup>24</sup> *22<sup>nd</sup> An. Rep. of SDA*, (1891-92), GD17/1/28.
- <sup>25</sup> *Notes on British Asylums*, *AJI*, 39 (1882-1883), p.281.
- <sup>26</sup> *Mins of the Perth Dist. Lun. Bd*, (1896), CC1 11/1/3.
- <sup>27</sup> *Ibid*.
- <sup>28</sup> Foucault, *Madness and Civilisation*, p.252.
- <sup>29</sup> *Mins of the Perth Dist. Lun. Bd*, (1904), CC 11/1/4.
- <sup>30</sup> *32<sup>nd</sup> An. Rep. of PDA*, (1896), GD17/1/32.
- <sup>31</sup> Foucault, *Discipline and Punish: The Birth of the Prison*, (Penguin, 1977), p.250-51.
- <sup>32</sup> *PDA Daily Case Book*, (1881-1885).
- <sup>33</sup> Finnane, *Insanity and the Insane*, p.196.
- <sup>34</sup> *CRI Casebook of Male Admissions*, (1885), DUM.CR1989.138.
- <sup>35</sup> *PDA Daily Case Book*, (1881 - 1885).
- <sup>36</sup> *Ibid*.
- <sup>37</sup> *English Retrospect*, *JMS*, 29 (1883-84), p.285.
- <sup>38</sup> *28<sup>th</sup> An. Rep. of PDA*, (1892), GD17/1/28.
- <sup>39</sup> *CRI Casebook of Male Admissions*, (1885), DUM.CR1989.138.
- <sup>40</sup> *55<sup>th</sup> An. Rep. of CRI*, (1894), DUM.CR1989.249.
- <sup>41</sup> Finnane, *Insanity and the Insane*, p.197.
- <sup>42</sup> A. Paterson, 'The Poor Law in Nineteenth-Century Scotland', in D. Fraser (ed), *The New Poor Law in the 19<sup>th</sup> Century*, (Macmillan, 1976), p.178 &187.
- <sup>43</sup> *30<sup>th</sup> An. Rep. of PDA*, (1894), GD17/1/30.
- <sup>44</sup> A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat 1796-1914*, (Cambridge University Press, 1985), p.66.
- <sup>45</sup> Anon., 'On Rewarding and Employing Patients', *JMS* (April 1883) quoted in *AJI*, 40 (1883-84), p.79.
- <sup>46</sup> *CRI Casebook of Female Admissions*, (1873-1887), DUM.CR1989.89.
- <sup>47</sup> *Ibid*.
- <sup>48</sup> *Gartloch Casebook of Male Admissions*, (1899), HB1/14/4.
- <sup>49</sup> *Bangour Village Asylum Male Discharges* (No dates or references are available for Bangour casebooks. Casebooks were not compiled chronologically but moved between different years).
- <sup>50</sup> O. Walsh, 'Lunatics and criminal alliances in nineteenth-century Ireland', in P. Bartlett & D. Wright, *Outside the walls of the asylum: Historical perspectives on 'care in the community' in modern Britain and Ireland*, (Althone, 1999), p.147.
- <sup>51</sup> *Woodilee Case Book of Male Admissions*, (1897), HB30/4/4.
- <sup>52</sup> *CRI Case Book of Female Admissions*, (1903-07), DUM.CR1989.100.
- <sup>53</sup> *CRI Casebook of Male Admissions*, (1895) DUM.CRI1989.144.
- <sup>54</sup> *CRI Case Book of Female Admissions*, (1873-1887), DUM.CR1989.89.

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55 *CRI Case Book of Male Admissions*, (1885), DUM.CR1989.138.

56 *Ibid.*

57 *Ibid.*

58 *Ibid.*

59 Crowther, *The Workhouse System*, p.201.

## Chapter four Liberty and Asylum Practice

Just as much as want of self control is an index of diseased mental state, so indeed is it a cause of insanity in the individual...Were the public more thoroughly to realise this, less indignation would be expressed regarding attempts to "interfere with the "liberty of the subject" whose conduct brings untold misery.<sup>1</sup>

### Introduction

The issue of liberty was explicit to asylum care as the committal of an individual to an asylum meant the obvious removal of his or her personal freedom. Within asylum culture, patients were expected to follow a strict discipline and their progress throughout the institution was often reliant on the asylum doctors. Recent research by Oonagh Walsh suggests that patients were more than passive victims in the asylum system and sometimes resisted confinement through non-cooperation or rebellion.<sup>2</sup> Although Scull argues that the extent of patient autonomy should not be exaggerated,<sup>3</sup> this research has also found that patients often responded to the removal of their liberty by refusing to work (discussed in the previous chapter) and through resistance.

The issue of 'liberty' in the asylum was perceived by Commissioners in Lunacy to be an important part of the Scottish asylum system after 1857. Commissioners aimed to remove the 'prison like' features of asylum care and promoted the 'open door' policy where asylum wards and doors remained unlocked. Commissioners achieved the recognition of voluntary admission and probationary release in legislation in 1862. Commissioners also promoted non-restraint as part of the distinctive Scottish approach to mental health care.

Yet, policies and legislation that were promoted centrally did not always achieve local implementation. At local asylums, medical superintendents asserted their right to



'therapeutic autonomy' and did not practise policies against their individual philosophy.<sup>4</sup> When Woodilee opened in 1875, it was considered a 'model' for the Commissioners in its use of unlocked doors. Some medical superintendents supported the use of minimal restraint and the 'open door' policy whereas others were openly critical of the Commissioners' attempts to impose practices they felt to be unrealistic and foolhardy.

The removal of liberties coupled with institutional life denotes similarities with a custodial regime. The use of probation and parole in the asylum also highlights parallels with the nineteenth century prison identified by Revisionists such as Foucault and Ignatieff. Revisionists suggest that prison life was subject to a series of reformatory stages where the final step of the prisoner's reform included 'rewards' such as parole and release on probation.<sup>5</sup> Certainly, similarities do exist and asylums utilised parole as a 'reward' for patients who conformed to asylum treatment and participated in work. In the asylum, probation was also used for a small percentage of patients (often alcoholic cases) in order to test their suitability for release. Both asylum and prison probation could be revoked at any time.

There were differences in the use of probation and parole in asylums and prisons, not least in attitudinal differences towards asylum patients and prisoners. Whereas all prisoners were deemed culpable of their crime, this was untrue of asylum patients. Only patients seen to be at fault for their own moral downfall (i.e. alcoholic or syphilitic insanity) were seen as responsible for their condition. Probation was often used by medical superintendents as a response to overcrowding rather than as a test of 'responsible' behaviour. Prison parole was utilised only in the final stages of 'reform',

whereas asylum doctors used parole consistently throughout the stay of suitable patients.

The presence of voluntary patients in the Scottish asylum system sits uncomfortably with Scull's history of the British asylum system as it challenges his perception of the asylum as a warehouse for the unwanted.<sup>6</sup> While the individual autonomy of the voluntary boarder is questionable, their presence in asylum culture supports recent historiography's emphasis on the role of family members in the committal of asylum patients. The use of probation for alcoholic patients also disputes Scull's view of the asylum as a convenient place to remove unwanted relatives. It is suggested that while alcoholic people were often removed to asylums, family members viewed the asylum as the last resort for their kin and friends.

### Voluntary Boarders

This group of patients were admitted to an asylum under Section 15 of the Act 29 and 30 Vict. Cap 51 (1862). As a voluntary boarder, the individual was not certified and could not be detained for more than three days after giving notice of their intention or desire to leave.<sup>7</sup> A voluntary person could be admitted to any institution that housed the mentally ill including both Royal and District Asylums. Commissioners favoured the voluntary clause because

We continue to be of opinion that it is a useful provision of the law which permits persons who desire to place themselves under care in an asylum to do so in a way which does not require them to go through forms from which they naturally shrink and yet affords sufficient guarantee against abuse.<sup>8</sup>

Admission as a voluntary patient apparently reduced the stigma of certification and implied that a voluntary patient had entered the asylum of his or her own free will. In

England, voluntary admission was restricted to patients who had already been confined to an asylum in the past five years. In contrast to the Scottish system, English law did not sanction voluntary admission to an English public asylum until 1930.<sup>9</sup>

Although voluntary admission in Scotland remained a small percentage of total admissions, the percentage of this group did increase between 1881 to 1914 from 1.2% to 4.3% (see table 5). In 1892, the Commissioners had noted 'the increasing extent to which this provision of the law is being taken advantage of and the greater variety of cases admitted under it'.<sup>10</sup> Although the increase between 1913 and 1914 is out of proportion to the gradual rise, the percentage of voluntary admissions between 1881 and 1914 had more than doubled.

It is unclear why there was a marked increase of voluntary admissions in 1914. The number of total admissions had not declined in 1913-1914 and a new asylum was not opened in these years (which might increase the percentage of voluntary patients). The rise of voluntary patients cannot be conclusively linked to the outbreak of the First World War and consequent effects of shell-shock without a more detailed investigation of admissions. Babington and Shepherd do suggest that family and friends as well as the general public were concerned at the prospect of soldiers being sent to asylums as 'pauper lunatics' and certified indefinitely.<sup>11</sup> This public concern was present from the early days of war and led to the introduction of the Mental Health Bill in 1915. This bill made provisions for soldiers who were suffering from the psychological effects of war to remain uncertified in an asylum for a period of 6 months. It is plausible then that soldiers may have been admitted as voluntary patients in order to avoid the label of 'insanity' which was seen by many in the general public as inappropriate.

**Table 5**  
**Voluntary admissions to Scottish Asylums (1881-1914)**

Year	Voluntary admissions	Total admissions Scottish asylums	% of total admissions
1881	38	3043	1.2%
1882	42	2828	1.5%
1883	55	2979	1.8%
1884	33	2988	1.1%
1885	55	3041	1.8%
1886	49	2870	1.7%
1887	55	2892	1.9%
1888	55	2991	1.8%
1889	76	3022	2.5%
1890	98	3086	3.2%
1891	77	3310	2.3%
1892	73	3339	2.2%
1893	90	3416	2.6%
1894	63	3634	1.7%
1895	87	3802	2.3%
1896	87	3708	2.3%
1897	86	4120	2.1%
1898	88	4010	2.2%
1899	74	3924	1.9%
1900	84	4000	2.1%
1901	90	3977	2.3%
1902	79	4198	1.9%
1903	70	3627	1.9%
1904	66	4597	1.4%
1905	96	3892	2.5%
1906	103	4114	2.5%
1907	120	4252	2.8%
1908	106	3881	2.7%
1909	91	3768	2.4%
1910	108	3675	2.9%
1911	119	3900	3.1%
1912	115	3885	3.0%
1913	112	4053	2.8%
1914	181	4165	4.3%

Voluntary patients in Scotland were nearly always private patients and were admitted to the Royal asylums. Very few voluntary patients were admitted to the district asylums. The fact that the parochial board incurred costs of accommodating a person in an asylum would suggest that it was unlikely that the parochial board encouraged the admission of voluntary patients. A perusal of asylum annual reports shows, for example, that one voluntary patient was admitted to Gartloch District Asylum,



Glasgow in 1903. Voluntary admissions to the Argyll and Bute District Asylum (ABDA) did not rise over one voluntary patient per year between 1881 and 1885. After this date, no more voluntary patients were admitted, potentially due to the need to keep overcrowded wards free for certified pauper patients.

This small number of pauper voluntary patients differentiates from a study of voluntary admissions to a Parisian asylum. Patricia Prestwich found that half of voluntary patients admitted to the Sainte-Anne asylum between 1876 and 1914 were non-paying patients.<sup>12</sup> The differences in committal procedures between Scottish and French asylums is influential in the higher number of non paying voluntary patients in France. Here, asylum admission was stigmatised because the Prefect of police administered the committal of people perceived as a threat to public safety.

People were taken first to the central police detention cells and then if deemed insane, were transferred to the Sainte-Anne asylum. In order to reduce the construed link between mental illness and criminality, French physicians were influential in introducing the *placement volontaire* in 1876. Relatives or friends could place a person in an asylum without police involvement and could withdraw the patient at any time. As such, the percentage of voluntary patients in Prestwich's study was far higher than Scotland, accounting for nearly 30% of admissions by 1910.<sup>13</sup> In Scotland, asylum committal was not linked to the police department except in the case of the 'dangerous or criminally insane'.<sup>14</sup>

The Crichton Royal Institution, Dumfries (CRI) illustrates voluntary admissions to a Scottish Royal asylum between 1891 - 1908. (Although it would have been useful to include figures up until 1914, the bound annual reports of Scottish asylums do not

continue until this date). Table 6 highlights that voluntary admission to the CRI accounted for nearly 35% of total Scottish asylum admissions in 1894. These figures tie in with Prestwich's findings of the proportion of French voluntary patients. This large proportion of voluntary patients from the CRI shows that voluntary admissions were not evenly distributed across other Scottish asylums. In support of this, Commissioners highlighted in a circular to superintendents that voluntary admissions were at the discretion of the superintendent (see appendix eight).

Table 6  
Proportion of CRI voluntary admissions to voluntary patients  
admitted to all Scottish asylums (1891-1908)

Year	Voluntary	CRI Vol. Admissions	% of CRI to total
1891	77	19	24.7%
1892	73	16	21.9%
1893	90	23	25.6%
1894	63	22	34.9%
1895	87	29	33.3%
1896	87	28	32.2%
1897	86	18	20.9%
1898	88	24	27.3%
1899	74	15	20.3%
1900	84	18	21.4%
1901	90	22	24.4%
1902	79	14	17.7%
1903	70	14	20.0%
1904	66	17	25.8%
1905	96	19	19.8%
1906	103	28	27.2%
1907	120	21	17.5%
1908	106	28	26.4%

Table 7 on the next page highlights the proportion of voluntary to total admissions to the CRI between 1891 and 1908. The percentage of voluntary to total admissions ranged between 3.8 and 17.1% and averaged nearly 10% of total admissions between 1891-1908. Co-incidentally, the decline in total admissions to the CRI also disputes Scull's assertion of Victorian asylums as overcrowded warehouses.

Table 7  
Proportion of CRI voluntary admissions to CRI total admissions (1891-1908)

Date	CRI total admissions	CRI voluntary	% of vol. to total admissions
1891	412	19	4.6%
1892	423	16	3.8%
1893	366	23	6.3%
1894	352	22	6.3%
1895	282	29	10.3%
1896	235	28	11.9%
1897	213	18	8.5%
1898	176	24	13.6%
1899	180	15	8.3%
1900	159	18	11.3%
1901	208	22	10.6%
1902	189	14	7.4%
1903	201	14	7.0%
1904	172	17	9.9%
1905	199	19	9.5%
1906	164	28	17.1%
1907	192	21	10.9%
1908	182	28	15.4%

Prestwich argues that so-called 'voluntary' admission did not involve the consent of the patient.<sup>15</sup> The extent to which Scottish voluntary patients were 'voluntary' is also questionable. The circular sent by the Scottish Commissioners in 1892 suggested

Persons who have entered asylums as voluntary boarders are not infrequently found to be in a condition requiring certification and compulsory detained and often regard themselves, not unnaturally, as having been entrapped by the procedure, and feel a sense of resentment at their voluntary action having been, as it seems to them, taken advantage of to secure their confinement.<sup>16</sup>

The comments imply that a patient could be persuaded to enter an asylum on the pretext of a voluntary status but it would then be revoked to certify the patient. The circular suggests a feeling of 'entrapment' when the individual has been compulsorily detained. Case B in appendix three shows that E.B. was admitted to the CRI as a voluntary patient on December 22<sup>nd</sup> 1884. On December 27<sup>th</sup> the patient was certified

and compulsorily detained. It is apparent that the patient was not told that she had been certified until her final discharge.

22.12.86           ...She is very much agitated on learning that she was now a certified patient and that her husband and daughter have gone to the continent. She now however is becoming more reconciled to the facts, though is still much aggrieved at the way in which her relatives have berated her.

Discharged.

Her notes imply that her husband had an influential role in her initial admission and discharge when she was in the CRI. Throughout her stay, the patient was discharged on probation on a number of occasions. In October 1886 she was discharged but had been brought back to the institution by her husband in the following month.

Prestwich argues that families were vital in the committal of a voluntary patient to the Parisian asylum.<sup>17</sup> It is certainly likely that Scottish voluntary committal was one of persuasion by other family members. This would tie in with more recent research that asserts the importance of the family in committal.<sup>18</sup> Of further interest would be whether the family was the main player in committal of voluntary patients, or if admission was a result of friends' or medical influence. The role of parochial board and the Inspectors of the Poor in preventing the committal of voluntary pauper borders to District asylums may also be questioned. Prestwich argues that in the Sainte-Anne asylum, the patients who were committed by their family had a significantly higher rate of release.<sup>19</sup> A systematic study of Scottish voluntary admissions that included length of stay and outcome could either support or dispute these findings in Scotland.



### Patient Resistance

Although families might have seen the asylum as a necessary resort, it is unlikely that the patients agreed.<sup>20</sup> For asylum patients, there were methods of rebellion in order to protest against their removed liberty. An indicator of patient resistance was an unwillingness to work and attempts by doctors to encourage activity was explored in the previous chapter. Walsh notes that disruption and disobedience was a common occurrence by patients at the Connaugh District Lunatic asylum, Co. Galway.<sup>21</sup> Scottish asylum case notes frequently show that patients were often aware of their surroundings and refused to bow to the physician's authority. The case the CRI patient A.G.S 'protests against being kept in this "damned democratic hole" and expresses his intention of burning it to the ground' (see Case C, Appendix three). M.G. or O.'s state on admission to Gartloch asylum in 1901 was noted as resistive, and refusing to talk.

Sept 4<sup>th</sup>           ... most markedly resistive. She won't sit, stand, lie down, dress undress etc.. She is filthy and lousy. She is not noisy but is in a very excited condition and yet very stupid. She won't speak at all. Her strength is very considerable and she is very obstinate.<sup>22</sup>

The husband was influential in the admission of his wife and although the patient did show delusions and violence towards her partner, the reasoning for committal by the husband is of interest. A reference made to his wife's 'loose' life and husband stated that the patient's unborn child was not his. The child was born shortly after admission and removed from the mother's care.

Removal to the asylum from prison was an unquestionable lack of individual autonomy. On March 6 1907, E. T. (a 22 year old domestic servant) was transferred to the CRI from Dumfries prison (see *Dumfries Courier* 6/3/07). Prior to her prison sentence, the woman was in the local poorhouse under the Vagrancy Act. The woman had previously been in the CRI and her arrest was a consequence of a threatened

suicide attempt in a local chemist. She was sentenced to 14 days imprisonment for a breach of peace.

#### LIVELY SCENES IN DUMFRIES

##### YOUNG WOMAN THREATENING SUICIDE

There was a series of scenes on the streets of Dumfries on Saturday morning, caused by a young woman with her hair hanging down her back, who had that morning been released from prison. Her name is Lizzie T. and as was recently reported in these columns she was the victim of an extraordinary case in connection with which Patrick Foley, a labourer, was sentenced to 6 months imprisonment. The girl has been creating little excitement for sometime owing to losing her situation as a domestic servant. She had fallen into rather poor circumstances and was for a time in the poorhouse, then under the Vagrancy Act she was sent to prison.

On Saturday morning after she was released she went into a chemist shop in High Street, and asked to be supplied with some carbolic acid, but in view of her curious attitude, and some remarks passed, the attendant refused supply. The girl then asked for some different kinds of poison, and on these also being refused she produced a newly bought razor, with which she threatened to "finish the job on the spot". The attendant telephoned for the police, and anticipating his intentions the girl bolted. She wended her way towards English Street, followed by crowds of children, and creating much alarm by her gesticulations with the razors. She was ultimately arrested and taken to the Police Office, where she was examined by Dr Hunter who said she was not an insane person but highly hysterical. She stated that she belonged to Langholm and had friends in Hawick to whom she wanted to go, and in proof of her Border origin shouted some lines of "Teribus" with "terrible" vim. As to the purchase of the razor that morning she said she bought it as a present for her brother next time she saw him, and rambled on in confusing fashion. Later in the day she was brought before Bailie Thomson on a charge of committing a breach of the peace, and after much shouting and gesticulating to the amusement of the court, she pleaded guilty and was sent to prison for 14 days.<sup>23</sup>

Two days into her sentence, the woman was transferred to the CRI. Her medical certificate highlighted that 'she has been so violent as to require severe restraint and that she threatened suicide'.<sup>24</sup> On admission to the CRI her notes state the forced nature of her committal.

Patient was quiet when first seen on admission then when she knew where she was she yelled out "I'm not insane!" "My master took advantage of me in the absence of his wife!" She then yelled and lay down on the floor and it was with the greatest difficulty she could be taken through to the female side.<sup>25</sup>

The case also shows up the lack of control possessed by asylum doctors over such cases. The woman had been moved to the CRI for threatening suicide at the prison. However, as she had not been certified under the Lunacy Act, she was discharged from the CRI at the end of her prison sentence. Within a few months however, she was re-admitted to the CRI where she remained until 1922.

The nature of asylum admission meant that many patients were sent there against their will and as a result, opposed asylum treatment and confinement. Although there was not a high percentage of forced admissions, i.e. from prison, patients protested equally if their admission arose from family action. In line with recent historians it is therefore suggested that non-medical groups played an active role in persuading an individual to enter an asylum for treatment

### The 'Open Door' Policy

The 'open door' policy was described by contemporaries and since as a distinct feature of the Scottish asylum system.<sup>26</sup> 'Open door' advocates saw the policy as a progression from the non-restraint system and a truly liberal method of treatment. Commissioners heralded that

Liberty has in one form or another been the most prominent of all the reforms which have taken place in modern times in the management of the insane.<sup>27</sup>

In its early years, some Scottish asylums implemented the policy of 'open doors' where ward and outside doors were unlocked and airing courts were abandoned. The 'open door' policy was first exercised in Britain in the 1870s at Fife and Kinross District Asylum (FKDA) where its then medical head John Batty Tuke was an ardent supporter of the scheme. Other asylums, which unlocked doors, included the Midlothian and Peebles District Asylum and Saughton Hall Asylum, Edinburgh in the 1870s. Woodilee

in Glasgow under James Rutherford was the first to open with all doors unlocked in 1875. As such, the asylum was subject to both national and international scrutiny by the medical press.

How 'unlocked' were asylums with 'open doors'? Unsurprisingly, all asylum ward and outside doors were locked at night. Woodilee was exceptional in that all doors (both ward and main door) were unlocked throughout the day. At Woodilee, although doors to the wards did not have *locks*, there was no inside handle to the dormitories and single rooms (presumably to prevent escape during the night or during periods of seclusion).

Entrance to all the rooms single and associated dormitories is gained by turning a single handle, but these doors once shut cannot in most instances be opened from the inside, there being no knob, especially in the single rooms...outer doors open and shut freely from both sides.<sup>28</sup>

In 1880 it was reported that the FKDA had only two locked wards (one for 20 patients and one for 30 male patients). Although Scottish Lunacy Commissioners boasted that by 1900, the open-door system was adapted to 'some extent' in most of Scotland's asylums, they also admitted that it had never come into general use. By the early twentieth century, the evolution of the segregation system meant that 'open doors' were only used in villas/wards for 'trustworthy' patients who were close to release (see chapter nine).

While the Commissioners urged 'open doors' at all asylums, its application depended on the individual medical superintendent's interest. Yellowlees of Glasgow Royal Asylum opposed Rutherford's support for 'open doors'. Andrews highlighted that Yellowlees dismissed the use of 'open doors' as pretence and retained locked wards and



walled airing courts at Gartnavel Royal in Glasgow.<sup>29</sup> Yellowlees annual report for 1887 stated

As the asylum is intended for the care of insane folk, there is no pretence of keeping 'open doors' and no affectation of unreal liberty.<sup>30</sup>

There was a history of hostility between Rutherford and Yellowlees. The two men were openly scathing of the other's practice and commonly criticised each other at *MPA* meetings.<sup>31</sup> An anonymous American doctor visiting Scottish asylums in the early 1880s highlighted that 'it was amusing and suggestive to observe the differences of opinion between the two medical superintendents' [Rutherford and Yellowlees].<sup>32</sup> Andrews also points to the tensions in Glasgow between Yellowlees at the Royal asylum and district/parochial asylum doctors. This resulted in part from Yellowlees removal of all pauper patients at the Glasgow Royal Asylum to district asylums such as Woodilee.<sup>33</sup>

Criticism did not just come from Rutherford's old sparring partner. Although Rutherford's policy of 'open doors' gained him points with the Commissioners in Lunacy and a promotion to the Crichton Royal in Dumfries, his support for liberty and manner in which he attained the new CRI post received criticism.

it would have been much more satisfactory had the appointment to which he succeeded been advertised as vacant and had he been elected to it after an open competition...the medical profession, the relations and friends of the inmates and the public have good ground of complaint against the governors of the CRI for the manner in which they've filled up the recent vacancy...<sup>34</sup>

The *Lancet* questioned the responsibility of Rutherford's organisation of shooting parties for CRI private male patients.<sup>35</sup> Further criticism was made by the medical paper when a patient committed suicide while on a shooting party in 1885. The *Lancet*

was quick to condemn the incidence, describing the occurrence as 'double barreled madness'.<sup>36</sup>

Contrasting medical practices of medical superintendents are demonstrated by managerial changes at Woodilee. Comparable differences can be drawn between James Rutherford and his successor Robert Blair at Woodilee. After Rutherford's promotion in 1883, Blair was appointed as medical superintendent to Woodilee. Blair had previously worked at the Glasgow Royal under Yellowlees and the 'open door' policy underwent a decline with Robert Blair, although it was not completely abandoned. An American doctor visiting Woodilee in 1888 commented

I found nearly all the doors on the male side open and but a few of the patients indoors, nearly all being out at work. On the female side the doors were either locked or the patients were out on the lawns under charge of attendants.<sup>37</sup>

Although plausibly influenced by his old boss Yellowlees, an escape and death by a patient may also have forced Blair to lessen the number of 'open doors'. In the first months of Blair's appointment, a female patient had escaped from Woodilee and was killed on the local railway line by a passing train. At the inquiry, the public prosecutor had indicated that should a similar instance occur, an inquiry would be made into negligence at the asylum.<sup>38</sup>

In response Blair heightened the fence between the asylum and railway. This move was commented on unfavourably by both the Commissioners and the medical press.

The commissioners are ...are not happy about the prospect of heightening the fence between the ground and the railway. How does this sound in an asylum which used to take the lead in experimental administration. Perhaps Dr Blair thinks that enough has already been done for fame and that it is now time to increase safeguard and tighten discipline....<sup>39</sup>

However, Blair was also supported for his action. An American visitor to Woodilee in 1888 described it as a 'model institution' and suggested that the 'open door' system practised by Rutherford at the CRI to be little more than a 'simple mockery... a delusion and a snare'.<sup>40</sup>

This allusion to the 'open door' system as a mockery raises the question of how liberal 'open doors' actually was. In the asylum, the most logical barrier to escape was the surround of a high fence or wall. Andrews argues that Commissioners campaigned tirelessly to remove 'prison-like' features of asylums such as the high boundary walls<sup>41</sup>. A number of Scottish asylums were constructed without asylum walls after 1857. Woodilee was built without a surrounding wall although it has been noted that there was a high fence between the institution and the railway line. Haddington asylum near Edinburgh opened in 1866 without a surrounding wall.<sup>42</sup> Yet walls did remained and the Commissioners' criticised Roxburgh District for their new asylum built with boundary wall in 1875.<sup>43</sup> Even under Rutherford at the CRI, the high wall around the institution remained, most likely at the instigation of the asylums' governors. It was reported in the 1880s that 'the whole grounds are enclosed by a high stone wall, which it is not supposed that patients can surmount' at the CRI.<sup>44</sup> Unsurprisingly, Yellowlees at Glasgow Royal retained a boundary wall at the asylum.

Another suggestion is that asylums practising 'open doors' used high levels of sedatives. Andrews proposes that the issue of non-restraint and liberty was influenced by 'chemical restraint' and that critics of 'open doors' accused superintendents such as Rutherford of using excess sedatives.<sup>45</sup> The use of drug therapy in asylums is charted in chapter two and it was highlighted that drugs such as sedatives were used in asylum treatment by the late nineteenth century. There is no direct link between increased sedative use and asylums that practised 'open doors'. A visitor to CRI in 1887 highlighted that 'narcotics are used to a limited extent'.<sup>46</sup> Another visitor to Woodilee commented in 1882

Dr Rutherford is a strong believer in the *vis medicatrix nature*. Only a small proportion of his patients take a sleeping draught at night and stimulants are very sparingly employed.<sup>47</sup>

Similarly, visiting Commissioners to Woodilee during Rutherford's superintendence commented continually that 'stimulants and narcotics are practically in disuse'.<sup>48</sup>

Alternatively at Woodilee, patients were occupied all day in work and were under the strict attention of attendants and nurses. The previous chapter documented Rutherford's discipline of a 'full working day' in order to control large numbers of patients. A strong element of 'open door' life was staff diligence and the system shows some analogy with Foucault's description of the 'model' attendant. According to Foucault,

The keeper intervenes, without weapons, without instruments of constraint, with observation and language only; he advances upon madness.<sup>49</sup>

Commissioners reported in 1880 that

It becomes necessary that he [the attendant] should keep himself aware at all times of where and what they [patients] were doing...The relations of an attendant thus assume less of the character of a goaler and more the character of a companion or nurse.<sup>50</sup>



Of course, the commissioners' ideal did not necessary filter down to all asylums. Restraint and seclusion remained in asylum culture and the numbers of asylums with unlocked doors had declined by the twentieth century.

In the asylums that did have unlocked doors, patients were never out of the sight of attendants. A visitor to Woodilee in 1882 observed

... that a patient in one of the sitting or day rooms who attempted to leave, was met at the door by a vigilant attendant, who did not resign his or her charge of the patient, until the responsibility had been turned over to some other attendant either upon the lawn or in one of the shops or numerous work parties<sup>51</sup>

Annual reports do not state an increase in the numbers of attendants employed. Batty Tuke who practised 'open doors' at both the FKDA and private Saughtonhall in Edinburgh did not believe that it resulted in an increase number of employees.

As far as my experience goes, it involves no increase of expense...I have never added to the staff in consequence of its adoption.<sup>52</sup>

However contemporaries construed the continual presence of the attendant as a false liberty.

My observations did not impress me favourably on the question of open-doors as the system was practised in the institutions I visited...At Woodilee and the Crichton ... where the doors were left unlocked the patients were either out of the ward under the charge of attendants, or were not allowed to leave the ward when inside, the attendants keeping the door constantly in view.<sup>53</sup>

The English superintendent J. A. Campbell criticised the practice arguing that 'if the door though open, is guarded, it is merely reproducing the sufferings of Tantalus'.<sup>54</sup>

The practice of 'open doors' was regarded as a distinct feature of the Scottish asylum system and generated both national and international interest. Despite its promotion by the Commissioners in Lunacy, its use varied between medical superintendents, who

were concerned about the implications of increased liberty for asylum patients. By the early twentieth century, 'open doors' were mainly in the 'parole' villas of asylums and even the 'model' Woodilee had abandoned its full 'open door' policy. Although asylums did not increase physical or chemical restraint where 'open doors' were practised and the numbers of attendants were not increased, patients were not out of sight of the attendants and participated in organised working parties.

### Probation and Parole

The use of probation and parole for asylum patients draws parallels between the prison and the asylum system. According to Foucault, the model prison was a process of reform and model of discipline.

...the self evidence of the prison is based on its role supposed or demanded ,  
As an apparatus for transforming the individual...it was from the outset a form  
of legal detention entrusted with an additional corrective task...In short,  
penal imprisonment from the beginning of the nineteenth century covered both  
the deprivation of liberty and the technical transformation of individuals.<sup>55</sup>

In the 'model' prison, the patient's will was firstly broken through confinement and solitude. The prisoner then progressed to participation in work in order to restore proper habits and to make him/her a productive member of society. As prisoners 'reformed' they were granted a series of privileges, which culminated in a ticket of leave (later probation). In Britain, the ticket of leave was the final process of the prisoner's penal servitude and was given as a 'reward' for good behaviour. Parole was less common because it released the prisoner temporarily *before* the sentence expired. Parole was popular among prison officers if only because it could be used as a reward for good behaviour.<sup>56</sup>

To assess the extent of probation and parole in depth across the whole of Scotland is problematic as there is a lack of explicit sources such as probationary registers. This perhaps clarifies why so little research has been conducted into the topic and is generally passed over in the existing literature. In this research, a probationary discharge register exists for the CRI and a register for probation and parole at the Ayr District Asylum (ADA). National figures for probation are included in the Commissioners' reports. The use of parole for patients on pass (28 days probation) is included in the ADA register. Although case notes frequently refer to the use of parole issued on a day to day basis (i.e. as a reward or incentive), no official figures exist for this type of parole. Beveridge highlights that similar 'notes of stay' are often under-recorded in the casenotes, so it is impossible to provide accurate statistics to their use.<sup>57</sup>

Like the prison system, liberation on probation in asylums took place on the patient's official release from the asylum. Under the same Act that extended admissions to voluntary patients, a patient could be returned to the asylum without new medical certificates if he or she broke the terms of probation. The period of probation was up to one year. Table 8 refers to the number of entries in the registers of probation for the CRI and ADA and compares these figures with those for whole of Scotland. Over 15 years between 1890 and 1904, 177 entries were made in the ADA's register. In comparison, 220 entries were included in the CRI register. Contrasting trends are apparent in the two institutions. Whereas the number of probationary discharges increased over 15 years at the CRI, the figure was in decline at the ADA.

**Table 8**

**Comparison between probationary release from all Scottish asylums with the CRI and ADA (1890-1904)**

Date	Total	ADA	% of total probation ADA	CRI	% of total probation CRI
1890	105	19	18.1	2	1.9
1891	137	25	18.2	3	2.2
1892	106	15	14.2	5	4.7
1893	141	8	5.7	5	3.5
1894	172	14	8.1	14	8.1
1895	138	22	15.9	10	7.2
1896	148	19	12.8	27	18.2
1897	109	11	10.1	16	14.7
1898	123	5	4.1	17	13.8
1899	136	10	7.4	21	15.4
1900	134	6	4.5	25	18.7
1901	152	10	6.6	14	9.2
1902	139	6	4.3	26	18.7
1903	163	4	2.5	19	11.7
1904	149	3	2.0	16	10.7
Total	2052	177	8.6	220	10.7

While probation was a central policy, not all asylums utilised probation. Of the 20 plus asylums in Scotland by the early twentieth century, table 8 shows that the ADA alone accounted for over 8% of total probationary releases and the CRI for 10%. The figures included in table 8 span most of James Rutherford's superintendence at the CRI and even Rutherford did not use probation consistently throughout.

A main use of probation was to relieve asylum wards during periods of overcrowding.

In a visit by the Commissioners to the CRI in 1896 it was reported

that there are pauper patients at present in the asylum who could be safely and properly treated out of an asylum and that it is desirable that the overcrowding should be as far as possible relieved by the removal of these patients.<sup>58</sup>

The majority of patients given probation were often harmless and incurable patients.

This is supportive of Andrews' view that probation was recommended by the General Board of Lunacy to Superintendents, only for incurable and harmless patients.<sup>59</sup> This



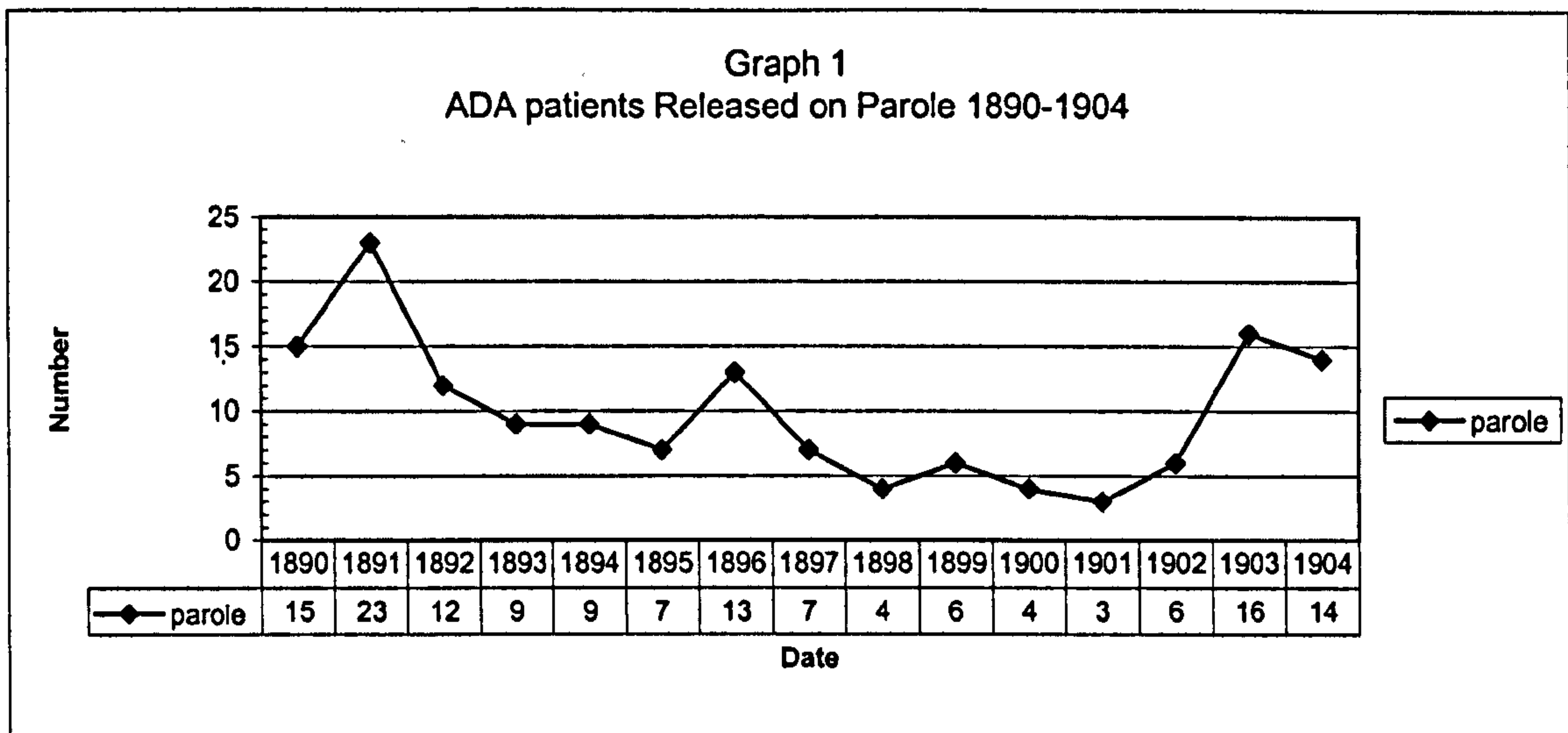
use of probation is similar to the Australia system for transported convicts. Here, the ticket was not given on the basis of good behaviour but according to the convict's chance of self-sufficiency.<sup>60</sup>

Table 8 crosses over the two superintendencies of Charles Skae and Charles Easterbrook at the ADA. When Easterbrook was appointed superintendent after 1902, the use of probation declined. This is attributable to Easterbrook's development of classification and segregation at the institution. In this system, accommodation was provided in the asylum grounds for 'trustworthy patients'. Easterbrook's report on accommodation (1902) on patient classification at the asylum noted the category:

*Trustworthy able-bodied:* these include all quiet harmless chronic cases and convalescent curable patients who have recovered sufficiently to be trusted. All are able to work, either outdoors or indoors, and work perhaps forms their chief medicine. They are the patients who may be trusted with the parole of the grounds, who live in wards with 'open doors' by day and sleep without supervision at night.<sup>61</sup>

Although trustworthy patients were housed in less secure accommodation, they were not considered as probationary discharges.

A further type of probation was parole on a 28-day pass. In the ADA register, details are included of 28-day parole. Graph 1 shows that 148 patients were given parole *outside the asylum grounds* (i.e. at home) between 1890 and 1904. As shown in the graph, the number of patients released on parole at home never rose above 20 (less than 4% of the patient population) on an annual basis. These figures correspond with Andrews' argument that like probation, discharge on parole was limited in numbers.<sup>62</sup>



The registers of probation do indicate how many times a patient was released on probation. Examining details of patient who were returned to the asylum helps indicate *why* probation was used for release. Table 9 shows that the majority of probationary patients were released on only one occasion and not readmitted in the period of James Rutherford's superintendence 1884 to 1907. Table 10 also shows a similar pattern at the ADA where nearly 80% of patients who were released on probation did not return.

Table 9: CRI patients  
Number of Times Liberated on Probation (1885-1907)

No. of times liberated (including final discharge or death)	No.	%
Eleven times	1	0.3
Five times	1	0.3
Four times	1	0.3
Three times	4	1.1
Readmitted once before release	49	14.1
Once (but died after readmission)	36	10
Once (not readmitted)	261	73.9
Total	353	100.0

Table 10: ADA patients  
Number of Times Liberated on Probation and Pass (1885-1907)

Number of times liberated (including final discharge or death)	No.	%
Eight times	1	0.2
Four times	2	0.4
Three times	6	1.3
Two times	12	2.6
Once (readmitted)*	72	15.7
Once (not readmitted)	367	79.8
Total	460	100.0

\*Not stated if the patient died after readmission.

The probationary registers also help dispute Scull's view that by the late nineteenth century, asylums were filling up with long stay patients. Recent statistical analyses of British asylums show that patient turnover was more fluid than previously thought.<sup>63</sup> The following table 11 highlights the average length of stay for patients who had been readmitted to the asylum after losing their probation (including multiple releases) at the CRI. The probationary register did not include the admission date for patients who were not returned from probation, so that it has not been possible to include this group in the figures. Nearly 30% of the patients remained in the asylum for less than two years after return from their probation. As the final discharge date is not included in the ADA register, it is not possible contrast length of stay here.

Table 11: CRI  
Length of stay for re-admitted patients(1885-1907)

Length of stay	No.	%
0.3	1	1.1
1	12	13
2	14	15.2
3 to 5 years	13	14.1
5 to 7 years	10	10.9
7 to 10 years	8	8.7
10 - 15 years	11	12
15 to 20 years	5	5.4
20 to 25 years	3	3.3
25 to 30 years	8	8.7
30 years +	7	7.6
TOTAL	92	100.0

For some medical superintendents, probation was a method of testing the patients' suitability for release. Although it is unclear how many medical superintendents practised this, both James Rutherford at the CRI and ADA superintendent Charles Skae utilised probation for alcoholic or other 'untrustworthy' cases as a way of testing the patient's self control. Table 9 has shown that around 25% of CRI probationary patients were returned to the institution after readmission. Although 36% of this figure died before they could be released again, nearly 16% of patients were re-released on probation and the remainder were discharged as recovered or relieved. Closer scrutiny of readmitted patient notes to the CRI show that a relapse to drinking was the most common reason for the revoke of probation.

The figures for ADA readmission were slightly less, accounting for approximately 20% of returns (see table 10). The superintendent Skae utilised pass on for 28 days to see if a patient could manage outside the asylum without drinking. E.D. (male patient) was liberated on pass for 28 days in August 1895 and when this expired it was extended to six months probation. However, in October he returned to the asylum as

he has been "drinking" heavily...Acknowledges that he had been drinking and said he couldn't help it.<sup>64</sup>

The patient was discharged as recovered the following February. J.C. admitted in April 1894, was liberated on pass for 28 days in July 1896. He was brought back to the asylum two weeks late as 'he had again been drinking'.<sup>65</sup> This use of probation as a test of release ties in with the Foucauldian perception of the prison as a final stage of reform where release was subject to the continued moral behaviour of the patient.<sup>66</sup>

Although the use of multiple probation was not a common phenomenon, it highlights problems in handling alcoholism within the asylums. The vast number of patients



discharged on probation and the CRI were released on no more than one or two occasions. 'J.A.' was admitted to the ADA in 1894 and was released from the asylum on no less than 8 occasions between 1894 and 1901.

He has for many years been greatly addicted to drink and for 20 years was very frequently in the asylum, frequently being absent on probation, but constantly lapsing before the year's probation expired. It is however five years since he was last here. He has for some months past been behaving strangely, becoming at times very excited; but it could not be ascertained whether he was drinking or not.<sup>67</sup>

On each occasion the patient was released on one year's probationary period. On four occasions the patient made it through probation and gained permanent release from the asylum as a relieved case. Yet on all occasions the patient was later returned to the asylum or did not complete the probation period. His case notes highlight alcoholic relapse as the main reason for his return.

29 Nov 1895                      Was brought back today. He had been drinking it is said and creating a disturbance.

21 April 1897                    Re-admitted...he had been working steadily and doing very well till last week. He then began "drinking" again and became very excited.<sup>68</sup>

In 1901, 'J.A.' disappeared from the register after the final probationary release. It is unclear if he succeeded in stopping drinking or had died before he could be permanently released from the asylum.

A further example of alcoholic relapse was 'W.S.' at the CRI. Admitted in 1895, the male patient had previously been in the institution in 1892 and 1894, suffering each time from alcoholism. In August 1895, 'W.S.' was released on probation.

15 Oct 1895                    Mr S. was brought back today he states that he did not taste drink until the fair but that since then he has practically been drunk every day. He is very persistent and was not 10 minutes before he had begun to make good resolutions that he did formerly. Begged us not to think too badly of him.

24 Oct 1895                    Mr S is alright once more. Very much ashamed of his recent behaviour he is promising great achievements in the future.<sup>69</sup>

The patient was released on probation a further five times before his eventual permanent release. Throughout this period, the patient declared he would never touch drink again and signed the 'pledge' for two years.

Although excessive probation was not common practice, the issue of alcohol and mental illness was at the forefront of medical debate in the late nineteenth and early twentieth centuries. The term alcoholism had been coined in the 1850s and was a model for degeneration in that it combined moral and physical symptoms, was rife in the working classes and demonstrated a decline of good character. Contemporary medical opinion was divided as to whether alcoholism was a disease or was a moral weakness. Medical attitudes to patients with alcohol problems were not typically sympathetic and linked alcohol indulgence with loss of self-control. A shared medical belief was that the asylum was not a suitable place for the treatment of alcoholism. Clouston disliked treating alcoholics in his asylum because they resisted cure.<sup>70</sup> Not until 1898 were Inebriate Homes established under the 1898 Habitual Drunkardness Act. However, an individual had to be convicted of drunkenness on more than four occasions per year before being placed in a Home, under the terms of the 1898 Act.

The admission of alcoholic patients to Glasgow asylums was of concern for the Woodilee head Hamilton Clelland Marr around the turn of the century. The pages of this institution's annual reports were littered with this issue.

In 31.8% of the patients admitted, there was a history where alcohol excess played the chief part in the causation of insanity. One feature brought out on analysis of these cases shows that many of the patients began to take alcoholic liquors as early as 12...when the nervous system is most impressionable, and the impressions made on it have immense importance of the future moral and intellectual welfare of the individual.<sup>71</sup>

In 1903, a committee was set up to inquire into alcoholism at Gartloch and Woodilee asylums in Glasgow. Its findings suggested that nearly one third of admissions to the asylums resulted from 'alcohol indulgence'.<sup>72</sup> As with many other asylums, a register of probation has not survived so it is not possible to gauge the extent that Marr used probation.

On the one hand, the committal of people with alcoholism ties in with the Foucauldian theory of social control and Scull's argument that the casting out of undesirables from society was partly fuelled by family desire.<sup>73</sup> Scull suggests that the presence of the asylum *created* demand and was a socially accepted dumping ground for unwanted friends and relatives.<sup>74</sup> Recent research has long stressed the importance of the family in the process of committal.<sup>75</sup> This helps challenge the Foucauldian view that the nineteenth century physician '...becomes the essential figure of the asylum [and] he is in charge of entry'.<sup>76</sup>

The role of the family in committing or returning a patient to the asylum is consistently telling in casebook letters and notes made by the doctors. It is possible that some families used the asylum as a 'convenient' place to put a 'difficult' relative. Yet letters written by relatives show up the dilemma often faced in committing a family member to an asylum. C.A.D was admitted to the CRI in June 1891 suffering from 'epilepsy and alcoholism'. In December 1892 his wife wrote to James Rutherford.

Every article of value he or I possessed carried off secretly...there is a public house in Edinburgh where I am told they have a most valuable collection of his sketches, given for drink...He even drank furniture polish. All our friends said the only way to save his life was to put him where he could get no drink... if he were free again I believe he would kill himself within a few weeks.<sup>77</sup>

Admitted to Woodilee in 1898, the patient J.R. had a history of alcoholism. A letter written by his wife after his admission highlights that he had previously been in the asylum.

...I have very good reason to remember your words that we would have trouble with him. To begin with he did very well, got into a situation but only kept it for one week. Started in another but only kept it one day...He had not started to drink at this time so I did not know of any reason for dismissal... he got a situation in Belfast, but didn't get any work, returned in fearful condition. Singing hymns, cursing and swearing...eventually with over work and worry my health seems to be breaking up and I could not stand it any longer. In fact, I have lived with a madman for nine years...<sup>78</sup>

Such examples demonstrate that alcoholic relatives were usually committed when family members were no longer able to cope with their partner's erratic behaviour.

Of course, alcohol was not the only reason for return from probation and it is probable that a number of patients and carers were unable to cope when outside the asylum. The following examples are taken from the ADA. The male patient D.G. was liberated on probation in July 1895 but was returned to the asylum in the following September.

He had again become very excited and threatened to kill the nephew with whom he was staying. On admission he was very excited and violent but this soon passed off.<sup>79</sup>

T.M. had been liberated on parole for one year in June 1896 but was returned to the asylum in September after threatening suicide.



14/9/96 Brought back today. He had been quite certain that as soon as he got home he would get back to his old employment. Being disappointed in this he brooded much and yesterday went into the water cistern in his house and remained there several hours but apparently his courage failed him in his desire to drown himself. He is very depressed he says himself at being brought back here and implores to be at once sent home again.<sup>80</sup>

The patient was discharged as recovered in March 1897. The female ADA patient B.K. was returned from probation in September 1896 in 'a very excited condition...Is violent and expresses many delusions and hallucinations about her intimate acquaintance with the devil'.<sup>81</sup> The case of C.M. in appendix seven highlights his return because he could not be managed at home (see letter 5).

The use of parole in the asylum grounds or as a day pass for a reward for 'good behaviour' was very common. No national figures are compiled for this type of parole, mainly because it could be given and removed on an ad hoc basis. Anne Digby highlights that moral management was a two way process that involved the imposition of a moral discipline and the development of a self-control by the patients.<sup>82</sup> Similarly, the use of parole as a reward in the asylum parallels the prison regime. Morris and Rothman argue that parole was popular among prison officers because it could be used as a reward for good behaviour.<sup>83</sup> A difference in the use of asylum parole was that parole was not typically a final stage before the patient's release. In the asylum, parole was used throughout the patient's stay and could be given and taken away several times. The punitive nature of the prison makes it unlikely that prisoners were given similar liberties.

The most detailed descriptions of parole occur when patients broke the terms of the practice. E.B. was given parole at the CRI in December 1885 but this was taken away in the following February because of her drinking.

21.12.85            She has outside parole and pocket money but has never abused the privilege.

She attends the amusements and enjoys a hand at whist.

14.2.86            Mrs B.'s parole has been stopped (a month ago) owing to her coming home on two or three occasions with appearance of drink. She grumbled and was very low-spirited for a week after the withdrawal of her privileges but is now quite cheerful again.<sup>84</sup>

Similarly, 'E.D.', a male ADA patient was liberated on pass for 28 days in August 1895.

After successfully completing the parole period, he was granted a year's probation. By the end of October the patient had been returned to the asylum for "drinking heavily".<sup>85</sup> 'J.M.', an alcoholic CRI patient was granted parole in June 1908, as he is 'doing well...and gives no trouble'. In August, the patient was permitted to go on an outing with another patient and attendant.

Patient who had parole of the grounds and was doing very well was allowed to go to some sports with Mr P. (another gentleman) and an attendant. The two of them gave the attendant 'the slip' and managed to get some drink – beer they said...although not drunk, was distinctly under the influence. His parole has been temporarily stopped.<sup>86</sup>

Parole was also linked to accommodation privileges. As chapter nine shows, 'trustworthy' patients lived in wards or villas where they had parole and slept without the supervision of a nurse or attendant.

Breaking the rules of parole (even if there was no drink involved) led to the privilege being halted. The male patient 'F.A.' was admitted to Bangour Village in September 1906. The patient was deemed to have abused his parole after forming a relationship with another patient.

4/11/07            Is practically well...polishing floors in the hospital. Has been stoker and had parole till he was plotting elopement with a female patient.<sup>87</sup>

Despite the positive nature of this note, 'F.A.' was not granted release from Bangour for a further 2 years. 'M.S.' was admitted to the ADA as 'highly strung, neurotic, believes people are trying to take her money and a gentleman is attempting to poison her'. Her later parole was removed somewhat harshly as the 'patient abused her parole by sending away letters and today she was removed to the admission ward and parole stopped'.<sup>88</sup> Although patients could send letters, staff read correspondence before it was posted. (This was set down by the 1862 Act earlier referred to for voluntary patients). Some patients were not subjected to this rigour and in the notes for Case H in appendix three, the patient had 'no restriction on letters'. Another CRI patient 'Mr P' was given parole of the grounds in June 1908 with another 'gentleman'.

24 Nov            Nothing special to report about this gentleman...he has full parole of the house...he has one afternoon off a week where he usually goes to town with an attendant.

July 1909            He is polite and "useful" especially with the library but is distinctly officious (in fact he does not regard himself as a patient). Still, he has not in anyway abused the liberties that have been given to him.<sup>89</sup>

Although the patient did not break parole, the note clearly expresses the doctor's concern as to the non-submissive nature of his attitude.

Probation in asylums and prisons was alike in its use at the patient's release date. The fact that probation could be revoked at any time also shows up similarities with the prison system. Most similarities between prisoners and patients are drawn between the

use of probation for alcoholic patients, where release was a test of responsibility and reform. The use of parole also shows up parallels with the prison in its use as a reward for good behaviour. While Rutherford and Skae favoured probation and parole for alcoholic patients, Easterbrook's use of the practice declined with segregate system of accommodation. Many doctors also used probation to relieve overcrowded wards. The fact that so few parole and probation registers seem to have survived is perhaps reflective of its minimal use by other medical superintendents.

### Restraint and Seclusion

Mechanical restraint was the ultimate resort when other methods of moral management failed.<sup>90</sup> Mechanical restraint meant the coercive control of patients by means of a straitjacket, camisole or 'polka'. A patient might also be tied to the bed with the use of a sheet. These methods of restraint were deployed in cases of self-harm suicide or violence towards others. Restraint and seclusion was also used to prevent patients from removing bandages. While its practice declined as a result of the early nineteenth century non-restraint movement, coercive treatments underwent a revival in the late nineteenth century. In a comparison of Anglo-American psychiatry, Tomes argues that while the use of restraint was stigmatised in Britain by the late nineteenth century, the practice of restraint and seclusion was never completely abolished.<sup>91</sup>

Although Commissioners promoted the non-restraint movement as official policy, it is clear that they did not object to the use of restraint for patients deemed a danger to themselves or others. Their 1909 report of the CRI indicated

In the management of this large institution restraint and seclusion do not appear to be often found necessary but it is understood that they are resorted to without hesitation whenever the necessity arises.<sup>92</sup>



It is unlikely that the involved Commissioner would have objected to the use of restraint when in the ADA's inspection, the patient 'J.K.' was restrained for 'homicidal behaviour and violent threats to Commissioner Fraser during his official visit'.<sup>93</sup>

Andrews argues that Scottish superintendents were divided over the use of restraint and seclusion. At the Midlothian and Peebles District Asylum (MPDA), its medical head, Robert Cameron, publicly advocated the use of restraint and seclusion.<sup>94</sup> In 1882, Cameron published an article in the *JMS* entitled 'The Philosophy of Restraint in the Management and Treatment of the Insane'.

So long as insanity continues to exist . . . , so long will restraint of some kind be required, for it is plain that society has a right to subject the anti-social being to such restraining influences as are calculated to make him conform to its laws, and prevent him from doing that which is detrimental to its welfare.<sup>95</sup>

Superintendents such as Yellowlees viewed the right to use restraint as the expression of their right to individual practice.

As such, the use of restraint and seclusion did vary between institutions and medical superintendents. In order to reflect this, the superintendence of Charles Skae at the ADA is compared with the CRI under James Rutherford. The period covered is divided into three time bands of 5 years duration. It is not possible to separate those who were restrained from those secluded, as patients who were restrained, were almost invariably secluded.

The ADA register for 1888 to 1902 refers to 694 entries for 110 patients (see table 12 on the following page). The figures do not demonstrate an overt use of the practice. Between 1888 and 1892, 47 patients or about 9% of the asylum population were subjected to restraint and seclusion. Between 1893 and 1902 this figure had risen

slightly to approximately 12%. Most commonly, patients were restrained between one and five times. The register took note of daily restraint and seclusion. For example, if a patient was restrained daily for 16 days, then this number of entries were made in the register.

Table 12  
ADA Register of Restraint and Seclusion 1888 –1902

	1888-1892		1893-1897		1898-1902	
	Male	Female	Male	Female	Male	Female
1 time	10	6	13	7	9	7
2-5 times	10	16	14	18	13	11
6-10 times	2	1	4	3	7	8
11-15 times	0	0	0	1	3	2
16+	1	1	3	0	0	0
SubTotal	23	24	34	29	32	28
Total	47		63		60	

Although Skae's use of restraint and seclusion at the ADA was not overt, in the same period, James Rutherford used restraint and seclusion on only 60 occasions for 39 patients. Table 13 on the following page shows that between 1888 and 1902, 8 patients (or 3.3 %) were restrained or secluded. Between 1893 and 1897 this rose to 24 (nearly 10%) and between 1898 and 1902 had declined again to 7 patients or 3.7%. Typically restraint or seclusion was resorted to on only one or two occasions. Rutherford's minimal use of restraint and seclusion is not necessarily typical of other Scottish superintendents, and Skae's moderate usage is perhaps more reflective of other Scottish superintendents and in line with the Commissioners' recommendations.

**Table 13**  
**CRI Register of restraint and seclusion 1888-1902**

	1888-1892		1893-1897		1898-1902	
	Male	Female	Male	Female	Male	Female
1 time	3	4	5	7	5	0
2-5 times	1	0	3	9	0	2
6-10 times	0	0	0	0	0	0
11-15 times	0	0	0	0	0	0
16+	0	0	0	0	0	0
SubTotal	4	4	8	16	5	2
Total	8		24		7	

While levels of restraint and seclusion varied between superintendents, the reasons for its use were similar. A common use of restraint and seclusion was for a patient's attempt to exacerbate an injury (see extract 2 over leaf). The patient H.C. was restrained with gloves for 'tearing off bandages in January 1897.<sup>96</sup> The male ADA patient 'P.M.' had a sheet passed across his chest and his foot secured to the bedstead because he 'is determined and persistent in his struggles to free himself. Several times he has found to have got out of bed and to have endeavoured to walk [on a] fractured femour'.<sup>97</sup> Patients at the ADA and CRI were also restrained or had their hands tied in order to prevent the removal of dressings.

## Extract 2: CRI Register of Restraint and Seclusion (1897)

No.	Name of Patient	Form of Restraint	Form of Seclusion	Signature of Superintendent or Medical Attendant	Date of Report	REMARKS
1897						
JAN 26	William Embury	Gloves	-----	James Hutchingson	27 <sup>th</sup> January 1897	Leaving off in
27	Do.	Do.	-----	James Hutchingson	Do.	bandage
28	Do.	Do.	-----	James Hutchingson	Do.	Do.
28	Mr. Donald Young	Camisole	-----	James Hutchingson	Do.	Washing his head with
29	Catherine Jenkin	-----	Locked room during the day.	James Hutchingson	1 Feb 1897	State of excitement
31	Emily Redford	-----	Do	James Hutchingson	1 Feb 1897	Morose, restless
31	William Embury	Gloves	-----	James Hutchingson	1 July 1897	Leaving off bandage
3	James A. Ross & Barnetson	Camisole	-----	James Hutchingson	5 <sup>th</sup> Feb 1897	Great noise & noise
4	Do.	Do.	-----	James Hutchingson	Do.	to no purpose in
5	Do.	Do.	-----	James Hutchingson	Do.	Report attended

Source: CRI Register of Restraint and Seclusion, (1886-1973), DUM.CRI.1983.72.

Restraint was also used for suicidal or violent cases. The ADA female patient 'M.H.A.' 'had to be restrained' [with a polka] 'to prevent suicide'.<sup>98</sup> Coercive treatment also attempted to correct 'immoral' tendencies. The female patient M.G. was fitted with a 'jacket' in order to prevent masturbation. Likewise, 'J.S.B.' was put in a padded cell with a straitjacket on in order to 'prevent her stripping naked'.<sup>99</sup> At the end of April 1907, the CRI patient 'C.M.M.' was recorded to be 'terribly resistive and struggles most violently when she is being fed ...Still intensely restless and very bad in her habits'. A few days later her behaviour was deemed as 'depraved habits' and 'patient had to be put in a straight jacket last night...Habits are so bad that it has been necessary to put her in a straightjacket on several occasions'.<sup>100</sup>

Violence to others often resulted in restraint and almost certainly seclusion. Seclusion meant isolation in a single room or a padded cell. The ADA patient 'T.K.' was put in a locked single room 'for excessive violence and for other patients safety'. Often, violence was directed at the attendants and nurses. At the ADA the female 'J.T.' was



put in the 'pad' for consistently attacking the attendant'.<sup>101</sup> T.M. was put in a 'strong room' for threatening to murder an attendant. Rutherford was not impressed with the private patient A.G.S. when he was admitted in 1888. This was primarily due to his lack of respect for authority and his exaggerated ideas of his own importance.

6.5.88 Mr S. smashed 12 panes of glass in one of the windows of the gallery today. He showed no excitement, saying merely that he wishes to get out. He cut his finger slightly. He was kept in the padded room for the rest of the day and put on short rations. He tore his underclothing to ribbons and the straitjacket applied. This seemed to cow him completely.<sup>102</sup>

This case is useful in illustrating the variety of 'treatments' adopted by medical superintendents. As well as the short rations, seclusion and straitjacket, the patient was also subjected to a cold plunge and work with the pauper squad.

Medical superintendents who did not use restraint and seclusion did adopt alternatives. At the ADA, restraint and seclusion declined with the appointment of Charles Easterbrook as superintendent in 1903. The register of restraint and seclusion for Easterbrook's superintendence between 1903 and 1907 included only 24 entries. As an alternative to restraint and seclusion, Easterbrook practised open-air bed rest for violent patients. The use of open air bed rest (discussed in chapter six) for these cases was not common practice by superintendents<sup>103</sup>

Restraint and seclusion was never completely abandoned although some superintendents such as Easterbrook adopted alternatives such as open air bed rest. Most superintendents continued to use restraint and seclusion to a varying degree. Even Rutherford who was a strong supporter of non-restraint continued to use restraint as a final resort for severely violent or restless patients.

## Conclusion

Although the Commissioners espoused liberty as an important part of their policy, medical superintendents retained their own medical autonomy. The debate over 'open doors' highlights the opposing views of liberty. Rutherford was fully supportive of open doors and minimal restraint whereas Yellowlees campaigned to retain locked doors and restraint. Although most doctors maintained the middle ground in the use of restraint, some individuals adopted their own methods of 'restraint', such as Easterbrook's extensive use of bed rest for violent or 'problem' patients.

Committal to an asylum was akin to prison life as it meant the removal of the individual's liberty. Although asylums used parole and probation, its main use differed from the prison. Typically, asylum probation was used to relieve overcrowded wards and was intended for 'harmless' patients. In the use of probation for alcoholic patients, similarities lie between prison life and the asylum in probation's role as a test of release. Again though, not all superintendents used probation for this group. Perhaps the greatest similarity between the prison and asylum is that central policy did not always filter down to local practice. This is evident in the limited spread of 'open doors' across Scotland.

An extensive study of voluntary patient case notes is needed to fully understand the reasons for voluntary committal and the numbers who were certified after voluntary admission. In line with post Foucauldian thought, the probable role of the family in voluntary admission supports recent historiographical emphasis of this group in the asylum system. Although Scull agrees that the family was important in committal, their role was perhaps not so self advantageous as Scull portrays. Partners with violent alcoholic relatives did not see the asylum as a convenient place of disposal but as a final

resort when they were at breaking point. While Scull is right to not overplay patient autonomy, patients did resist and oppose asylum treatment and discipline. Ultimately though, patients were reliant on the physician's will in their journey through the asylum. As such, doctors were free to deploy any treatment or to remove patient liberties in order to retain their authority.

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<sup>1</sup> Dr McRae, (Medical Superintendent) in *39<sup>th</sup> Annual Report of the Ayr District Asylum*, (1909), quoted in *Minute Book of the Ayr District Lunacy Board*, (1907-09), AA17/4/6.

<sup>2</sup> O. Walsh, 'Lunatics and criminal alliances in nineteenth-century Ireland', in P. Bartlett & D. Wright, *Outside the walls of the asylum: Historical perspectives on 'care in the community' in modern Britain and Ireland*, (Althone, 1999), p.147-8.

<sup>3</sup> A. Scull, 'Rethinking the History of Asylumdom', in J. Melling and B. Forsythe (ed), *Insanity, Institutions and Society 1880 – 1914: A Social History of Madness in Comparative Perspective*, (Routledge, 1999), p.309.

<sup>4</sup> Termed by Jonathan Andrews in 'A failure to flourish? David Yellowlees and the Glasgow School of Psychiatry: part 2', *History of Psychiatry*, 8 (1997), p.343.

<sup>5</sup> M. Foucault, *Discipline and Punish The Birth of the Prison*, (Penguin, 1977), p.236-248 and M. Ignatieff, *A Just Measure of Pain: The Penitentiary in the Industrial Revolution 1750-1850*, (Macmillan, 1978), p.201.

<sup>6</sup> A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900*, (Yale University Press, 1993), p.352.

<sup>7</sup> To commit a person to an asylum in Scotland, two medical certificates were required along with a petition from either the Inspector of Poor (if a pauper patient) or a family member or friend (if a private patient). The certificates and petition were sent to the Sheriff who decided if the petition should be granted.

<sup>8</sup> *33<sup>rd</sup> Annual Report of the Commissioners in Lunacy for Scotland*, (1891), GD17/5/15.

<sup>9</sup> J. Andrews, '*They're in the Trade...of Lunacy They 'cannot interfere' – they say*': *The Scottish Lunacy Commissioners and Lunacy Reform in Nineteenth-Century Scotland*, (Occasional Publications, The Wellcome Trust, 1998), p.58.

<sup>10</sup> *34<sup>th</sup> An. Rep. of Com. in Lun. Scot.*, (1892), GD17/5/15.

<sup>11</sup> A. Babington, *Shell-Shock A History of the Changing Attitudes to War Neurosis*, (Leo Cooper, 1997), p.54 and B. Shephard, *A War of Nerves*, (Jonathan Cape, 2000), p.157.

<sup>12</sup> P.E. Prestwich, 'Family strategies and medical power: 'Voluntary' committal in a Parisian asylum, 1876-1914', *Journal of Social History*, 27 (1994), p.800.

<sup>13</sup> *Ibid.*, p.800.

<sup>14</sup> Up until 1909 'dangerous lunatics' could be sent to an asylum at the instance of the Procurator Fiscal. However, the objection of medical superintendents meant that numbers were minimal, never rising above 15 per annum. After 1909, all mentally ill persons convicted as 'dangerous lunatics' were sent to the lunatic ward of Perth Prison.

<sup>15</sup> Prestwich, 'Family strategies and medical power', p.799.

<sup>16</sup> See appendix eight.

<sup>17</sup> Prestwich, 'Family strategies and medical power', p.800.

<sup>18</sup> C. Mackenzie, 'Social factors in the admission, discharge and continuing stay of patients at Ticehurst Asylum, 1845-1917' in W.F. Bynum, R. Porter & M. Shepherd, *The Anatomy of Madness: Essays in the History of Psychiatry Volume 2*, (Tavistock, 1985); J. Walton, 'Casting Out and Bringing back in Victorian England: Pauper lunatics, 1840-1870' in *Ibid.*, and D. Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, 10/1 (1997).

<sup>19</sup> Prestwich, 'Family strategies and medical power', p.806.

<sup>20</sup> *Ibid.*, p.811.

<sup>21</sup> Walsh, 'Lunatics and criminal alliances', p.147.

<sup>22</sup> See Case F, Appendix three.

<sup>23</sup> *CRI Casebook of Female Admissions*, (1903-1907), DUM.CR1989.100.

<sup>24</sup> *Ibid.*



- 25 *Ibid*
- 26 Andrews, *'They're in the Trade...of Lunacy'*, p.21.
- 27 *23rd An. Rep. of Com. in Lun. Scot.*, (1881), GD17/5/11.
- 28 *American Journal of Insanity*, (39) 1882-83, p.283.
- 29 Andrews, 'A failure to flourish?', p.344.
- 30 Quoted in *Foreign Correspondence*, *AJI*, 44 (1887-88), p.561.
- 31 Andrews, 'A failure to flourish?', p.354.
- 32 *AJI*, 39 (1882-83), p.283.
- 33 See for example J. Andrews, 'Raising the Tone of Asylumdom: maintaining and expelling pauper lunatics at the Glasgow Royal Asylum in the nineteenth century', in Melling and Forsythe (ed), *Insanity, Institutions and Society*, p.200-222.
- 34 *Medical Press and Circular*, (4/4/83) in *Presscuttings Book 1862 - 1881*, LHB7/12/1.
- 35 *Abstracts and Extracts*, *AJI*, 41 (1884-85), p.337-8.
- 36 *Ibid.*, 42 (1885-86), p.351-52.
- 37 *Ibid.*, 44 (1887-88), p.554.
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- 39 *Medical Press*, (3/2/86) in *Presscuttings Book 1885-1889*, LHB7/12/3.
- 40 *Foreign Correspondence*, *AJI*, 44 (1888), p.552.
- 41 Andrews, *'They're in the Trade...of Lunacy'*, p.59.
- 42 *Abstracts and Extracts*, *AJI*, 41 (1884-85), p.473.
- 43 Andrews, *'They're in the Trade...of Lunacy'*, p.59.
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- 45 Andrews, 'A failure to flourish?', p.334.
- 46 *Foreign Correspondence*, *AJI*, 44 (1887-88), p.558.
- 47 *Notes on British asylums*, *AJI*, 39 (1882-83), p.285.
- 48 *Annual Report of the Visiting Commissioners to Woodilee*, (1880), HB10/2/1.
- 49 Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, (Routledge, 1961), p.251.
- 50 *23rd An. Rep. of Com. in Lun. Scot.*, (1881), GD17/5.
- 51 *Notes on British Asylums*, *AJI*, 39 (1882-3), p.283.
- 52 *JMS*, 27 (1882), p.407.
- 53 *Foreign Correspondence*, *AJI*, 44 (1888), p.552.
- 54 J.A. Campbell, 'On Escapes, Liberty, Happiness and "Unlocked Doors" as they affect Patients in Asylums', *JMS*, 30 (1884), p.202.
- 55 Foucault, *Discipline and Punish*, p.233.
- 56 N. Morris & D.J. Rothman (ed), *The Oxford History of the Prison*, (Open University Press, 1995), p.211.
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- 69 *CRI Casebook of Male Admissions*, (1895), DUM.CR1989.146.
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- <sup>75</sup> Mackenzie, 'Social Factors in the Admission, Discharge and Continuing Stay'; Walton, 'Casting Out and Bringing back in Victorian England', and Wright, 'Getting out of the Asylum'.
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- <sup>91</sup> N. Tomes, 'The great restraint controversy: a comparative perspective on Anglo-American Psychiatry in the 19<sup>th</sup> century', in W.F. Bynum, R. Porter & M. Shepherd (ed), *The Anatomy of Madness Volume 3* (Routledge, 1988), p.190.
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- <sup>93</sup> *ADA Register of Restraint and Seclusion*, (1869-1967), AA17/1/27.
- <sup>94</sup> R. Cameron, 'The Philosophy of Restraint in the Management and Treatment of the Insane', *JMS*, 28 (1883), p.353.
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- <sup>97</sup> *ADA Register of Restraint and Seclusion*, (1869-1967), AA17/1/27.
- <sup>98</sup> *Ibid.*
- <sup>99</sup> *Ibid.*
- <sup>100</sup> *CRI Casebook of Female Admissions*, (1903-1907), DUM.CR1989.100.
- <sup>101</sup> *ADA Register of Restraint and Seclusion*, (1869-1967), AA17/1/27.
- <sup>102</sup> See Case C, Appendix three.
- <sup>103</sup> Commissioners supported open-air bed rest for tubercular cases in order to halt the spread of disease and to promote physical health.

## Chapter five

### Charitable Endeavours and the Poor Law

#### Introduction

The philanthropist Eliza Jane Brabazon devised the Brabazon Employment Scheme (BES) in the 1880s. The scheme aimed to occupy those unsuited (i.e. the old, sick and mentally ill) to workhouse employment in craft activities. The scheme became highly successful in workhouses, prisons and hospitals and by the 1890s had spread to nearly 300 such institutions. In the 1890s the BES transferred to some Scottish asylums. In Scotland, the Woodilee District asylum in Glasgow was the first asylum in Britain to initiate the scheme. However, the BES only succeeded in establishing a further five branches in asylums, arguably making its presence in asylum culture very low key. Even in the asylums itself, the impact of the BES upon treatment was limited.

Why then is it necessary to look at the operations of the BES in asylums? Underlying the discussion is that the scheme was established as a result of local decision making rather than as a central policy. The BES was not an official policy implemented by the General Board of Lunacy, and as such, local factors and interest illustrate the importance of the scheme's (albeit limited) success. The chapter provides a case study of the BES in the Glasgow area, where it was implemented at first the local poorhouse and then Woodilee and Gartloch, both asylums that practised hospitalisation.

Poor law ideology helps understand the limited impact of the BES. The diversity in the spread of the BES in England and Scotland can be understood in relation to the country's contrasting poor laws. The scheme flourished in many English workhouses because it helped solve the dilemma of how to employ the aged infirm and mentally ill in occupation other than traditional workhouse activities. The ideology of the Scottish

poorhouse suggested that work was not deterrence and as such, no inmates could be forced to work. Of course, this was not entirely true in reality. Larger urban poorhouses like Barnhill in the Barony Parish of Glasgow adopted a discipline regime that was similar to the urban English workhouses. As such, Guardians at Barnhill faced similar dilemmas in occupying the old and infirm.

The appeal of the BES in asylum was its prescription of useful work for all. The practice of craft activities in the BES is fitting with traditional early nineteenth century moral therapy such as fancy knitting, origami and other craft activities. Interestingly however, the BES did not spread to the traditional centres of moral treatment such as the CRI and was only utilised for pauper patients. The employment of non-able bodied patients in the BES is indicative of the continuing philosophy that work was a vital component of asylum culture. The BES only entered asylum life where it was already present in the local poorhouse. As such, this demonstrates the continued interlink between local personalities involved in poor law administration and the asylum system.

The spread of charitable endeavours by middle class females in the Victorian period helps explain why the BES was able to emerge. The vast number of middle-class philanthropic 'visitors' to institutions such as workhouses, prisons and hospitals helps clarify why this group was able to any gain access to asylum patients. The influence of philanthropy also denotes similarities with recent historians who emphasis that the asylum should be viewed in the context of the local community and wider society.

As such, the tradition of philanthropy in asylum culture must be examined. Although philanthropy was vital in the construction of Scotland's Royal Asylums, charitable influence was minimal in the late nineteenth century. This is also highlighted by the

failure of the 'Mental After Care Association' to achieve significant footing in Scottish asylums in comparison to England. It can therefore be questioned if the very nature of Scottish charity and society and the emphasis placed on 'self-help' contributed to the limited general spread of philanthropy in Scottish asylums. It is also plausible that the stigma attached to asylum care resulted in a lesser involvement of philanthropists in mental health charitable ventures.

### The Context of Victorian Philanthropy

It is appropriate to place charity within the asylum in the broader context of Victorian middle class philanthropy. It is not necessary to discuss at length reasons behind the spread of middle class female philanthropy in the nineteenth century. Prochaska and Checkland respectively provide histories of philanthropy in England and Scotland.<sup>1</sup> The moral overtones of philanthropy included religious education as well devotion to raising the so-called 'immorality' of the working class. Ignatieff argues that in the Victorian tradition, no attempt was made to improve the condition of housing, education or sanitation without an attempt to colonise the poor's minds.<sup>2</sup>

In Scotland, the tradition of Presbyterianism had its own effect upon attitudes towards charity. Traditionally, the Presbyterian Church was based on the Calvinist philosophy, which did not attempt to make the lives of the poor any easier, as this went against God's will.<sup>3</sup> In the early nineteenth century, much of charity's clout was drawn from the evangelical movement. This movement ambitiously aimed to halt the tide of secularism in the 'uneducated' masses as well as raise the moral standards of the working classes. Although the harsh doctrine of Calvinism lessened throughout the Victorian age, much charity remained heavily pious and moralistic. Smout argues that



it was important for charity to be discriminatory so that values of thrift and self-help were not undermined.<sup>4</sup>

In the early nineteenth century, philanthropy played an important part in the preservation of traditional Scottish values. Lorraine Walsh suggests that the construction of the chartered asylums as charitable institutions was a demonstration of the town's individual humanitarian nature.<sup>5</sup> Although there was no legal requirement for the construction of asylums in Scotland until 1857, eight Scottish asylums were built as a result of philanthropic impulse before this date. Murray Royal (Perth) and the Crichton Royal (Dumfries) were constructed with funding from individual charitable endeavours. The other six 'Royals' were reliant upon the support of public finance in the institutions' towns.<sup>6</sup> Philanthropic donations were poured into institutions such as orphanages and Royal asylums in order to prevent a compulsory levying of poor rates by the authorities.

As such, philanthropy infiltrated Victorian society in a number of ways. Philanthropists established schools and orphanages as well as Night Asylums and medical missions.<sup>7</sup> Philanthropy attempted to tackle a number of social problems such as homelessness, prostitution, ill health and poor standards of education as well as spreading religious education. Middle-class women participated in door-to-door visiting of the sick, poor and outcast or institutions like workhouses and prisons, with the intention of bringing the 'non-practicing' back the religious fold and raising the moral values of the working classes.<sup>8</sup>

### Origins and Founders

The BES founders were part and parcel of this philanthropic tradition in England. Lord and Lady Meath or (also known as Reginald and Eliza Jane Brabazon) were well known social campaigners in the late nineteenth and early twentieth centuries. The couple's interests spanned from the promotion of open spaces in cities to education and both Brabazons were interested in asylum related activities. Reginald Brabazon was appointed as the president of the Mental After Care Association in England in the early 1890s. Also in this decade, the 'Meath Home of Comfort for Epileptics' opened in Surrey for women and girls aged 2 up to 35 years. The emphasis upon useful occupation was inherent in the Meath Home. In a letter to the *Times* (undated) Meath appealed to potential benefactors by emphasising that 'the inmates are to be provided with employment, and are to be encouraged to assist by their work towards their own maintenance'.<sup>9</sup> Institutionalization and occupation was common practice in the treatment of epilepsy at this time. Meath's emphasis upon the attention paid to occupation reflects a need to appeal to an apparently industrious climate in society.

The BES was the brainchild of the philanthropist Lady Mary Jane Brabazon and was first proposed by Mary Jane Brabazon at a meeting of the Metropolitan Poor Law Guardians' Association in 1882. The philanthropic based Brabazon Employment Scheme aimed to occupy English workhouse inmates who were unsuited to traditional institutional work. At the Metropolitan Guardians' meeting Mary Jane Brabazon suggested

#### NEED THE INFIRMARY INDOOR PAUPERS BE UNEMPLOYED?

Men or women maybe seen with hands lying idly before them dreaming

away precious weeks, months and years. Such an existence is not life;

if it must be so designated, it is the life of a brute rather than a man endowed

with reasoning faculties.<sup>10</sup>

In 1883, the Union Poorhouse in Tonbridge, Kent was the first to implement the BES with funds provided by Lady Brabazon. Here, female philanthropists who visited the workhouses, usually for one morning per week, ran activities such as basket weaving and rug making.

By the late 1890s, the BES was in operation in over 156 workhouses, infirmaries and prisons. By 1904, this figure had increased to over 300.<sup>11</sup> Few records of the BES remain and it has not been possible to accurately compare the operation of BES in English and Scottish institutions. However, it is evident that scheme's spread was extensive in England when compared to Scotland. A trawl of existing records gives some example of where the scheme operated. The NRA archives identify surviving records of the scheme in Kensington, Stroud in Gloucestershire and Burton upon Trent in Staffordshire.<sup>12</sup> One of the BES's earliest branches started under Miss Jean Alexander at a Kensington workhouse. Alexander came from a local philanthropic family and was also interested in prison reform.<sup>13</sup> In 1899, the BES was also extended to sick and wounded soldiers presumably returning home from combat in the Boer war in a number of English towns.<sup>14</sup> Reginald Brabazon highlighted

Its object is to help these men who are prevented by their disablement from following their former trades or those who have never been taught a trade to support themselves partially, if not entirely and thus to render themselves independent.<sup>15</sup>

Workshops were opened in a number of towns for this group. Ex soldiers who were too severely injured to attend these sessions did not miss out on this opportunity to maintain their respectability. BES men taught these men in their own homes 'if too crippled to move'.<sup>16</sup>

### Elderly and Infirm Workhouse Inmates

Guardians were perplexed in deciding if the traditional workhouse discipline and occupations should apply to the health aged poor, mentally ill and infirm. Crowther highlights that the anti poor law campaign was critical of the employment of old and infirm people in workhouse occupations.<sup>17</sup> The BES tried to solve this problem by setting the elderly to work separate from the workhouse administration. Inmates accepted the BES because the workhouse staff did not run the scheme and it was a more attractive alternative to the workhouse occupations.<sup>18</sup>

Prochaska points out that workhouse masters did not usually look favorably upon female visitors roaming around their institutions and perhaps uncovering any abuses.<sup>19</sup> However, the BES encouraged all those unsuited or unable to physical work to participate in some form of occupation. The ability of the BES philanthropists to attract the support of local workhouse masters was therefore its dedication to the prevention of idleness.

It is conceivable that the fundamental difference in characteristics between the Scottish poorhouse and English workhouse were important in the geographical unevenness of the scheme. Whereas the workhouses worked on principles of less eligibility, the Scottish poorhouses could not theoretically force people to work. However, this was untrue of the large urban poorhouses where work was used to maintain discipline. The extension of the BES to Barnhill in Glasgow and its subsequent implementation at the local Glasgow asylums illustrate the parallels that can be drawn with English workhouses.



### Local Personalities in Glasgow

In Scotland, local interest in the BES was raised if the scheme benefited a local poorhouse. This necessity to attract support at a local level is important in explaining why the BES failed to make an impact in a number of Scottish asylums and poorhouses. Although larger urban poorhouses were attracted to the BES, it is plausible that smaller poorhouses did not face similar concerns in finding occupation for large numbers of old and infirm inmates.

The Barnhill poorhouse opened in the Barony parish of Glasgow in 1850. In 1898, Barnhill merged with the city of Glasgow and became the largest poorhouse in Scotland with over 2000 inmates and 61 staff. The institution observed strict discipline in order to maintain order. Like the English workhouse, all inmates were made to participate in work. Men helped with the maintenance of the building and women carried out domestic chores. The elderly were also put to work, for example carrying firewood or doing knitting.

The start of the BES at Barnhill coupled with the instructions issued by the London based BES central committee highlights how local individuals were expected to pave the way of BES in their areas. The BES central instructions to potential organisers are included in the excerpt below. Local philanthropists were instructed to approach an institution and engage the interest of the staff. The matron was responsible for selecting cases that she deemed appropriate for the scheme. Also important was that the BES did not undermine the authority of staff. The BES therefore provided no threat to traditional institutional authority and was always implemented with the full co-operation and authorization of the local parish and relevant members of staff.

1. The permission of the Board must first be secured. This done, it must be ascertained how often the Board will permit the ladies to come and teach. Permission is generally granted for one afternoon a week.
2. The interest and co operation of the matron must next be gained, if possible , as it is the matron who must point out the various individuals who are fit to come under the scheme.
3. A committee of ladies must then be formed. These undertake to teach the infirm any kind of work they happen to know themselves. One of the committee is appointed as secretary and treasurer, unless these offices are assigned to separate persons. The secretary undertakes the general supervision of the work. She assigns a certain number of pupils to each teacher, buys the materials, and gives them out as needed...<sup>20</sup>

Prochaska suggests that an introductory letter from the authorities was a way for philanthropists to break down the workhouse masters.<sup>21</sup> Miss Allan of Carstairs adopted these methods in order to implement the BES at Barnhill poorhouse in the Barony parish of Glasgow. In 1895, Allan wrote to the House Committee of the Barnhill Poorhouse, suggesting that the BES should be introduced at the institution. Despite an extensive search of archives, it was not possible to uncover any further details of Miss Allan. It appears from the Barony Council minutes that Miss Allan was a possible member of the Brabazon scheme as it was indicated in the minutes that her letter to the committee included BES pamphlets and information.

In 1895, the Governor of Barnhill was advised by the House Committee to give the scheme a trial 'subject to the ordinary rules of the poorhouse'.<sup>22</sup> After a trial of 6 months, it was recorded of the scheme that

There is not doubt that the scheme has been the means of providing a variety of employment for the inmates engaged in it, creating new interest and giving them relief from the routine work and life of the house and this has been accomplished without in anyway interfering with the management or discipline of the institution.<sup>23</sup>

Allan was responsible for implementing the trial run of the BES at Barnhill and actively participated in taking classes and organising activities. Allan also became the Secretary of the Scottish branch of the Brabazon Society.<sup>24</sup> The above comments highlight the use of work in the poorhouse but also denote the use of the BES for those unsuited to traditional poorhouse occupation.

The subsequent spread of the BES to Woodilee shows up continued links between the local asylum and parochial board. As a prolific social reformer in Glasgow, Aikman was a member of both the Barnhill House Committee and WAC. Her position on both the Barnhill committee and Woodilee Asylum Committee and her involvement in the BES suggest a high level of respect and influence in local Glasgow society. Aikman sat on the Barnhill House Committee between 1895-1902 along with the WAC. Aikman began her career as a voluntary probation officer for Cranstonhill District. She was elected as a member of Barony Parish Council in 1895 and Glasgow Parish Council in 1907.

On the Barnhill House Committee, Eliza Jane Aikman was a prominent figure who pressed for the BES introduction along with Allan. Aikman was responsible for reporting the scheme's progress to the Barnhill committee. Aikman reported in April 1896

There is no doubt that the scheme has been the means of providing a variety of employment for the inmates engaged in it...and this has been accomplished without in any way interfering with the management of discipline of the institution. Your reporter has every confidence in recommending the committee to allow Miss Allan to continue her good work.<sup>25</sup>

Aikman's involvement with the BES is heavily commented upon in her *Memoirs*. The Minister of her local parish wrote her *Memoirs* posthumously.

Under Miss Aikman's convenership a party of twelve ladies attended weekly and taught the patients...The inspiration of all this great humane work was Miss Aikman.<sup>26</sup>

The very nature of a memoir suggests a certain amount of bias and flattery within the source. Yet her individual commitment was a long-term one and throughout World War One, Aikman single-handedly took on teaching the BES classes at Woodilee.

The spread of the scheme locally came from the example of existing practice. A meeting of the Glasgow District Lunacy Board discussed the possibility of extending the scheme to further institutions.

In furtherance of the remit from the Asylums and House committees, dated respectively 1st and 28th march, the joint Sub Committee [of the asylum] met in conference, with Lady Bell, President; Miss Allan, Vice president; Mrs Pettigrew, Hon. Sec; Miss Aikman, and a number of other ladies representing the local branch of the Brabazon Society, together with prospective additional helpers. The chairman having explained the object of the meeting, it was unanimously resolved, after a general conversation, 1) that the ladies should appoint 2 additional committees for the extension of the scheme to the City poorhouse and Gartloch asylum respectively, as already prevailing at Barnhill and Woodilee.<sup>27</sup>

It was also suggested that application be made to the central BES branch in London in order to obtain a grant to launch the BES at the prison in Parliamentary Road in Glasgow. The spread of the BES to the local asylums, prison and poorhouses seems to have relied on a 'word of mouth' philosophy and also denotes the crossover of individuals like Aikman between the asylum and parochial boards.

### Support from Medical Superintendents

Such as the BES had to secure interest from the poorhouse Guardian and staff to introduce the scheme, it was necessary to attract support from asylum medical superintendents. Scull suggests that the psychiatric profession used asylums to assert



its dominance and authority in society.<sup>28</sup> The fact that so few asylums introduced the BES makes it possible that even where there was local support for the BES by philanthropists, this was thwarted by the disinterest of the asylum's medical superintendent. However, no concrete evidence exists to support this view and any such argument is merely speculative. It is evident that some asylums that introduced the BES, did employ medical superintendents who avidly supported the principles of hospitalisation (such as Hamilton Marr). As Marr had recently attained the position of medical superintendent at Woodilee, human nature suggests that his support for the BES stemmed from an enthusiastic desire to introduce new initiatives to the institution. In 1899, Marr published an article about the BES in the *Journal of Mental Science* urging other medical superintendents to adopt the scheme.<sup>29</sup>

The extension of the scheme to Gartloch perhaps came more from the Woodilee example rather than any special impetus by its then medical superintendent Landel Oswald. After Oswald attained the post of medical superintendent of Gartnavel Royal in Glasgow, Dr Parker (medical assistant at Gartloch) was promoted to the post of superintendent. While we can presume Marr was active in his support for the BES (due to his *JMS* publication), no similar support is evident from Parker. While Parker briefly notes his thanks to the BES volunteers in his annual reports, there is no evidence that he thought of it as anything but recreation for patients.

The appeal of the BES in individual asylums was its adherence to the work ethic. Marr viewed the scheme as a useful tool for occupying male patients unsuited to traditional asylum work, bedridden patients and female patients.<sup>30</sup> This figure never rose above 10% of the population at Woodilee. Marr drew on the example of an afternoon's BES activities in his *JMS* article.

In the variety of occupations taught room is found for the most mindless.

One idiot paints cards and matchboxes and other knickknacks...other patients work at fancy knitting and embroidery; others at Smyrna rugs; while some are busily employed making up multicoloured papers into flowers, lampshades and other ornaments. Macramé work and drawn linen work are also engaged in. Each individual's aptitude is tested and the work assigned that is best fitted for each.<sup>31</sup>

Marr suggested

I can call to mind one or two cases whose recoveries maybe traced to the good offices of the Brabazon society; but were there not a single recovery, the brightening and elevating influences of the work...are sufficient evidence of the beneficial work of the society.<sup>32</sup>

Although difficult to locate references to the BES in case notes, one example does show that the BES provided some therapeutic benefit. F.M. was admitted to Woodilee in June 1897, suffering from Epileptic Insanity. His notes record that soon after admission, he was subject to several fits. However, his involvement with the Brabazon scheme was deemed to have an improvement upon his mental state.

- |         |   |
|---------|---|
| 5/5/98  | Has started working with the Brabazon Class and is taking a great interest in the work.   |
| 2/11/98 | Has done very good work at the Brabazon Class. Being employed seems to have done him a lot of good...he still takes fits but they are as a rule light.      |
| 20/3/99 | Is still working hard at his Brabazon work. He is now working on a large rug, which is to be sent to London. Fits are not nearly so frequent. <sup>33</sup> |

Such work let people who had previously been unoccupied to partake in activities, which provided them with a sense of accomplishment. For the doctor who witnessed the daily drudgery of institution life, it is hard not to believe that doctors saw the BES to be a method of brightening monotonous existences.

There were difficulties in engaging female patients in traditional asylum occupations.

Marr highlighted

With the female patients it has ever been a vexed question with asylum authorities how to occupy them suitably and satisfactorily. Purely mechanical work...manifestly unsuited to relieve their minds of morbid thought.<sup>34</sup>

Chapter three highlighted the difficulties of finding suitable occupations for females.

The chapter also showed how extended outdoor occupations for able-bodied female patients emerged in asylums like Gartloch and Stirling by the late nineteenth century.

Alternatively, the 'refined' activities of the BES provided activities such as macramé and needlecraft that were more suited to the perceived female sphere of occupation.

### The BES as a Reward

A difference in the use of the BES in the asylum was its benefit as a reward for patients. In the asylum, Brabazon volunteers treated a minority of asylum patients to excursions outside the asylum. The following extract outlined a trip organised by Aikman, although the asylum in question is not named.

Mrs Aikman and the lady who was paying the expense, with thirty patients, matron and nurses, sailed from the Broomielaw for Rothesay where a happy time was spent on the beach. On the return journey a sumptuous high tea was provided. All behaved splendidly and amply repaid Miss Aikman and her friend for the 'rather daring experiment'.<sup>35</sup>

Similarly, a Brabazon volunteer named Mrs Inglis organised a seaside outing for Gartloch patients in 1903.<sup>36</sup> In 1901, an Art and Crafts Exhibition in Glasgow displayed items made by Brabazon classes. In this year, a gift of exhibition tickets was given to Woodilee for patient use. In August 1901, the Woodilee asylum committee noted that '8 men and 13 women' have made visits to the exhibition.<sup>37</sup>

Leisure activities organised by Brabazon workers included plays and musical events for inmates. At Woodilee, BES volunteers organised a picnic in the summer for the Brabazon participants. In the winter months, a Christmas production was held for all patients.

The ladies of the Brabazon society ...have given two entertainments, one in the summer to the patients connected with the Brabazon society and one in the winter to all the patients.<sup>38</sup>

On a more frequent basis, volunteers also participated in sports at asylums. Dr Parker, superintendent of Gartloch commented

I have to thank the ladies of the Brabazon Society for their kindly help to and interest in so many of the patients, whose lives are greatly brightened by their ministrations. Their generosity has been the means of extending the enthusiasm for the game of ping pong and has helped to make many a happy evening in the wards.<sup>39</sup>

The *Memoirs* highlight that

...patients who were refractory used to be threatened with deprivation from the Brabazon class, and...this threat was sufficient to have the desired effect.<sup>40</sup>

It would seem that even leisure time in the asylum, appeared to have its own moral undertones.

Chapter three highlighted how occupation in Woodilee was primarily used to control large numbers of patients. Like the poorhouse, this created difficulties in employing patients unsuited to traditional asylum occupations. In its operation of alternative activities, the BES therefore provided a partial solution for the medical superintendent. However, the interest that craft activities presumably attracted in the tedium of the asylum environment allowed it to be adopted as an incentive to engage people in activity or reward people's 'behaviour'.



### Decline of Philanthropy

Although the BES sustained a position in the Glasgow area, the failure of the scheme to spread nationwide (in either asylums or poorhouses) is perhaps reflective of traditional Scottish attitudes towards charity. This final section considers the general influence of Scottish charitable values on philanthropy in asylums. In viewing the wider picture of philanthropy in Scottish asylum culture, it is apparent that After-Care also failed to make an impact. In comparison, England had established a wider (albeit not fully extensive) philanthropic system of aftercare at many of its asylums.

In England and Wales, the Mental After Care Association (MACA) was formed in 1877 after Reverend Hawkins (chaplain of Colney Hatch Asylum) published two articles in the 1870s, which called for the after care of discharged asylum patients.<sup>41</sup> He was concerned with practical problems faced by discharged patients (in obtaining essentials such as clothing and employment). Hawkins also identified the group of patients who were forced to remain in the asylum because they had no friends or relatives to look after them. For these patients, the workhouse was often the only alternative. The association aimed to bridge the gap for patients between asylum life and society. This bridge was through monetary support, development of convalescent homes for patients close to discharge and local organisations attached to individual institutions.<sup>42</sup> Although the impact of after care was reasonably systematic in England, the association lacked extensive financial backing from philanthropists.

It may be tentatively suggested that Scottish attitudes to charity (i.e. promoting self-help and independence) were influential in the failure of any Scottish after-care system. As noted earlier in the chapter, Victorian society (and Presbyterian influence in particular) did not favour support for those who were able to support themselves.

Even after 1845, the wider poor law ideology operated on the assumption that those who were able to work should do so. In this context, the perhaps somewhat simplistic link may be made between recovery and ability to work. If a patient had been discharged, it was therefore assumed that he/she had recovered and was able-bodied. As such, an able-bodied individual was capable of work and not entitled to relief.

However, this view does not clarify why after care was provided in England, which practiced the harsher doctrine of less eligibility. This Scottish philosophy extended wider than the Scottish asylum and thus does not explain why after care was provided in other Scottish institutions. Marr argued that

Prisoners on their discharge from prison are well look after. It seems anomalous that a helping hand is seldom offered to those who have recovered from insanity and who most of all demand and require social sympathy.<sup>43</sup>

In the 1898 Gartloch report Oswald had commented:

There are many associations and charities appealing to the benevolent of Glasgow, but none dealing with the insane poor...yet an association to give care and help to the insane poor discharged from asylums would yield a rich harvest of thanks and good result...it would be well that public interest should be aroused.<sup>44</sup>

Medical superintendents made a link between the release of a patient and the need to support him/her after release in order to maintain their independence. Macpherson, medical head of Stirling District Asylum (SDA) noted in 1892,

It very often happens that a person perhaps without a fixed abode, becomes insane and is placed in an asylum...and when he recovers from his illness he has to face the world without any money, with only a working suit of clothes and distrusted by the employers of labour from whom he seeks work. The result not infrequently is that the worry and poverty of his altered circumstances bring on a relapse...during his enforced stay in the asylum where he engages in all sorts of manual labour no remuneration is made to him which might, after his

release, help him to support himself in the interval until he finds employment.<sup>45</sup>

Medical superintendents commented on the stigma that often prevented many discharged patients find work. After care was seen to help patients achieve independence and therefore prevent a return to the asylum.

Like the spread of the BES to the asylum, any form of systematic support was typically carried out through the auspices of the Brabazon society's volunteers.

At Gartloch, Parker reported in 1905:

it is pleasant to be able to report that during the year the ladies of the Brabazon association have taken steps to form an after care association to assist patients discharged from our asylums...to get a good start.<sup>46</sup>

Medical superintendents occasionally set aside small amounts to assist patients on their discharge. For example, Marr at Glasgow established an after care fund for the use of the Brabazon volunteers. Aikman again appears to have played an active (and financial role) in the after-care of patients.

The problem of after-care of discharged inmates was very dear to her and she often dreamed of a solution that might be made possible by an endowment or bequest from someone deeply interested.<sup>47</sup>

Again, it was Glasgow that led the way in establishing an organisation of patient after-care in the community. The BES formed an After-Care association for Gartloch and Woodilee patients in 1910. Its principal purpose was to 'facilitate the return of indoor poor chargeable to the Parish of Glasgow into the social life of the community'.<sup>48</sup>

However, the association's subsequent control by the Inspector of the Poor meant that the issue of after-care became more entwined with issues of eligibility and poor law criteria than a support network for discharged patients.

It is feasible that the failure of mental health care to engage significant charitable input in the late nineteenth century came from a stigmatisation attached to mental health. Prejudiced views of people with mental health problems were rife in society and the so-called dangerous nature of mental illness was often sensationalised by national newspapers. The criticism of sensationalism was raised by the *British Medical Journal* in 1897. National press had leapt upon the case of a Miss Camp in England who had allegedly been murdered by a 'liberated lunatic'. The *BMJ* responded that

From time to time to public is in a state of fear lest everyone with a peculiarity or kink in his mind should be sent to an asylum; the next it is afraid that too many of these mentally weak are allowed to be at large. The public is a very unreasonable body, and medical opinion should do what it can to guide ....the idea that Miss Camp was murdered...by a liberated lunatic has not a single grain of evidence to support it.<sup>49</sup>

The *BMJ* drew upon the benefits of the After Care association as a method of support for people after their discharge from an asylum. It also made an appeal highlighting that 'it [After Care] could do much more good work if more means were at its disposal'.<sup>50</sup> Speculatively, the reluctance of Victorian philanthropy to put its money into mental health issues, when charity infiltrated so many other fields denotes the wider social stigma of mental illness and asylum care.

### Conclusion

This case study of the BES in Glasgow highlights the connections between local individuals involved in both asylum care and poorhouse provisions. Its influence was unlinked to central policy or to the medical profession. It is unlikely that if the BES had not proved attractive to the Barnhill poorhouse that the scheme would be introduced to the local asylums. This also helps explain why the BES was introduced to so few institutions in Scotland compared to England. The BES was popular in Glasgow because of the similarities between the local poorhouse and English



workhouse. Parallels between the asylum and poorhouse are apparent in the use of the BES for patients and inmates unable to participate in traditional occupations.

The lack of impact that the BES had in asylums sits uncomfortably in comparison with the success it had elsewhere. Although philanthropists had been willing to pour money into the construction of Scottish asylums, public opinion appeared less inclined towards improving asylum life or association with the liberation of patients. The influence of Scottish charity in the lack of support for philanthropy does not clarify why after care influenced an English society geared towards less eligibility and indoor relief.

This chapter has provided an example of a scheme that made an (albeit slight) impact on asylum culture in the era of hospitalisation. The next chapter discusses the open-air rest cure that emerged in the early twentieth century. Similarly, this new treatment was shaped not by official policy but by endemic disease. However, unlike the BES, which operated on a minor scale in a handful of asylums, the activities of individual doctors led to open-air rest becoming an official part of the central approach to tuberculosis prevention in asylum life.

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<sup>1</sup> F.K. Prochaska, *Women and Philanthropy in Nineteenth Century England*, (Open University Press, 1980) and O. Checkland, *Philanthropy in Victorian Scotland*, (John Donald Publishers Ltd, 1980).

<sup>2</sup> M. Ignatieff, *A Just Measure of Pain: the Penitentiary in the Industrial Revolution, 1750-1850*, (Pantheon, 1978), p.214.

<sup>3</sup> Checkland, *Philanthropy in Victorian Scotland*, p.31.

<sup>4</sup> T.C. Smout, *A Century of the Scottish People 1830-1950*, (Fontana Press, 1997), p.51.

<sup>5</sup> L. Walsh 'The Property of the Whole Community' in J. Melling and B. Forsythe (ed), *Insanity, Institutions and Society 1880 - 1914: A Social History of Madness in Comparative Perspective*, (Routledge, 1999), p.182.

<sup>6</sup> *Ibid.*

<sup>7</sup> Smout, *A Century of the Scottish People*, p.51.

<sup>8</sup> Prochaska, *Women and Philanthropy*, p.138.

<sup>9</sup> *The Times*, (undated), Contemporary Medical Archives Centre, SA/MAC/M1/1.

<sup>10</sup> R. Brabazon, *Brabazon Potpourri*, (Hutchison and Co., 1928), p.29.

<sup>11</sup> *Annual Report of the Brabazon Employment Society*, (1904) available in *Parish of Glasgow Prints Vol. 15*, T:Par 1.3.

<sup>12</sup> [www.hmc.gov.uk/nra](http://www.hmc.gov.uk/nra)

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- <sup>13</sup> 'Brabazon Employment Society', Reference 21241 - 46 located at Kensington and Chelsea Libraries and Arts Services, Central Library, Phillimore Walk, London, W8 7RX.
- <sup>14</sup> R. Brabazon, *Memories of the Twentieth Century*, (John Murray, 1924), p.7.
- <sup>15</sup> R. Brabazon, *Brabazon Potpourri*, p.32.
- <sup>16</sup> *Ibid.*, p.33.
- <sup>17</sup> M.A. Crowther, *The Workhouse System 1834-1929 The History of an English Social Institution*, (Batsford Academic and Educational Ltd, 1981), p.200.
- <sup>18</sup> p.201.
- <sup>19</sup> Prochaska, *Women and Philanthropy*, p.140.
- <sup>20</sup> *An. Rep. of the BES*, (1904), in *Par. of Glas. Print. Vol. 15*, T.Par 1.3.
- <sup>21</sup> *Ibid.*, p.177.
- <sup>22</sup> *Minutes of the Barony Parish Council and Committee Vol. 20*, (11/4/95 – 30/11/96), D – Hew 2.2.19.
- <sup>23</sup> *Ibid.*
- <sup>24</sup> *Ibid.*
- <sup>25</sup> *Ibid.*
- <sup>26</sup> H.A.D. Alexander, *Eliza Jane Aikman*, (1930), p.12-13.
- <sup>27</sup> *Minutes of the Glasgow District Lunacy Board*, (1899), HB30/1/1.
- <sup>28</sup> A. Scull in Melling and Forsythe, *Insanity, Institutions and Society*, (1999), p.313.
- <sup>29</sup> H.C. Marr, 'The Brabazon Scheme in an Asylum; History of its Introduction, and a Record of a Year's Working', *Journal of Mental Science*, 45 (1899).
- <sup>30</sup> *Ibid.*, p.534.
- <sup>31</sup> *Ibid.*, p.535.
- <sup>32</sup> *27<sup>th</sup> An. Rep. of Woodilee*, (1901-2), HB30/2/12A.
- <sup>33</sup> *Woodilee Casebook of Male Admissions*, (1897), HB30/4/4.
- <sup>34</sup> H.C. Marr, 'The Brabazon Scheme in an Asylum', p.534.
- <sup>35</sup> *Ibid.*
- <sup>36</sup> *7<sup>th</sup> An. Rep. of Gartloch*, (1904), HB1/6/5.
- <sup>37</sup> *Minutes of the Glasgow District Lunacy Board*, (1901), HB30/1/1.
- <sup>38</sup> *33<sup>rd</sup> An. Rep. Of Woodilee*, (1908-09), HB30/2/16.
- <sup>39</sup> *5<sup>th</sup> An. Rep. of Gartloch*, (1902), HB1/6/5.
- <sup>40</sup> Alexander, *Eliza Jane Aikman*, p.14.
- <sup>41</sup> H. Hawkins, 'A plea for convalescent homes in connection with asylums for the insane poor', *JMS*, 16 (1871) and 'After Care', *JMS*, 25 (1879-80).
- <sup>42</sup> J. Smith, 'Forging the Missing Link': the significance of the Mental After Care Association Archive', *History of Psychiatry*, 8 (1997), p.408.
- <sup>43</sup> *Ibid.*
- <sup>44</sup> *2<sup>nd</sup> An. Rep. of Gartloch*, (1898-99), HB1/6/2.
- <sup>45</sup> *22<sup>nd</sup> An. Rep. of Stirling District Lunacy Board*, (1891-92), GD17/1/28.
- <sup>46</sup> *8<sup>th</sup> An. Rep. of Gartloch*, (1905-06), HB1/6/6.
- <sup>47</sup> Alexander, *Eliza Jane Aikman*, p.14.
- <sup>48</sup> *35<sup>th</sup> An. Rep. of Woodilee*, (1910), HB30/2/17.
- <sup>49</sup> *British Medical Journal*, (March, 1897) included in the records of the Aftercare Association, SA/MAC/M1/1.
- <sup>50</sup> *Ibid.*

## Chapter six Open Air Rest Cure<sup>1</sup>

Sunshine and light makes for sanity<sup>2</sup>

Of the combined open air and rest "cure" ... of the insane, it may be fairly claimed that it ameliorates their condition and promotes their recovery; and a further effect of the open air regime which may be expected in the future is a reduction in the mortality of tubercle.<sup>3</sup>

### Introduction

In the late 1890s, there emerged a new type of asylum treatment termed open-air bed rest, which differed significantly from the earlier moral approaches. The term 'open-air bed rest' is self-explanatory. In some asylums, open-air rest confined patients to bed on verandahs in the open air throughout daylight hours. Patients were put to bed on purpose-built verandahs attached to the asylum hospitals. They also received meals and any additional treatment out of doors.

Open-air bed rest in asylum stemmed from the contemporary treatment for tuberculosis in society. During the late nineteenth century, sanatorium treatment (that promoted fresh air, rest and exercise) was considered by contemporary medicine as the most advanced form of treatment for tuberculosis. The introduction of verandah treatment for tubercular cases paralleled the construction of sanatoriums at asylums. The extent of the tuberculosis concern highlights why open-air bed rest became an important treatment relatively quickly in Scottish asylums.

The notion of the 'total institutions' such as the asylum, poorhouse and prison implies that they were cut off from everyday society. However, the tuberculosis problem in these institutions reflects how asylum culture could mirror the outside world. As such,

the introduction of sanatoriums and open-air treatment to the asylum demonstrates how life in the asylum was influenced by wider medical treatment. The Commissioners recommended the use of open-air treatment for tuberculosis and most asylum doctors adopted it in a bid to reduce mortality levels of the disease. By 1913, Lunacy Commissioners calculated that 'there is at the present time scarcely an asylum for the insane in Scotland where the system is not more or less extensively applied'.<sup>4</sup>

The use of open-air bed rest for non-tubercular cases should be understood in the context of indoor bed rest. New trends in treatment such as the Weir Mitchell Rest Cure and the increase of hospital beds at asylums in the 1890s fuelled debate as to whether rest or exercise was most beneficial in the treatment of mental illness. Rest was traditionally utilised for patients with physical ailments. However, some doctors became convinced of the benefits in treating active insanity with rest. Most doctors remained unconvinced, preferring to prescribe the traditional therapy of work to patients who were physically fit. With the general construction of admission wards from the 1900s however, most doctors came to accept the use of standardized bed rest for patients on admission.

Open-air bed rest in non-tubercular cases came to be utilized by doctors for a variety of reasons. The open-air aspect of rest was important in verandah treatment's monitorial role. Larger urban asylums that had a large annual intake often admitted patients from other institutions. The use of verandah treatment meant that new cases were monitored for tuberculosis within a controlled environment, thus minimizing the spread of disease. Most doctors also saw no harm in putting a patient to bed out of doors if they were confined to bed in any case. This tied in with the contemporary fresh air movement that was currently in vogue. Open-air bed rest was also linked to



improvements in weight and physical health. Although weight gain resulted more from the rest and diet than the open skies, this links back to the view that if the patient was in bed, they could also receive the benefits of fresh air.

Some individual doctors tacked on open-air bed rest as a novel form of asylum treatment and control. This is evident in the practice of Charles Easterbrook, medical superintendent of the Ayr District Asylum (1902 - 1907) and at the Crichton Royal in Dumfries from 1907. Easterbrook utilised open-air rest in order to isolate and control violent and suicidal patients or potential escapees from the rest of the asylum population. Most other asylum doctors however, did not appear to accept Easterbrook's lead and continued to espouse the benefits of occupation for this group.

### The Tuberculosis Problem

By the twentieth century the tuberculosis problem in Britain raised both social and political worries.<sup>5</sup> Where people were grouped together, tuberculosis had an impact. Although tuberculosis was as much a problem in rural as it was in urban locations, industrialization lent itself to poverty, malnutrition and overcrowding. In 1900, Dublin was recorded to have 36% of its dwelling consisting of one room only, Glasgow came second with 26%. The instance of tuberculosis in Dublin was 10 times that of London and in Glasgow, five times higher than the metropolis.<sup>6</sup>

Institutions suffered from the onslaught of disease and tuberculosis was a concern in the workhouse, hospital and prison. The publication of post mortem surveys at the end of the nineteenth century provided evidence of this tuberculosis problem. At the Royal Hospital for Sick Children in Edinburgh, 39% of all deaths resulted from tuberculosis in the 1880s. Overcrowded prisons also spread disease rapidly. Between

1870 and 1890 half of the deaths annually at Chatham naval prison in England resulted from tuberculosis.<sup>7</sup>

Tuberculosis inevitably killed large numbers of asylum patients. The overcrowded establishments filled with often physically weak patients were a haven for the spread of disease. Historians of psychiatry tend to overlook the issue of tuberculosis. Institutional histories of asylums by authors such as Anne Digby and Jonathan Andrews only make minor reference to the serious issue of tuberculosis in asylums.<sup>8</sup> Likewise, modern historians of tuberculosis such as Bryder and Smith do not mention asylum tuberculosis in their research.<sup>9</sup> Contemporary reports show that in 1907, 11.2 per 1000 deaths in Scottish asylums were a result of tuberculosis. This compared with 2.1 per 1000 deaths in society.<sup>10</sup>

The asylum was considered an ideal breeding environment for tuberculosis. In 1909, the English medical superintendent Robert Jones documented the problem in the *British Journal of Tuberculosis*.

It is well known that asylum life with its cloistered detention – the patients being most of the twenty four hours under cover and in rooms often warmed as to interfere with ventilation – favours tuberculosis.<sup>11</sup>

From the 1890s, articles concerning the asylum tuberculosis problem began to emerge in contemporary journals such as *British Journal of Tuberculosis* and *Journal of Mental Science*.<sup>12</sup>

Tuberculosis was often noted as a common cause of death in various annual reports of Scottish asylums. In 1902, the Woodilee District Asylum (Woodilee) medical head, Hamilton Marr highlighted 'consumption to be a prominent cause of death' in the

asylum.<sup>13</sup> In the ADA report for 1907, the percentage of deaths from tuberculosis was 19%.<sup>14</sup> In 1902-03, the number of deaths from pulmonary tuberculosis at the Argyll and Bute District Asylum (ABDA) was recorded as 'comparatively high' in the annual report.<sup>15</sup> At the CRI, the death rate reached as high as 25% of total deaths in 1904. On average, tuberculosis mortality at the CRI remained at approximately 15% of total deaths and there is little to suggest why the level rose in 1904. Even by 1913, the Registrar - General Report indicated that in British asylums, deaths among mentally ill men had risen by 155% in that year and by 106% among female patients in British asylums.<sup>16</sup>

The current medical approach for tuberculosis treatment in the nineteenth century was the sanatorium model. The sanatorium ideal materialised in the mid to late nineteenth century when many doctors became convinced that fresh air and general bodily rest (ideally in a Swiss alpine setting) was the best method of combating the killer disease. Hermann Brehmer, established a well known sanatorium at Goebersdorf, Silesia in 1859. Subsequent sanatoriums were modeled on Brehmers', including Nordrach sanatorium in the Black Forest under Otto Walther.

The British sanatorium movement catered largely for the working class. Bryder suggests that the expansion of sanatoria must be understood in the context of the growth of institutions in this period.<sup>17</sup> Scotland led the way in providing sanatoriums and assistance for working-class sufferers of tuberculosis. This is further evidence of the Scottish acceptance of an institutional solution for health and welfare. In 1906, the Local Government (Scotland) Act stated that tuberculosis was an infectious disease, thereby enforcing local authorities to deal with tuberculosis along with other infectious

diseases.<sup>18</sup> By 1911, Scotland was providing 480 beds for the treatment of tuberculosis.

Prior to this official intervention, localised efforts had made moves to combat the disease. The most documented initiative in Scotland was Edinburgh's doctor Robert Philip who founded the City's Victoria dispensary in 1887. Philips, also opened the Victoria Hospital for Consumption (RVH) in Craighleith, Edinburgh in the 1890s. From its inception the hospital catered solely for the treatment of early tuberculosis (although a hospital for dying cases was later opened). The hospital operated under the motto 'fresh air is the food of the lungs'.<sup>19</sup> Accordingly, patients were subjected to an extensive regime of outdoor treatment that included both rest and exercise. Thomas Clouston (then Royal Edinburgh asylum's Medical Superintendent) sat on the general committee of the hospital in its first year and was potentially influenced by the application of open-air rest to tuberculosis patients.<sup>20</sup>

One of the most obvious features of treatment in the twentieth century sanatorium was participation in work in the open air. Bryder argues that the 'pickaxe cure for consumptives' aimed to meet the public objection that working class people would acquire lazy habits through sanatorium treatment.<sup>21</sup> Robert Philips saw the working class sanatorium as

...A busy hive, where patients subject to doctor's directions, contribute...by their own regulated efforts to the upkeep and beauty of the place- a kind of working sanatorium.<sup>22</sup>

Philips' dream colony was realized with his farm colony at Springfield in 1910. Patients deemed curable and capable of work were selected from the RVH and transferred to the farm colony.



The use of sanatorium treatment in asylums emerged not long after the opening of the RVH and other sanatoriums. A *Medico-Psychological Association (MPA)* prize-winning essay by F.G. Crookshank in 1899 brought national attention as to how tuberculosis in asylums should be treated. Crookshank, the then medical assistant of Northampton County Asylum, indicated both the causes and solutions of the tuberculosis issue.

The principles are simple: complete separation of tuberculosis from non tuberculosis patients; for the tuberculosis patients the modern, approved sanatorium treatment.<sup>23</sup>

The *MPA* set up a commission in the early twentieth century to investigate tuberculosis in the insane, whose committee members included Thomas Clouston. The committee arrived at conclusions similar to those suggested by Crookshank, namely the need for infectious cases to be isolated and the provision of sanatorium treatment for tuberculosis cases.<sup>24</sup>

*MPA* investigations did not take place in isolation. Across the Atlantic, American doctors also adopted open-air rest to combat tuberculosis in asylums. Varying slightly from verandah treatment, American patients were put in tents throughout daylight hours. The first documented use of tent life for the insane was in 1885 at the Birmingham State Hospital for the Chronic Insane under the physician T.S. Armstrong.<sup>25</sup> In 1901, the superintendent A.E. Macdonald inaugurated tent-life for the 'phthisical'<sup>26</sup> insane at the Manhattan State Hospital, New York. C. Floyd Haviland, medical assistant at the Manhattan State Hospital wrote in 1902 that 'I believe no practical plan of treatment for the phthisical insane at once offers so many advantages as does the system of tent-care'.<sup>27</sup>

Tent treatment remained a mainly American phenomenon with the emphasis in Britain placed upon verandah and sanatorium treatment for patients. Although Landel Oswald introduced some tent treatment to Gartnavel Royal Asylum in the early twentieth century, this was combined with verandahs and open-air beds.<sup>28</sup> The explanation perhaps was the British contemporary 'Asylum-Hospital' movement, which allowed alterations to be made to the existing asylum buildings. It is also plausible that the inclement Scottish climate induced a need for more robust sheltered accommodation out of doors.

Like Philips' earlier mentioned efforts, Scottish asylums led the way in tuberculosis prevention in Britain. An article in the *British Journal of Tuberculosis* (1909) highlighted that 'great credit is due to the administrators of the Scottish asylums for their practical appreciation of the modern treatment of tubercular disease'.<sup>29</sup> Many of these developments centered upon the erection of separate sanatoria in asylum grounds. Sanatoria were opened at Glasgow's Woodilee and Gartloch asylums in 1902 and 1903 respectively. A new sanatorium opened for CRI patients in 1903. At Ayr, the new hospital provided extended accommodation for sufferers of tuberculosis in 1906. Within the hospital, 30 beds were set aside for pulmonary tuberculosis cases.<sup>30</sup>

Sanatoria built at asylums closely resembled tuberculosis hospitals such as the RVH. The Woodilee and Gartloch sanatoria are typical examples. Woodilee's sanatorium was constructed out of wood and corrugated iron with large windows in the walls for ventilation. There was accommodation for 60 patients, who all remained frequently in the open air and slept with the windows open. Cubic space per person in the Woodilee sanatorium was 1,500 feet compared to 1,200 feet at the RVH.

After the erection of the sanatorium at Woodilee, her sister asylum Gartloch, pressed for similar accommodation. Gartloch's sanatorium opened in 1903

Standing on southern slope it faces due south. Each ward has a verandah on its northern angle and 2 verandahs separated by a large square window on the southern aspect. To the verandah access is got by large trench windows through which the beds can be easily wheeled.<sup>31</sup>

The sanatorium housed 60 patients and provided 2000 cubic feet of space per patient. It was built without shutters or blinds (which were deemed to interfere with the passage of fresh air). On a visit to Gartloch sanatorium in 1903, the visiting Commissioner recorded 'with a few exceptions all [patients] were found in the open air, either walking about or in beds which had been wheeled out to the verandah'.<sup>32</sup>

The main difference between asylum sanatoriums and tuberculosis hospitals was the use of verandahs. Tuberculosis doctors such as Philips believed verandahs interfered with the movement of fresh air in sanatoria. However, asylum open-air rest was nearly always practised on verandahs. This can perhaps be explained by the necessity of separating the tuberculosis sufferers from the non-tuberculosis patients in asylums. This was an unnecessary concern in mainstream sanatoria where all patients were sufferers.

Failure to comply with recommended verandah rest for tuberculosis led to criticism from the General Board of Lunacy. In 1913, the Commissioners in Lunacy sent round a circular that questioned the measures taken by institutions to prevent tuberculosis. An extract from this circular sent to and completed by the ADA in 1913 is included in extract 3.

Extract 3Circular sent by Commissioners in Lunacy to Scottish Asylums (1913)

Numbers suffering from active phthisis	2 women and 3 men
Are cases isolated from other patients?	Ventilated rooms and verandah treatment
How long has this accommodation been in use?	Since 1906 (hospital opened)
Are phthisis patients treated by verandah treatment in the open air? State number of beds	30 verandah beds

Source: *Correspondence from the General Board of Commissioners in Lunacy for Scotland, 1869 – 1951*, AA17/6/2.

However, Commissioners could only advise asylums to construct verandahs and the General Board was not able to force developments. Some years earlier, the ABDA under Superintendent Cameron experienced delays in introducing sanatorium treatment. In 1906, the Visiting Commissioner reported that ‘it is to be greatly regretted that there is no separate accommodation for such cases’.<sup>33</sup> The appointment of Dr Shaw to the position of medical superintendent in 1908 led to changes at the asylum. Shaw had been medical assistant at Gartnavel Royal Asylum where he worked under Landel Oswald. As highlighted, Oswald supported open-air treatment and used it extensively at Gartnavel.<sup>34</sup> By 1908, open-air treatment was established as a mode of treatment for tuberculosis sufferers at the ABDA.<sup>35</sup>

Did the treatment of tuberculosis by open-air bed actually *work* in reducing mortality levels? Certainly, doctors were convinced that this method of treatment was the very best means by which tuberculosis should be treated. Like mainstream sanatoria, the open air and isolation had an effect in reducing mortality. At a Congress of Alienists in Amsterdam (1907), Easterbrook commented

As a means of treatment of the tuberculosis insane, and further, as diminishing the risk of the tuberculosis infection of other patients...the advantages [of open-air rest] are obvious.



Easterbrook believed that the extension of open-air bed rest after the opening of ADA's new hospital in 1906, led to a reduction of tuberculosis related deaths.

The principle cause of death...were general paralysis in  
19 per cent...[and] tuberculosis in 19% (21% in 1906).<sup>36</sup>

Tuberculosis though, still dominated the death rates. The isolation of infectious cases from the remaining asylum population may have had preventative advantages in lessening the spread of the disease. Yet in terms of cure, treatment for tuberculosis had to wait until treatment advances made throughout the twentieth century.

### Indoor Bed Rest

The use of outdoor bed rest should be examined in the context of indoor bed rest in asylums. The Weir Mitchell Rest Cure had emerged in the 1870s as a so-called solution to the newly termed neurasthenia (which compounded all nervous disease from depression to hysteria).<sup>37</sup> The concept of neurasthenia meant a nervous breakdown produced by the pressure of civilization, which thus fatigued the individual's nerves. Silas Weir Mitchell was an American doctor who had specialised as a society doctor after serving as a surgeon during the Civil War. Mitchell introduced his cure to the new private clinics and spas that emerged in the late nineteenth century. The cure promoted absolute rest and a milk pudding diet, electrical treatment and massage to restore the individual's health.

Scottish Royal Asylums such as Gartnavel in Glasgow and the CRI in Dumfries adopted the Mitchell Rest Cure for some of their private patients. Mitchell's Rest Cure was a popular form of treatment as it lessened stigma attached to asylum treatment. The upper classes regarded the rest cure as a fashionable form of treatment for ailments. 'U.C.', a private male patient was admitted to the CRI in 1910. His diagnosis

on admission was hypochondria and alcoholism. An anonymous party (most likely his doctor) had written to Dr Easterbrook (then medical superintendent at the CRI) prior to U.C.'s admission.

I have enclosed the medical certificates of a patient whom I have induced to come to Dumfries. My plan to get him away from his house has been to suggest he wants an entire change of surroundings and a rest cure for his nerves.<sup>38</sup>

On admission, the patient was duly put to bed and by the following month was deemed to be getting up and much improved.

The actual practice of the expensive Weir Mitchell at district asylums was non-existent although Easterbrook believed its theories to be influential

Value of indoor rest in the treatment of active insanity...is...more prevalent in asylums...and...dates from the teachings of Weir Mitchell.<sup>39</sup>

Typically, Weir Mitchell's cure was not adopted for patients with a mental illness. By the 1890s, the *JMS* recorded a backlash against the practice.

We must admit that the high hopes with which the Weir Mitchell treatment was ushered in have not been sustained...it has frequently proved a most conspicuous failure where its has had a fair trial. It appears to us that the balance of evidence is against it.<sup>40</sup>

In the same issue the journal indicated that 'Dr Playfair's<sup>41</sup> resolution not to employ it in mental cases is the outcome of untoward experience'.<sup>42</sup> The expensive practice remained limited to the private spas and clinics and not within the budgets or interest of the rate aided asylum.

An increase of hospital beds for asylum patients brought about by hospitalisation also sparked debate between superintendents as to whether rest or exercise was best. A *JMS* report of an *MPA* debate in 1895 polarized Thomas Clouston and John Batty Tuke's

respective practice of rest and exercise. At the meeting, John Batty Tuke stood in favour of using indoor bed rest for some cases of asylum admissions who were not physically ill. However, the cases in which he utilised bed rest were private admissions and in cases 'whose symptoms were not so advanced as to warrant certification' (i.e. not certified as insane).<sup>43</sup> Batty Tuke's use of massage and a special diet for these cases also tied in closely with the Weir Mitchell cure.

Thomas Clouston was described by the journal as entrenched in the tradition of exercise and occupation. The *JMS* commented in 1896

It is surely by the irony of fate that Dr Clouston who has used all the weight of his wide reaching intelligence in support of the hospitalisation of the insane, entered his dissent from the routine treatment of putting patients to bed for a few days or weeks - a practice which directly induces in the mind of the patients and staff the idea of medical care being requisite.<sup>44</sup>

Clouston did sum up that 'I believe that you can get the brain cell better nourished by exertion than by rest in many cases'.<sup>45</sup> However, it does not appear that Batty Tuke favoured rest for all patients either and Clouston was not opposed to the practice in all cases either. Clouston's views appeared to move further in favour of rest in the early twentieth century with his support for a psychiatric ward for new admissions in Edinburgh's Royal Infirmary.

Traditionally, most doctors including Clouston and Batty Tuke believed that a combination of rest and exercise was the best practice in mental illness. Despite being a model asylum of the Asylum-Hospital Movement, Gartloch in Glasgow came under particular attack from visiting Commissioners for the asylum's use of extensive bed rest. In 1905, their report highlighted

The average percentage of patients confined to bed in Scottish asylums is 8.1 but in many of the best asylums the average is under that figure. It is evident from these figures that the patients in this asylum [Gartloch] are confined to bed to an extent far beyond what is deemed beneficial in other asylums.<sup>46</sup>

John Urquhart, superintendent of Murray Royal, Perth recognised the different movements through which psychiatric treatment progressed.

I believe that the greater number of us will continue the middle course, which, in my opinion is the safest... some years ago nobody could be possibly right unless he had a farm, and now, although we still retain our farms for the purposes of exercise, nobody can possibly be right who has not a hospital for the purpose of rest.<sup>47</sup>

Similarly, George Robertson of the PDA expressed his continuing support for exercise.

We all agree that a certain amount of exertion is a right and proper thing in the majority of cases of insanity. In a few cases, however, we carry out the treatment of rest in bed.<sup>48</sup>

This comment is again reflective of continuing traditional methods, despite contemporary debate being overshadowed by the principles of hospitalisation.

The move to place patients in reception or admission wards on entry to the asylum extended the principles of bed rest in the 1900s. This was linked to the more extensive classification of patients in this period (see chapter nine). Charles Easterbrook practiced the use of indoor rest on admission when he was appointed as superintendent to Ayr.

I have no hesitation in recommending on both clinical and therapeutic grounds, the system of placing all newly admitted insane patients in bed amidst hospital surroundings for at least an initial period of observation and treatment.<sup>49</sup>

Easterbrook's support stemmed from the attempt to apply 'general hospital methods to the case of the newly admitted insane'.<sup>50</sup> Similarly, Lewis Bruce, PDA superintendent



commented on the change in thinking that had taken place in the early twentieth century.

A few years ago it was not considered necessary to treat cases of insanity in bed... advantage in knowledge of mental disease points to the case that all cases of acute mental disease should be treated in bed just as cases of acute bodily disease are treated in hospital. For the last 2 years we have treated all out acute cases in bed with good results.<sup>51</sup>

Lewis Bruce had succeeded Robertson at the PDA asylum in 1899. This highlights that Robertson had not advocated the use of indoor bed rest for new admissions throughout this superintendence.

A surprising convert to the practice, James Rutherford, indicates this changing climate of opinion. This thesis has highlighted James Rutherford to be an emphatic supporter of moral treatment and occupation for patients. In 1894, James Rutherford had outlined his disapproval of extensive bed rest.

Absolute rest in bed on admission has recently been advocated as a means of treatment but while not undervaluing the curative influence of rest, I consider that, as a rule, it is bad treatment in the great majority of cases...want of occupation is not rest to those portions of the brain affected in any special case of mental disease.<sup>52</sup>

In later years, Rutherford shifted his stance on the subject. Although it is unclear why Rutherford changed his mind, the CRI annual report (1902) highlighted that 'Dr Rutherford has now become a convert to the...treatment of the newly admitted insane by an initial period of rest in bed'.<sup>53</sup>

The use of indoor bed rest was closely linked to the attempt to present the asylum as a hospital. The CRI casenotes included in appendix three denote the increased emphasis placed on the physical condition of the patient as well as their mental illness (see for



Typically, indoor rest was supported for patients such as the old or physically sick who were perhaps unable to participate in traditional asylum occupation. The practice of Weir Mitchell did not impact on the district asylums although it influenced individual doctors such as Easterbrook and Batty Tuke. Doctors such as Easterbrook regarded indoor bed rest and application of clinical procedures as a way to promote the asylum as a hospital. Yet even the main supporters of hospitalisation, Robertson and Clouston remained emphatic in their use of exercise for the majority of patients. With the construction of reception wards from the 1900s, indoor bed rest for new admissions gained popularity. However its excess use remained subject to criticism by both commissioners and doctors.

#### Outdoor bed rest for non-tuberculosis patients

The support for outdoor bed rest is tied in with the tuberculosis problem. Tuberculosis did not simply materialise in the asylum. More often than not, carriers who spread the disease around the institution brought in tuberculosis from outside the asylum. As such, larger urban asylums that had a high annual intake utilised open air bed rest for new admissions as a monitorial practice. In his 1903 annual report, Dr Parker, medical superintendent at Gartloch explained the problem of tuberculosis infection in new admissions.

The high proportion of deaths from tubercular disease in a new institution was no doubt due to the widely spread infection among the transfers from the old city poorhouse wards and due to the huge proportion of the early admissions being residual cases transferred from other asylums. In the first year of the asylum, the number of deaths from tuberculosis was 27.2%.<sup>54</sup>

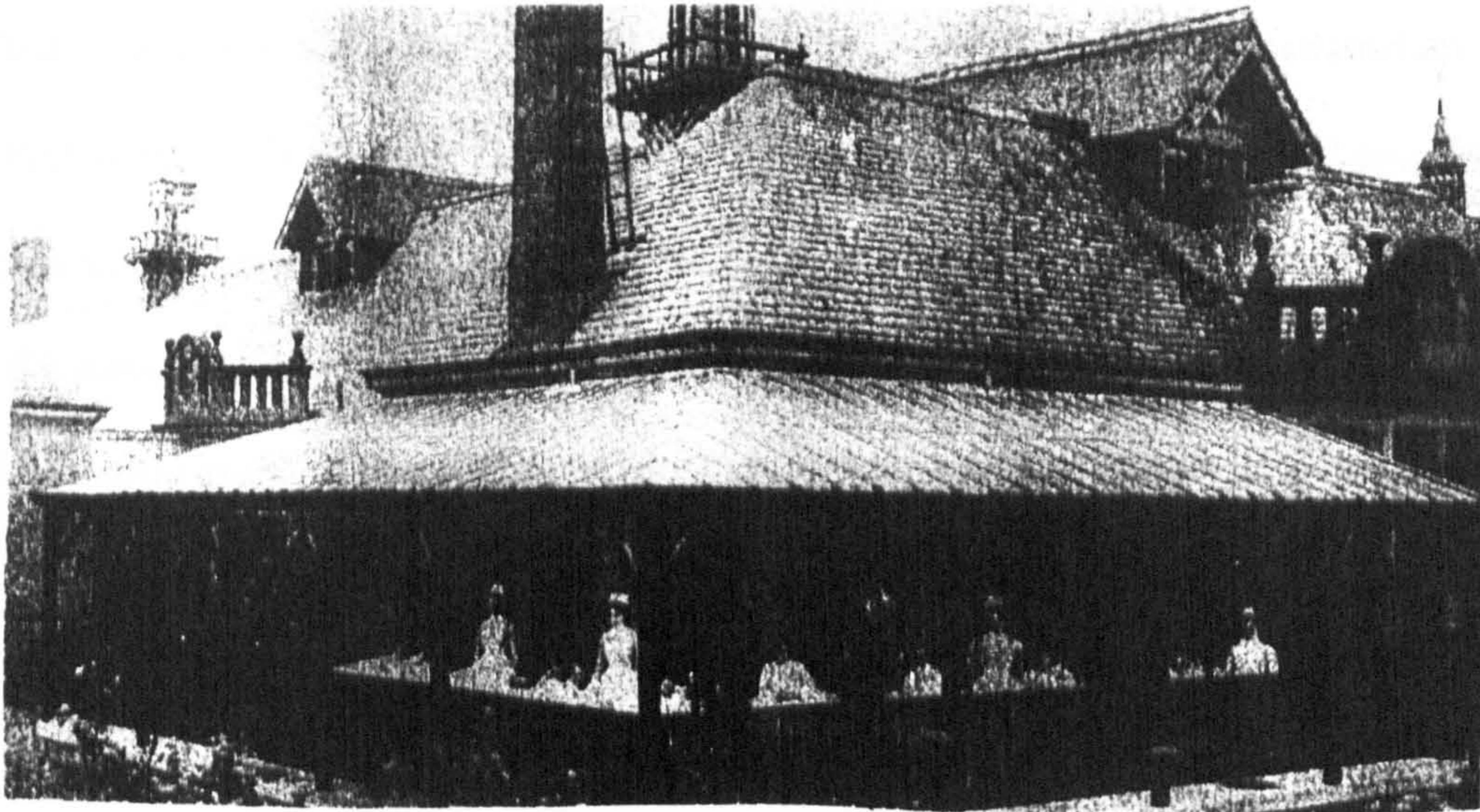
By confining new patients to open-air rest on admission, the potential spread of tuberculosis could be minimised (see illustrations 1 and 2). Then, if a patient



developed signs of tuberculosis, he or she could then be removed to the asylum's isolated sanatorium.

Illustration 1

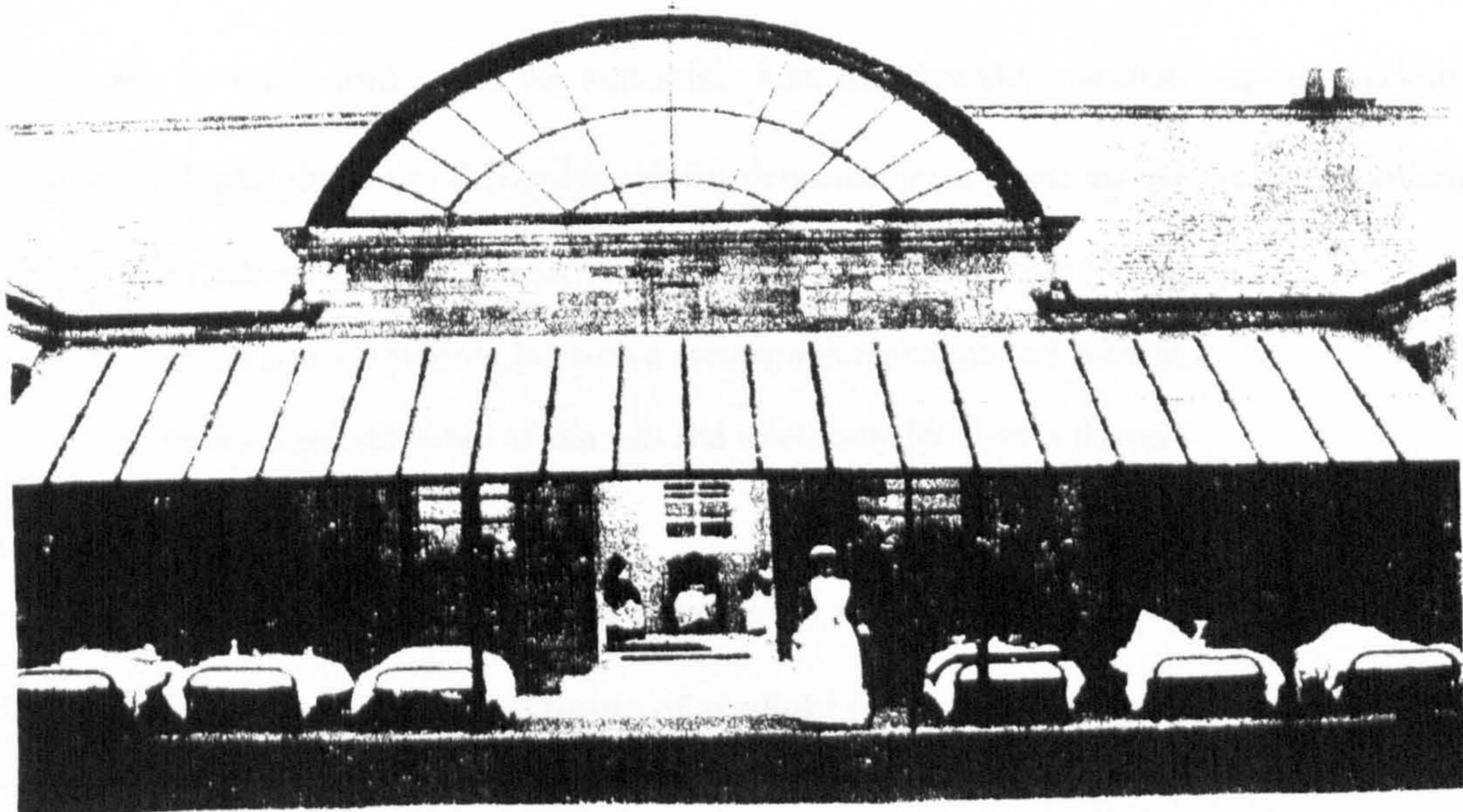
Gartloch admission ward verandah (1909)



*Source: G. Hutton, Gartloch Hospital 100 Years, (Richard Stenlake, 1994)*

Illustration 2

ADA Reception Ward Female Verandah (1907)



*Source: Source: C.C. Easterbrook, 'The Sanatorium Treatment of Active Insanity by Rest in Bed in the Open Air', JMS, 53 (1907)*



A slightly different procedure was in operation at Woodilee in Glasgow. Here, its Reception House was opened in 1902. All new inmates were admitted to its wards and a patient's length of stay depended upon their mental and physical condition. The building was of the same architectural style and construction of the sanatorium. In its first year, the Reception House received 373 admissions, of which 130 patients were discharged without having to mix with the main asylum patients.<sup>55</sup> A strong benefit of the Reception House was that tubercular cases were identified and then sent straight to the sanatorium without contact with the main asylum. Once in the sanatorium, patients received the standard form of open air treatment within the confines of the building and verandahs.

Doctors also did not object to placing patients in bed out of doors if they already required rest for their physical ailments. The open air element had a long history in asylum care and was demonstrated by the support of Commissioners and doctors for outdoor asylum occupations. The use of rest in the open air tied in with the fresh air theories and open spaces that were that were currently in vogue such as the promotion of parks in cities and open air schools. Landel Oswald, medical superintendent of Gartloch highlighted the difficulties in implementing an open-air life style in Scotland.

Abundance of fresh air, exercise and sunshine are often the best prescriptions we can give our patients, but such a prescription cannot be best taken in a climate where 42 inches of rain falls and where only 160 days in the year are dry.<sup>56</sup>

Oswald maintained a daily weather maintained a daily weather report for the institution and published the rainfall and hours of sunlight in his reports.

Whilst working as an assistant doctor at the Royal Edinburgh asylum, Easterbrook was influenced by Clouston's practice of allowing people to rest outside in the summer months at the REA.

I recalled certain sunbathed days in summer at Morningside when all the sick, infirm and bed-ridden patients in the women's hospital at West House were turned out of doors in beds, hammocks and chairs...I retained vivid impressions of the sunburnt faces, healthier bodies and more contented minds as the result thereof.<sup>57</sup>

Verandahs were attached to normal hospital wards in order to give hospital based patients the benefits of fresh air. Case H of H.A admitted to the asylum in 1911 is included in Appendix three. The patient was a suspected G.P.I case whose bodily health was poor on admission. The patient was put to bed for at least a month after admission after which he was given his clothes back and allowed up. W.R. was admitted to the CRI in September 1909. After a month of verandah treatment his notes also highlight that 'still outside in bed, which certainly seems to have improved his appetite and helped sleep'.<sup>58</sup> L.K., also a CRI male admission was 'out all day in bed in the open air' throughout July 1907 and 'is looking physically much better'.<sup>59</sup>

In 1909, Easterbrook reported of open-air rest that:

...for the promotion of bodily functions generally, there are few remedies so potent and at the same time so pleasant and easy of application as open air rest cure.<sup>60</sup>

In the 1911, Parker, then superintendent of Gartloch commented that

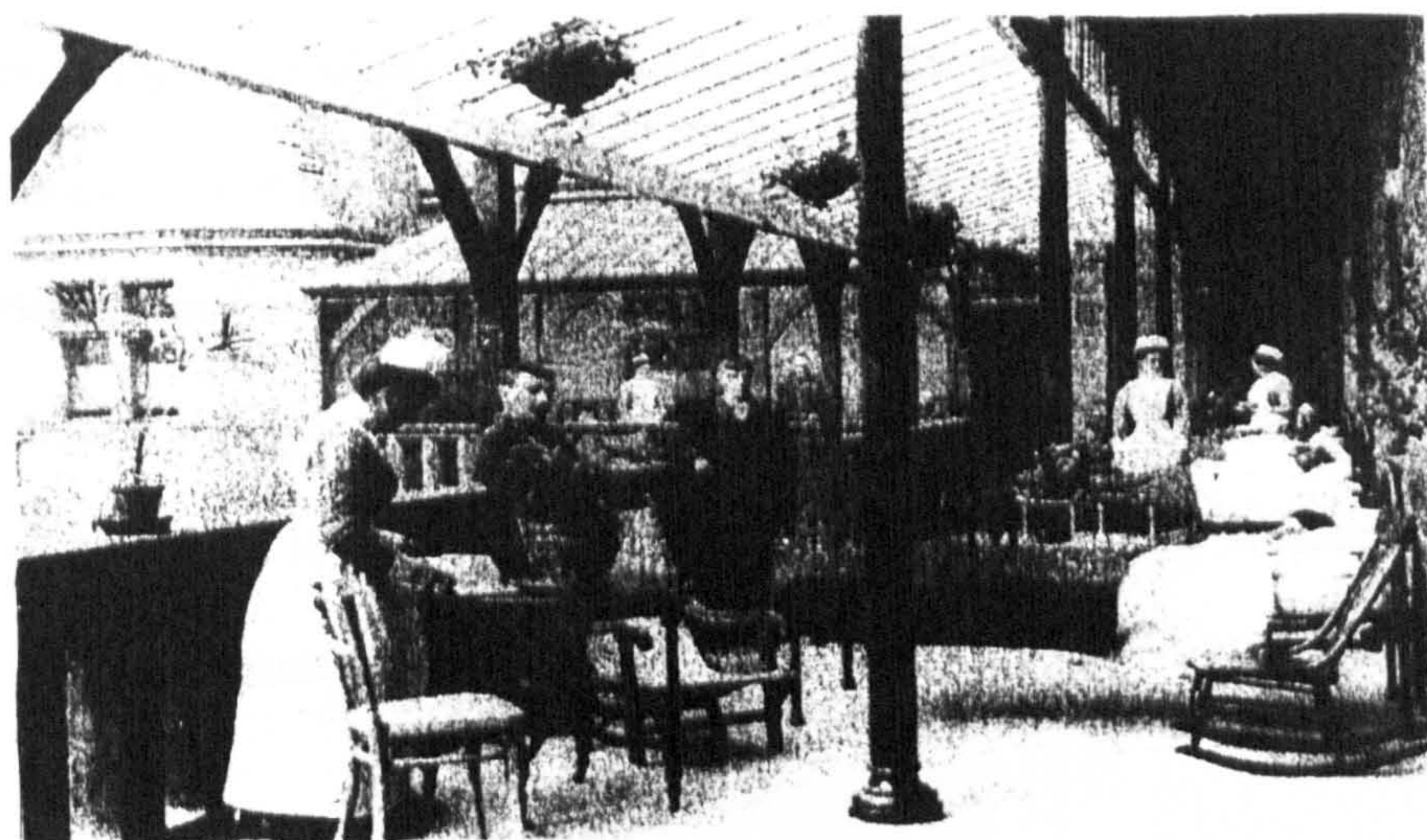
We have...used open air treatment very largely in our verandahs attached to our hospital section...The verandah treatment still provides here the open-air environment for the more detailed of our acute cases.<sup>61</sup>

Illustration 3 shows the verandah attached to Gartloch's male infirm ward. In this year the verandahs were also extended to non-hospital patients who were unable to work in



the open air. The visiting Commissioner to Gartloch commented that 'it would be a great boom for them to enjoy a more or less constant life in the open air'.<sup>62</sup>

Illustration 3  
Gartloch Male Infirm Ward Verandah (1909)



*Source: G. Hutton, Gartloch Hospital 100 Years, (Richard Stenlake, 1994)*

Easterbrook emphasised the apparent link between weight gain and open air rest. At the International Congress of Alienists held at Amsterdam in 1907, Easterbrook read his paper on open-air rest and highlighted 'there is... an increase of weight amounting to 5lb, 6lb, or 7lb occurring in the first two or three weeks'.<sup>63</sup> ADA case notes highlight weight gains and casenotes recorded weight along with details of the patient's diet. The male patient A.J. was discharged from the ADA in 1907: 'he has remained well and has gained 4 ½ lbs since admission'.<sup>64</sup> M.D. was discharged in February 1908: 'She has gained 13lb in weight'.<sup>65</sup> However, the link between weight gain and improving mental illness was not a new phenomenon in the treatment of mental illness. Beveridge highlights that Clouston believed stoutness to be a remedy for mental distress and consistently promoted a gospel of fatness at the REA.<sup>66</sup> The emphasis placed on a full



diet in the asylum detracts from comparisons with the prison regime where inmates often received an inadequate diet.

Doctors were supportive of the monitorial role that open-air rest could play in reducing tuberculosis levels on admission. There was little objection by men such as Clouston and the commissioners for open air to be used for hospital cases already in bed or for patients unable to occupy themselves. In contrast, the application of open air bed rest for active insanity (i.e. the violent, excited or uncontrollable) and those physically fit to work, was to be rejected by the majority of doctors as another new craze in the treatment of mental illness.

### Open Air Rest and Control

Easterbrook and a handful of other medical superintendents including Parker at Gartloch adopted open-air rest as a method of control for violent, noisy and suicidal patients. In 1905, Dr Parker, then medical superintendent of Gartloch commented:

The completely open door and open air life of the sanatorium has been developed by putting the restless, wandering and runaway to bed for their open-air treatment.<sup>67</sup>

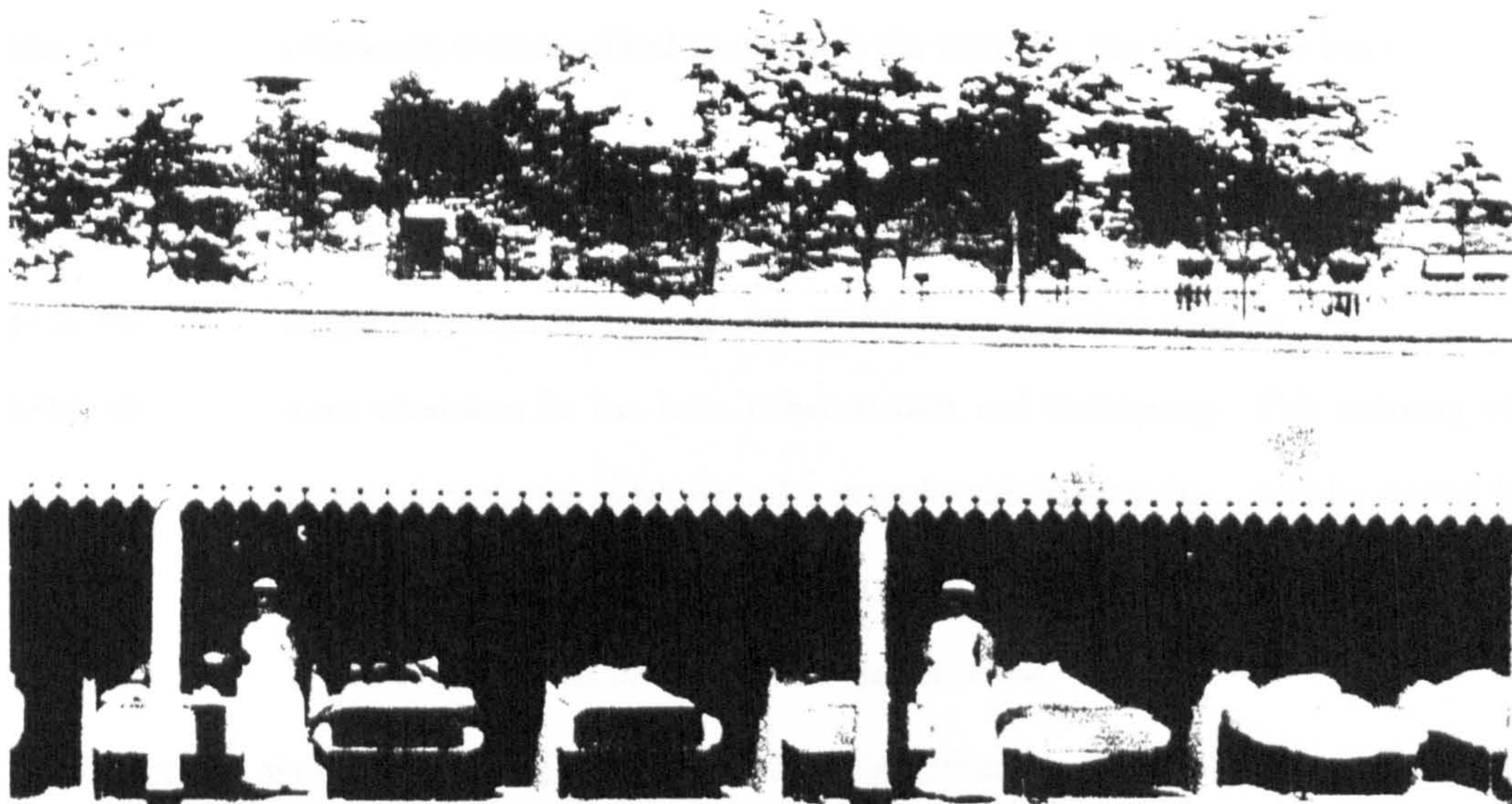
For Easterbrook, the partition of verandahs supported their use for isolation and control.

owing to the common feature of noisy excitement among such cases [active insanity], and the tendency of one excitable patient to disturb or to be by others... I found it advisable to have the beds in these verandahs isolated...by means of wooden partitions, thus adding to the valuable factor of isolation to the open-air rest treatment.<sup>68</sup>



Illustration 4 denotes the segregated nature of the ADA verandah for this group of patients. In comparison to the verandahs used for the sick and new admissions, the isolation verandah at Ayr allowed patients little to no contact with each other.

Illustration 4  
ADA Women's verandah at Main Building (1907)



*Source: Source: C.C. Easterbrook, 'The Sanatorium Treatment of Active Insanity by Rest in Bed in the Open Air', JMS, 53 (1907)*

Open air bed rest was utilized as a form of observation. O.M was admitted to the CRI in 1910 and in February 1911, doctors decided to 'give this patient a prolonged spell of bed treatment, hence he has been ordered to bed in the verandah. It is most unstable to go about crying...to be paranoid...he is evidently in a frail mental condition'. By the following month, he was deemed to be progressing so well that 'he is to be tried up again'.<sup>69</sup> Patients hinting escape also required observation. Miss W. admitted to the CRI in 1912 'is irritable and has had one or two struggles for liberty. [She] pleads to get away and is full of quite unreasonable demands. Is being treated in the verandah and seems to like this'. One month after admission, the patient was 'still on verandah' but was deemed to be 'more reasonable'.<sup>70</sup>



Violence towards medical staff or other patients could lead to confinement outside. In February 1912, a Gartloch female pauper patient, named J.G. was sent for verandah treatment after attacking a nurse.

Feb. 1912            patient impulsively assaulted the charge nurse with her boots, hitting her several times on the head and face. Put to bed on verandah.

Mar. 1912            after nearly 6 weeks of bed treatment in the verandah, this patient has been allowed up.<sup>71</sup>

B.B. was admitted to the ADA in September 1908, suffering from mania.

1/10/08            In bed on verandah. Quarrelsome, troublesome, threatens to strike.

8/10/08            since admission he has been rather restless and threatening. This morning when going out to the verandah he had a struggle with an attendant...said he wanted back for his money and when not allowed to go he knocked down the attendant.

20/10/08            since last note he has been in bed on the verandah.<sup>72</sup>

Most doctors were dubious of the extent that Easterbrook promoted open air rest as a cure for mental illness. The *BMJ* commented cautiously of his practice that 'this treatment has not been established long enough to be convinced of the results'.<sup>73</sup> Similarly, an *MPA* debate held after a paper by Easterbrook raised doubt about the use of open-air bed rest for active cases of mental illness. Clouston commented

People like Dr Yellowlees...and himself [Clouston] looked with admiration, with respect, with great approbation on a man like Dr Easterbrook coming and telling them about a new system, and therefore laying psychiatry under a special indebtedness to his efforts; but the author must not be offended if they said that they did not believe in its universal applicability.<sup>74</sup>

Dr Yellowlees stated that he was 'absolutely agreed to as to the value of fresh air for everyone' although commenting that

there were certainly some cases which did better with exercise in the open air than they did if sent to bed. For instance, a fell-blooded adolescent he would not put to bed, but would, if possible, set him to dig in the garden.<sup>75</sup>

Dr Thomson, an English superintendent attending the same debate commented of his support for work in a particular type of patient.

Self centred women, generally in the female sex, who had received all the attention and devotion possible at home. For them there was no treatment like that of the pail and scrubbing brush.<sup>76</sup>

This idea of reducing people's delusions as to their status is telling in the casenotes of patients who were perceived self absorbed or self important. The case of A.G.S. in appendix three (Case C) notes the various attempts used by the doctors to 'reduce his exhaled ideas of his own importance and powers'.

The use of open air bed rest as a form of control was not common practice. Like the use of excessive indoor rest, Commissioners objected to the unnecessary use of open-air bed rest. In 1917, Commissioner Carswell commented that it 'lends itself to being used as a convenient means of relieving the nursing staff of a troublesome patient who would probably have cause trouble if allowed the freedom of his or her own activities'.<sup>77</sup> However, this highlights the lack of control possessed by Commissioners over the individual practice of medical superintendents. Easterbrook continued to use open air bed rest at the CRI long into the 1930s.

### Patient Reactions

If the use of open-air rest for the mentally ill is bewildering in a modern context, then it must have appeared even more bizarre for its recipients. As is common in medical history, much of the narrative focuses upon the professional's views. It is therefore easy to overlook the human reaction of asylum patients to new treatments and to arrogantly presume their reactions.

Case notes provide an image of patient reactions despite their authorship by the asylum doctor. Some patients appeared to positively enjoy and benefit from this method of outdoor rest. Miss W. admitted to the CRI in 1912 'is being treated in the verandah and seems to like this.'<sup>78</sup> The male CRI admission W.B.A was reluctant to receive verandah treatment at first but then grew to enjoy it.

24/11/08            This patient is now much better. He has had nearly a month of bed treatment in the open air. First he resisted it but now he is greatly taken with it and is hopeful that in about a year's time he will recover.<sup>79</sup>

At the ADA, the female admission J.M. was diagnosed with acute melancholia

10/12/08            Patient is very depressed. Thinks she is about to die.

16/12/08            Still very depressed. In verandah during the day.

21/12/08            Greatly confused. Thinks she cannot get better.

04/01/09            During the past week [the] patient has smiled several times.

06/02/09            Patient has been up for 3 days and is now sewing.

In a letter written to the ADA doctors after her discharge in 1910, she outlined appreciation of her received asylum treatment.

Dear Sirs

08/10/10

You will be thinking me very ungratefull [ungrateful] to you for all that you have done for me. But that is not so for I am very thankfull [thankful] to you and there is never a day goes past that I don't remamber [remember] you and all the others for what you have done for me. I never felt better or happier in all my life. And had it not been for your care and kindness I would have been dead. I never thought when I was in your care I should be well again but I am...<sup>80</sup>

However, many patients were hostile to the peculiar nature of verandah treatment. This was certainly true of patients at the CRI who paid for their treatment. Mrs B. a private patient paying £80 per year received indoor rest on admission in 1911 but 'much to her annoyance has been ordered rest outside in bed in the verandah'.<sup>81</sup> M.G. a female patient paying £120 per year was 'very displeased at being put outside in



bed'.<sup>82</sup> J.C.Y. was admitted to the CRI in 1910 suffering from GPI. He was 'treated by rest in bed outside' but his notes record that 'but with this treatment he is very dissatisfied'.<sup>83</sup>

Although most patients continued to receive verandah treatment despite their dissatisfaction, some patients were removed from this treatment if it were deemed detrimental to their recovery. The male patient G.I.C. was admitted to Bangour in 1912. His mental condition was described as 'melancholic, mentally confused and subject to hallucinations that people are speaking ill of him'. On admission the medical superintendent George McRae ordered the patient verandah treatment. In a statement to McRae (included in the casenotes), the patient outlined his dislike of verandah treatment.

In the second place I should never have been here at all. Practically every word I speak is circulated among the nurses and patients with the result that I am now frightened to speak to anyone. The way I have been insulted since I came here is almost intolerable...*nearly every patient on the verandah has turned on [or] been turned against me.* Sooner or later I will become insane if I am made to lie in bed and bear these insults any longer.

The patient continued to believe that he was being harassed by both patients and staff, and soon after, was removed back to the ward.<sup>84</sup>

One unique and under researched method of gauging patient reaction is through the use of photographic material. The ADA case notes retain a vast number of photographs of patients receiving verandah treatment. Although such a source requires more research, suffice to say that many images of patients on camera show frightened and confused reactions. There is the obvious danger of misinterpretation in the use of this source. 'Mugshots' would have been taken on admission and many

patients would have been terrified by their incarceration in a Victorian asylum. Susannah Davis also comments in connection with nineteenth century criminal photographs that many people might not have seen a camera before and could have been frightened of the 'alien box' pointing at them.<sup>85</sup> Although the photographs only provide physical proof of verandah practice, the images provide a fascinating adjunct to the notes.

### Conclusion

Open-air rest came to Scottish asylums on the wave of tuberculosis prevention. The open-air principle of bed rest was vital in any existing or suspected case of tuberculosis. Verandah treatment allowed for the isolation of tuberculosis cases from the body of the main asylum and aimed to reduce the spread of the disease. Monitoring of tuberculosis was also achieved through the incarceration of new admissions on verandahs. This was particularly important if patients had been transferred from other institutions (such as poorhouses), where there was a high possibility that they would have contracted the disease.

If the patient was already confined to bed, doctors had little objection to the added bonus of fresh air. Whether the rest was inside or out was perhaps less important than the milky diet prescribed and the lack of exercise participated in by the patient. However, the novelty of outdoor rest did permit asylum doctors to be convinced that they were working along the most modern contemporary principles of fresh air. Of importance though is the objection of overusing bed rest whether indoors or outside. The move to utilise bed rest on admission through reception wards led to increased popularity in the practice of rest. In turn, this impacted on the increased acceptance of rest out of doors.

Most revealing, some doctors extended verandah to the 'problem' patients. By confining patients to bed, medicine and drugs were more easily administered and patient movement restricted. Whether the rest was indoor or outside was of little consequence. Other doctors and the Commissioners remained little convinced of verandah treatment for such cases and continued to support the traditional of physical activity. Yet the reality that some doctors became convinced that lying in bed out of doors was a method by which mental illness could be cured, demonstrates the undeniable ineffectuality that existed in both hospitalisation and traditional asylum treatment.

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<sup>1</sup> Interchangeable with the terms 'verandah treatment' or 'fresh air treatment'.

<sup>2</sup> Dr Landel Oswald (Medical Superintendent) in *3<sup>rd</sup> Annual Report of Gartloch Asylum and Hospital*, (1899-1900), HB1/6/3.

<sup>3</sup> C.C. Easterbrook (Medical Superintendent) in *37<sup>th</sup> An. Rep. of Ayr District Asylum*, (1907), AA17/7.

<sup>4</sup> *56<sup>th</sup> Report of the Commissioners in Lunacy for Scotland*, (1913), GD17/5/24.

<sup>5</sup> L. Bryder, *Below the Magic Mountain. A Social History of Tuberculosis in the 20<sup>th</sup> Century*, (Oxford University Press, 1988); T. Dormany, *The White Death A History of Tuberculosis*, (The Hambledon Press, 1999) and F.B. Smith, *The Retreat of Tuberculosis 1850-1950*, (Croom Helm, 1988).

<sup>6</sup> Dormany, *The White Death*, p.78-79.

<sup>7</sup> *Ibid.*, p.79.

<sup>8</sup> A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat 1796 - 1914*, (Cambridge University Press, 1985) and J. Andrews & I. Smith (ed), *Let There be Light Again: A History of Gartnavel Royal Hospital from its Beginnings to the Present Day*, (Gartnavel Royal Press, 1993).

<sup>9</sup> Bryder, *Below the Magic Mountain* and Smith, *The Retreat of Tuberculosis 1850-1950*,

<sup>10</sup> R. Jones, 'Tuberculosis in the Insane', *British Journal of Tuberculosis*, 3 (1909), p.15.

<sup>11</sup> *Ibid.*, p.9.

<sup>12</sup> See for example, F.G. Crookshank, 'The Frequency, Causation, Prevention and Treatment of Phthisis Pulmonalis in Asylums for the Insane', *Journal of Mental Science*, 45 (1899); D. Blair, 'Isolation and Open-Air treatment of the Phthisical Insane, with Notes on Seventy-four Cases treated', *JMS*, 96 (1900) and Jones, 'Tuberculosis in the Insane', *BJT*, (1909).

<sup>13</sup> *27<sup>th</sup> An. Rep. of Woodilee District Asylum*, (1902), HB30/2/12A.

<sup>14</sup> *37<sup>th</sup> An. Rep. of the ADA*, (1907), AA17/7.

<sup>15</sup> *40<sup>th</sup> An. Rep. of Argyll and Bute District Asylum*, (1903).

<sup>16</sup> Smith, *The Retreat of Tuberculosis*, P.171-72.

<sup>17</sup> Bryder, *Below the Magic Mountain*, p.29.

<sup>18</sup> *Ibid.*

<sup>19</sup> *2<sup>nd</sup> An. Rep. of the Royal Victoria Hospital*, (1897-8), SD3851.

<sup>20</sup> *1<sup>st</sup> An. Rep. of the RVH*, (1896-97), SD3851.

<sup>21</sup> Bryder, *Below the Magic Mountain*, p.56.

<sup>22</sup> *British Medical Journal*, 2 (1906), p.1534-5.

<sup>23</sup> Crookshank, 'The Frequency, Causation, Prevention and Treatment of Phthisis Pulmonalis in Asylums for the Insane', p.678-9.

<sup>24</sup> Jones, 'Tuberculosis in the Insane', p.10-11.

<sup>25</sup> O.J. Wilsey, 'Tent Life for the Insane', *American Journal of Insanity*, 59 (1902-03), p.629.

<sup>26</sup> Phthisis was an alternative medical term for tuberculosis.

<sup>27</sup> C. Floyd Haviland, 'Tent Life for the Tuberculosis Insane', *American Journal of Insanity*, 59 (1902-03), p.327.

<sup>28</sup> *24<sup>th</sup> An. Rep. of Gartnavel Royal Asylum*, (1907), HB13/2/94.



- 29 Jones, 'Tuberculosis in the Insane', p.16.
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- 31 *6<sup>th</sup> An. Rep. of Gartloch*, (1903), HB1/6/5i.
- 32 *Ibid.*
- 33 *Ibid.*
- 34 *24<sup>th</sup> An. Rep. of Gartnavel*, (1907) HB13/2/94.
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- 37 Termed by the American electrotherapist George Beard in 1869. See E. Shorter, *A History of Psychiatry From the Era of the Asylum to the Age of Prozac*, (John Wiley & Sons, 1997), p.129-130.
- 38 *CRI Casebook of Male Admissions*, (1908-1913), DUM.CR1989.153.
- 39 C.C. Easterbrook, 'The Sanatorium Treatment of Active Insanity by Rest in Bed in the Open Air', *JMS*, 53 (1907), p.731.
- 40 *Occasional Notes of the Quarter*, *JMS*, 42 (1896), p.347.
- 41 William Playfair, the London society gynecologist first introduced the rest cure to England in 1881. See M. Gijswijt-Hofstra & R. Porter (ed), *Cultures of Neurasthenia from Beard to the First World War*, (Rodopi, 2001).
- 42 *Occasional Notes of the Quarter*, *JMS*, 42 (1896), p.347.
- 43 'Rest and Exercise in the Treatment of Nervous and Mental Diseases', A discussion opened by T.S. Clouston and J. Batty Tuke at the Annual Meeting of the Medico-Psychological Association, July, 1895, *JMS* 41 (1895), p.612.
- 44 *Occasional Notes of the Quarter*, *JMS*, 42 (1896), p.347.
- 45 Clouston and Tuke, 'Rest and Exercise in the Treatment of Nervous and Mental Disease', p.607.
- 46 *9<sup>th</sup> An. Rep. of Gartloch*, (1905-06), HB1/6/6.
- 47 *Ibid.*, p.618.
- 48 *Ibid.*, p.620.
- 49 Easterbrook, 'The Sanatorium Treatment of Active Insanity', p.728.
- 50 *Ibid.*
- 51 *37<sup>th</sup> An. Rep. of the Perth District Asylum*, (1901).
- 52 *55<sup>th</sup> An. Rep. of the CRI*, (1894), DUM.CR1989.249.
- 53 C.C. Easterbrook, *A History of the Crichton Royal Institution*, (Dumfries Press, 1945), p.283.
- 54 *6<sup>th</sup> An. Rep. of Gartloch*, (1903), HB1/6/5i.
- 55 *29<sup>th</sup> An. Rep. of Woodilee*, (1903-04), HB30/2/14.
- 56 *3<sup>rd</sup> An. Rep. of Gartloch*, (1899-1900), HB1/6/3.
- 57 Easterbrook, 'The Sanatorium Treatment of Active Insanity', p.734.
- 58 *CRI Casebook of Male Admissions*, (1908-13), DUM.CR1989.153.
- 59 *Ibid.*
- 60 *72<sup>nd</sup> An. Rep. of CRI*, (1909), DUM.CR1989.259.
- 61 *12<sup>th</sup> An. Rep. of Gartloch*, (1911-12), HB1/6/6.
- 62 *Ibid.*
- 63 *British Medical Journal*, (19 Oct. 1907), p.1093.
- 64 *ADA Casebook of Male Admissions*, (1907-08), AA17/3/48.
- 65 *ADA Casebook of Female Admissions*, (1908-09), AA3/12.
- 66 A. Beveridge, 'Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873-1908 Part I', *History of Psychiatry*, 6 (1995), p.27.
- 67 *8<sup>th</sup> An. Rep. of Gartloch*, (1904-5), HB1/6/6.
- 68 Easterbrook, 'The Sanatorium Treatment of Active Insanity', p.734.
- 69 *CRI Casebook of Male Admissions*, (1908-13), DUM.CR1989.153.
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- 71 *Gartloch Casebook of Female Admissions*, (1907), HB1/13/15.
- 72 *ADA Casebook of Male Admissions*, (1907-08), AA17/3/48.
- 73 *BMJ*, (19 Oct. 1907), p.1093.
- 74 Discussion at the Annual Meeting held in London, July 25<sup>th</sup> 1907, included in Easterbrook, 'The Sanatorium Treatment of Active Insanity', *JMS*, (1907), p.748.
- 75 *Ibid.*, p.747
- 76 *Ibid.*
- 77 Easterbrook, *Chronicles of Crichton A History of the Crichton Royal Institution*, (Dumfries Press, 1945), p.416-417.
- 78 *CRI Casebook of Female Admissions*, (1909-13), DUM.CR1989.108.
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<sup>80</sup> *ADA Casebook of Female Admissions*, (1908-09), AA17/3/12.

<sup>81</sup> *CRI Casebook of Female Admissions*, (1909-13), DUM.CR1989.108.

<sup>82</sup> *Ibid.*

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<sup>84</sup> *Male Discharges. Bangour*, (various dates).

<sup>85</sup> S. Davis, 'Mugshots', [www.bbc.co.uk/community/family/mugshot\\_1.shtml](http://www.bbc.co.uk/community/family/mugshot_1.shtml)

**Chapter seven**  
**Scientific Research**  
*'A Plea for the Scientific Study of Insanity'*

There is unfortunately, an inevitable aloofness in asylum life. Medical observation and research is frequently pursued in uncongenial and remote surroundings; enthusiasm too, often wanes in the presence of dull routine and mechanical duties.<sup>1</sup>

Introduction

Scientific research was an important ideal of hospitalisation. The emergence of a research culture in British medicine and development of a more scientific based curriculum led to a desire by psychiatry to expand research in the field. From the 1890s, individuals such as Thomas Clouston and John Batty Tuke called for impetus to be taken in scientific research of psychiatry. This plea for scientific research came largely as a reaction to progress made in scientific research in British medicine as well as events in psychiatry in England and abroad. Scientific research had also been aided by the development of clinical and diagnostic tools, already outlined in chapter two.

By the early twentieth century, scientific research had made progress in Edinburgh and Glasgow's universities and asylums. Allan Beveridge and Jonathan Andrews have established this in their respective overviews of the topic.<sup>2</sup> Here a wide range of neuropathological and mental pathological research subjects included cerebral tumours, hemorrhage and epilepsy.<sup>3</sup> However, less is known about what was occurring outside the main established research centres. A Conjoint Laboratory Scheme of Scottish Asylums was established in 1897 in order to encourage research work outside Edinburgh and Glasgow. Efforts were also made by medical superintendents at asylums to establish laboratories and conduct research.

The chapter highlights how financial limits placed on scientific research was the biggest constraint to research work. The Conjoint scheme established in 1897 had no official funding. However, this is unsurprising in light of the lack of funding received for scientific research in general medicine. In the individual asylums, funding for pathologists was up to the discretion of the District Boards. More often than not, the District Boards were unwilling to loosen the purse strings in order to employ scientific staff.

Scientific research was typically left up to the efforts of individual medical superintendents and doctors who had an interest in this field. Over stretched medical staff were often expected to conduct research work along with the more routine pathological duties such as post-mortems. There were pockets of initiative in a number of asylums, such as Lewis Charles Bruce at Perth District Asylum, Charles Easterbrook at the Crichton Royal, Dumfries, Hamilton Clelland Marr at Woodilee District in Glasgow and Douglas McRae at Ayr District Asylum.

An influence on these men's interest in research was their mentor Thomas Clouston. Beveridge has highlighted the importance of the REA as a training centre for dozens of medical staff.<sup>4</sup> Similarly, Andrews agrees that Edinburgh and its Royal Asylum took the lead in pioneering research work<sup>5</sup>. This chapter shows how medical superintendents such as Lewis Bruce, Easterbrook and McRae had all worked under Clouston at the REA and took their knowledge and interest in scientific research to their individual asylums.

The chapter outlines the prejudices inherent in general medicine, which created barriers against scientific research in asylums. Firstly, doctors who secured funding for

pathologists at their asylums then found it difficult to attract scientific staff from the universities and major towns. Easterbrook's efforts at the Crichton are taken as illustration of this. Although the lack of interest in asylum posts was an opportunity for newly qualified female doctors and dispensers, there remained hostility from the male dominated ranks.

### Context of Scientific Research

While the British medical profession was by no means analogous in its attitudes, goals and standards, a research culture based on scientific medicine had been established by the late nineteenth century. This period witnessed the appearance of journals such as *Nature* (1869), *Journal of Physiology* (1878) and *Journal of Experimental Medicine*, (1896). Support for scientific research is also indicated by the medical community's lobbying for state funding for research in *Nature*, *British Medical Journal* and the *Lancet*.

From the 1870s developments were made in British physiology. In the 1830s, William Sharpey (an Edinburgh graduate) was appointed to the chair of anatomy and physiology at King's College, London. Following this, Michael Foster set up a research school in Cambridge and Edward Schaffey made inroads into muscular contraction in Edinburgh. From the late 1880s the bacteriological movement became one of most significant in scientific medicine. Lawrence argues that its acceptance was closely linked to the success of Listerism in the 1880s.<sup>6</sup>

Another indication of the growing interest taken by the medical community in scientific research was the emerging medical societies. Jacqueline Jenkinson argues that medical societies in Scotland formed an important part of the intellectual makeup of Scottish medicine and were forums of medico-political and professional debate.<sup>7</sup> In



the early nineteenth century phrenological science was seen (at least until the 1840s) to play a legitimate role in the expansion of medical knowledge and education. Consequently, the subject enjoyed significant medical debate in societies such as the Edinburgh Phrenological Society (formed 1820). Late nineteenth century interest in scientific research was exemplified by the formation of societies that promoted research. The increased use of the microscope by practitioners is demonstrated by the formation of the Microscopical Society of Glasgow in 1886 and Edinburgh's Scottish Microscopical Society in 1891.<sup>8</sup>

Medical education developed its scientific basis from the 1850s. In Glasgow for example, pathological anatomy formed part of Glasgow University's medical curriculum from 1865. Jacyna argues that the employment of Allen Thomson as Professor of the Institutes of Medicine in the University of Edinburgh from 1842 to 1848 marked a new departure in Edinburgh's physiology teaching. Thomson was influenced by German developments and like his European counterparts confined his work to teaching and research.<sup>9</sup> Laboratory science (usually science based on animal experimentation) was initially tied to the promotion of the universities in medicine and the reform of medical education.<sup>10</sup> However, the promotion of experimental medicine was not widespread and Lawrence argues that experimental physiology was often limited to small groups of doctors.<sup>11</sup>

Glasgow University insisted that a course of pathology anatomy should form part of the medical curriculum after 1865. However, most universities lacked teachers who were able to specialise or had time to specialise in scientific research. The teaching of most clinical and scientific subjects by 'part-timers' (men who also worked in private practice) was still evident after the First World War. Even in university based schools

such as Edinburgh and Glasgow, professors of medicine, surgery and obstetrics retained varying amounts of private practice.<sup>12</sup> Scottish university teachers were constrained by the need to attract student fees, and had little time for original research work. Also a problem was the financial obstacle to university based scientific research. Science teaching had the biggest impact on the university's finances as laboratories and equipment were not funded by the student fees. Government funding for university research remained at a low with more value placed by ministers on the treatment of disease.

As a result, scientific medicine certainly emerged more slowly in Britain than abroad. Porter argues that although British physiology gained a place on the international scene by the late nineteenth century, the British medical schools possessed little collective encouragement of clinical research.<sup>13</sup> Comparatively, German universities were stated funded and evolved a vast research ethos. This had partly come about from the distinct nature of, and academic competition between German states prior to unification in 1871.<sup>14</sup> Germany's dominance arose too from the freedom of university teachers to teach specialties and the ability of students to attend different universities. In America, developments included the formation of the Rockefeller Institute for Medical Research in 1901. Porter suggests that what Germany had been in the nineteenth century, America became in the twentieth century.<sup>15</sup>

In psychiatry, scientific research was developing both internationally and in England. British asylum doctors shared a common view that Britain lagged behind research that had been achieved on the continent. Beveridge highlights that whereas British psychiatrists developed independently of general medicine, and had become superintendents of asylums, German equivalents had established a place in the clinics

of the university hospitals.<sup>16</sup> German laboratory medicine was also renowned for its work in developed in microscopy, vivisection and chemical investigations. Shorter argues that Germany became the world leader in psychiatry in the nineteenth century, mainly due to the competition between universities and the asylums' access to state funding.<sup>17</sup>

Although the whole of British psychiatry lagged behind Europe, many of England's larger asylum laboratories had undergone expansion in the second half of the nineteenth century. The laboratory of the London County Asylums was fitted out at an approximate cost of £5000 and included a physical research room, chemical and bacteriological department, histological department, photographic studio and post-mortem room.<sup>18</sup> As director of the London laboratory, the pathologist Fredrick Mott received an annual salary of £1200. This localised London scheme received over £1000 per annum and additional funding from the Technical Education Board.

Large asylums in Yorkshire and Lancashire contained laboratories and employed professional pathologists. At the Wakefield Asylum, Yorkshire for example, the medical head, James Crichton Browne established a pathological laboratory in the 1860s under the direction of T.W. McDowell. The pathologist was responsible for issuing the West Riding hospital reports which described the renowned work undertaken in the laboratory. In 1878, at West Riding, David Ferrier conducted his famous work on the localisation of cerebral function.<sup>19</sup> Also at West Riding, Bevan Lewis established the first psychiatric outpatient department in Britain during the 1890s.<sup>20</sup>

England's asylums initiated a laboratory scheme that co-ordinated and developed research work. The laboratory of the London County Asylums was based at Claybury Asylum, Essex under the supervision of Frederick Mott. As a result of Mott's work and collaborations, several volumes of papers known as the *Archives of Neurology* were published, which received critical acclaim both home and abroad. The *American Journal of Insanity* considered Mott's first *Archive* (1900) to be 'in every way conducive to an extension of the present knowledge of the...nervous system'.<sup>21</sup> Many Scottish doctors were keen to emulate this type of success in their asylums.

#### Early developments in Scotland's asylums

The scientific research into mental illness in Edinburgh and Glasgow did not only take place in the asylums. In Glasgow, research centred around a group of pathologists who worked in Glasgow's Royal Infirmary and the Western Infirmary. Glasgow's most prominent nineteenth century pathologist was Joseph Coats, who published widely on mental and neuro-pathology. Joseph Coats was the first pathologist appointed to the Western Infirmary in 1876 and had previously worked as pathologist to the Royal Infirmary in Glasgow.<sup>22</sup> Other pathologists in the Glasgow group included John Lindsay Steven, Donald Fraser and James Findlayson. These men published widely in the *Glasgow Medical Journal* and were members of the city's Medico-Chirurgical society.<sup>23</sup> In Edinburgh, Thomas Clouston (medical head between 1878 and 1908) and his assistants at the Royal Edinburgh Asylum (REA) took the lead in scientific research. Clouston listed his ideal to be the link of his administrative duties with the scientific study of the brain and mental disease.<sup>24</sup> Clouston held the philosophy that insanity represented a loss of self-control and as such, was most appropriately treated through a regime of regular routine and work.<sup>25</sup> Clouston's strong belief in moral methods did not stop him from supporting 'modern' developments in scientific research. As such



he is an example of how moral methods in treatment could go hand in glove with hospitalisation.

Although not quite a 'Clouston-mafia', many of the mentioned medical superintendents in this chapter who initiated scientific research at their asylums, (for example, Easterbrook, Bruce, Marr and McRae as well as Ford Robertson) had all worked under Clouston at Morningside.<sup>26</sup> When Clouston retired in 1908, 35 junior assistants had worked under him and produced nearly 200 papers between them.<sup>27</sup>

Another early influence in scientific research was John Batty Tuke. In the late 1860s and 1870s, Batty Tuke was the medical head of the Fife and Kinross District Asylum (FKDA). Throughout his time at the FKDA, Batty Tuke expanded the asylum's laboratory and was a pioneer in the study of morbid anatomy of the brain and spinal cord. Batty Tuke was elected President of the Royal College of Physicians, Edinburgh in 1898. Tuke also successfully led a campaign to open a laboratory at the Royal College of Physicians in Edinburgh during the 1880s. Both Clouston and Batty Tuke had served under David Skae, medical superintendent of the Royal Edinburgh asylum in the mid nineteenth century.<sup>28</sup>

In 1891, Batty Tuke published a pamphlet entitled *A Plea for the Scientific Study of Insanity*. In his pamphlet, Batty Tuke called for a more scientific and hospital basis for the study and treatment of insanity. In his opening address, he argued that the pathological and the medical study of insanity lagged behind the rest of medicine.

Does the study of insanity occupy that position in the realm of medicine, which it ought to occupy? In my opinion it does not...and it is regarded by the profession and the public as a great measure disassociated from them.<sup>29</sup>

Batty Tuke blamed this lack of interest on apathy from the medical profession. Speaking in 1892 at a *Medico-Psychological Association (MPA)* meeting, Batty Tuke commented that reluctance for change was responsible for the slow development of hospital ideals in asylum treatment.

Few could help feeling deep disappointment at the almost unanimous expression of perfect satisfaction with the existing state of matters regarding the treatment of insanity...So long as the insane were well housed, well treated, well aired, and well amused, the asylum physician exhausted the chief resources of his art. Hospital treatment, as opposed to asylum treatment, was scouted, and scientific investigations were, by certain speakers, jeered at.<sup>30</sup>

This conflict between the asylum (or 'humane') treatment of insanity with the advance of research methods is highly synonymous with the struggle between the moral and medical approaches towards insanity.

#### Founding the Scottish Conjoint Asylum Laboratory Scheme (SCALS)

In 1896, Thomas Clouston put forward the Conjoint Laboratory Scheme, which proposed a link between Scotland's asylums and a central laboratory in Edinburgh. The SCALS aimed to co-ordinate and further mental pathological research in Scotland and to extend this research work at Scotland's asylums. William Ford Robertson was appointed as pathologist to the Scheme in 1897 and worked with his assistant Dr David Orr until Orr's resignation the following year. Robertson was responsible to all the associated asylums and received an annual wage of £400 (this had risen to £600 by 1905).

The laboratory was based at the premises of the Royal College of Physicians of Edinburgh. A hall was fitted up in their laboratory at Forrest Road at an annual lease of £50. Supporters of SCALS applauded the association between the Royal College and

the scheme. The Scottish *MPA* formally opened the laboratory at their quarterly divisional meeting on 11 November 1897. The *Journal of Mental Science* highlighted the achievement in linking the asylums' laboratory with the Royal College.

The Scottish division [of the Medico-Psychological Association] is to be congratulated upon having secured central and convenient premises in immediate contact with the laboratory of the Royal College... This is beneficial to the College as well as to the asylums, since the close association of workers in science is both stimulating and helpful.<sup>31</sup>

Batty Tuke attended the meeting and the meeting's report indicated that 'he [Batty Tuke] looks upon this undertaking as an important adjunct to the great Laboratory Scheme of the College with which his name is so deservedly associated'.<sup>32</sup>

It is apparent that there was little collaboration between the SCALS and already established RCPE laboratory. One bone of contention was the possible costs of such a venture. It had not been forgotten by the Royal College that considerable sums had been expended on fitting up the premises at Forrest Road for the College's own purposes.<sup>33</sup> The Fellows' reluctance to embrace college level research did not bode well for successful collaboration between the two laboratories. Consequently, when the lease then expired in 1900, the asylums' laboratory was evicted and relocated in the premises of the Royal College of Surgeons (RCSE) at 7 Hill Square, Edinburgh.

### SCALS Research Work at Asylums

The objects of the SCALS laboratory and its staff were: to carry on original researches upon the pathology of insanity; to examine pathological material sent from the asylums; to give training free of charge to members of the associated asylums in laboratory methods; and to visit the associated asylums and advise on pathological work conducted there. Certainly, more was achieved in terms of laboratory work than

if the SCALS had not been in place. Yet while asylum staff received training, it is debatable whether they had the time or inclination to put their research skills into practice. The conjoint research undertaken between asylums and Ford Robertson was hardly groundbreaking and was primarily limited to assistance with MD dissertations. The personal ambitions of Ford Robertson also interfered with his laboratory work at the associated asylums.

As pathologist to the associated asylums, Ford Robertson analysed and reported on clinical material sent out from the associated asylums. Ford Robertson's work was in line with similar schemes such as the laboratory of the London Asylums under Mott. However, Ford Robertson's lack of assistants meant that his tasks were hampered due to his heavy workload. In 1898, he managed to finish 33 such reports on pathological material received from the associated asylums. Ford Robertson's work was doubled when his assistant resigned in 1898 in order to take up the post of pathologist at the Prestwich Asylum in England. Although such an appointment was a compliment to the reputation of the SCALS, Orr was not replaced with another assistant. This left Ford Robertson to pursue his duties single-handedly.

An objective of SCALS designed to involve asylums in research was the training of medical officers in laboratory methods. Robertson's training sessions attracted a response from associated asylums. Between 1898 and 1901, 13 medical assistants from the 17 associate asylums received a course of laboratory instruction. Unfortunately, it is unclear from the sources which asylum doctors received training. In addition to training by Ford Robertson at the laboratory, 'demonstration' sets of microscopic specimens made up by Ford Robertson were sent out to the associated asylums. In the



first 4 years of the scheme's existence, demonstration sets were circulated around the associated asylums 124 times.

The training course on laboratory methods attracted attention from outside Scotland. In a *JMS* review of pathological laboratories in 1899, attention was directed to the training of Scottish asylum doctors in pathology.

This would appear to be one of those things they do better in Scotland. It may be said that at the laboratory of the London County asylums such demonstration-sets are in the course of preparation, and that the medical officers of the metropolitan asylums enjoy the same privileges as their Scottish colleagues. As regards English county asylums generally...we fear that much time is lost, and that many mistakes are apt to be made, by men who have to start pathological work without experience, often without guidance.<sup>34</sup>

Asylum doctors who were not associated with the SCALS were allowed to take advantage of the training course. Between 1898 and 1901, 6 English doctors received training under Ford Robertson at the Edinburgh laboratory.<sup>35</sup>

A further duty for Ford Robertson was to conduct research work with medical superintendents and pathologists at the member asylums. Evidently, collaboration was not compulsory and joint work only occurred where a medical superintendent had the time or inclination to work with Ford Robertson. An example is Charles Lewis Bruce, superintendent at the Perth District Asylum, who managed to combine his role of asylum head with scientific research. Bruce graduated from Glasgow University in 1894 and from then until 1899 trained as a medical officer under Clouston. In 1899, Bruce was appointed medical superintendent of the PDA. Throughout his time there, Bruce established and equipped a small laboratory for research where he worked for the most part alone or occasionally with the help of an assistant medical officer.

Bruce's work at the PDA received high praise from the American psychiatrist Adolf Meyer in 1901.

In one asylum in Great Britain, in which I found a remarkable wide-awake spirit for psychiatric work, the conditions were so strikingly different from those usually met in this country I wish to mention them...A happier and more hopeful and satisfied feeling I never carried away from a short visit to an asylum than from this Murthly Asylum, Perth and Dr L. Bruce.<sup>36</sup>

Bruce was a close supporter of Ford Robertson's work and collaborated with Robertson at the SCALS laboratory, making joint investigations into the pathogenesis of paralytic dementia.<sup>37</sup>

These collaborations were rare and typically Ford Robertson provided assistance to junior asylum doctors looking to finish their MDs. At the CRI, John Findlay, John Gilmour and Gilbert A. Welsh (assistant medical officers) all carried out work for their MD theses with the help of Ford Robertson. Findlay made a study of the choroid plexuses, part of the material for which was supplied from Ford Robertson's laboratory. Gilmour's research concentrated upon the study of senile insanity and Welsh made a study of syphilitic insanity.

Another requirement of the SCALS was to conduct original research. Ford Robertson's career reveals a natural ambition to establish himself as a renowned pathologist. Yet the consequence of his ambitions and the fact that he conducted the scheme single-handedly led to neglect of the SCALS work. Ford Robertson's most well known publication was *Textbook of Mental Pathology in Relation to Mental Diseases*, (1900). The text was the completion of an enterprise embarked upon by Ford Robertson and James Middlemas, while both were employed at the REA in the 1890s.<sup>38</sup> In 1899, the SCALS' Board gave Ford Robertson leave to continue with this research and

authorised the publication of his *Textbook of Pathology*. Throughout 1899, Ford Robertson made only 7 reports on material sent from the 14 associated asylums.<sup>39</sup> As noted, the comparative figure for the previous year was 33 reports.

While Ford Robertson's career plans generated publicity for SCALS, the attention was not always positive. Ford Robertson's blunders in his personal cancer research work damaged his career. Throughout the early 1900s, Ford Robertson worked closely with Henry Wade on the causes of cancer. Wade maintained that cancer was caused by the invasion of healthy cells by bacteria. Wade graduated from Edinburgh University in 1898 and since then had worked as an assistant surgeon in the Royal Infirmary of Edinburgh (RIE). Wade was advised to conduct research work and consequently went on to collaborate with Ford Robertson in the SCALS laboratory. From their work, Ford Robertson and Wade hastily concluded that cancer was a parasitic disease. Ford Robertson did not receive the critical acclaim he desired. Most damagingly, the *Lancet's* editor placed serious doubt upon their findings and conclusions, commenting that 'Dr Robertson and Mr Wade have not attempted to meet the objections, which have already been raised'.<sup>40</sup> Closer to home, Ford Robertson and Wade's work was torn apart by a meeting of the Glasgow Medical-Chirurgical society in 1905.<sup>41</sup> Ford Robertson never gained promotion and remained pathologist to the ever-dwindling SCALS until his death in 1923.

### Financial Constraints of the SCALS

The scheme was solely reliant on the financial contributions of participating asylums. When SCALS began in 1897, 14 out of 26 Scottish Royal and District Asylums joined. By 1900, this figure had risen to 16. Table 14 on the next page lists the asylums that had joined the Conjoint Scheme by 1900.

Table 14Members of the Conjoint Laboratory Scheme of Scottish Asylums (1900)

Crichton Royal Institution	Murray Royal Asylum, Perth
Royal Edinburgh Asylum	Gartloch District Asylum, Glasgow
Glasgow Royal Asylum	Kirklands Asylum, Bothwell
Aberdeen Royal Asylum	Roxburgh District Asylum, Melrose
Stirling District Asylum	Haddington District Asylum
Perth District Asylum	Govan District Asylum
Lanark District Asylum	Midlothian and Peebles District Asylum
Inverness District Asylum	Woodilee District Asylum, Glasgow

Members included 5 Royal Asylums and 11 District Asylums. Although the majority of Scottish asylums joined, not all Scottish asylums supported the SCALS. Table 15 highlights the asylums that had not joined by 1900.

Table 15Non-Members of the Conjoint Laboratory Scheme of Scottish Asylums (1900)

Argyll and Bute District Asylum	Elgin District Asylum
Ayr District Asylum	Fife and Kinross District Asylum
Banff District Asylum	Montrose Royal Asylum
Dundee Royal Asylum	Paisley District Asylum
Dundee District Asylum	Greenock Parochial Asylum

Of the District Asylums that did not join, all were relatively small. For example, the Elgin District Asylum catered for 160 patients and the Greenock Parochial Asylum for 227 patients. In this context, a number of the rural and smaller District Asylums that did not own laboratories were unwilling to join the scheme. Yet the small and rural nature of the Perth District and Ayr District Asylums did not deter the medical heads of both from pursuing scientific research. A distinct factor appears to be the reluctance of District Boards to contribute to the scheme.

The scheme's supporters pressured asylums that did not participate to join, as additional funding placed the scheme on a more secure footing. In 1903, Clouston commented in the REA report that:

For the assured success of this praiseworthy scheme, it is desirable that as many as possible of the remaining asylums which have not yet joined the scheme may find it consistent with their duty to do so.<sup>42</sup>



As shown in table 15, the Argyll and Bute District Asylum (ABDA) under John Cameron was not a member in 1900. The reluctance of either the medical superintendent or the District Board to support the SCALS is unclear. It is feasible that the remote situation of the ABDA from the laboratory in Edinburgh led the asylum head and District Board to believe that the ABDA's participation was not worthwhile. Charles Shaw became the new superintendent in 1907 after Cameron's death in that year. Under the direction of Shaw, the ABDA extended its research work and in the Commissioner's report for 1911 highlighted that the ABDA had finally joined the SCALS.

The asylum has now become associated in the scheme of the Scottish laboratory association. This practical course is most praiseworthy and in practical working will be found a source of stimulus and encouragement to the medical officers<sup>43</sup>

The Ayr District Asylum (ADA) had also not joined the scheme by 1900. District Board Minutes highlight that the principal objection to participation in the scheme had been financial.

The objection that the District Board had to joining in the scheme was of a monetary nature. It would cost the board the expense of a pathological assistant to do the work required by the scheme.<sup>44</sup>

The ADA eventually became a member in 1902, contributing an annual fee of £25.<sup>45</sup> Many other District Boards were also reluctant to pay substantial amounts to the scheme. When the medical heads of the PDA and CRI approached their District Boards to make larger contributions to the scheme, both requests were turned down.

The financial instability also arose from there being no set contribution fee to the scheme. Each asylum paid an annual subscription, which varied according to the size of the asylum and generosity of the District Board. For example, the CRI made an

annual donation of £150, Woodilee District Asylum contributed £60 and PDA donated £30 per annum. Overall, the SCALS survived on approximately £600-700 per year. This figure rose to £850 by 1905. Of this figure, the Royal Asylums contributed £460 (CRI £150, REA £150 and Gartnavel £100). The reliance on the associated asylums for financial support was an intrinsic problem in the scheme's stability and a limiting factor in the ability of the pathologist to pursue research.

An asylum could thus lower its contributions, or even withdraw from the scheme. The Lunacy Commissioners 1907 report commented

We regret to observe that some asylums have withdrawn from the scheme. We would prefer to see work of this importance placed upon a more secure financial basis than the voluntary payments of annual sums.<sup>46</sup>

This quote refers to the Glasgow District Lunacy Board's decision to pull out of the scheme in 1905. As a result, Woodilee and Gartloch District Asylums' subscriptions were lost. Woodilee's superintendent Hamilton Marr was greatly opposed to the decision, believing that 'it would be a calamity to carry such a suggestion'.<sup>47</sup> In the following year, the asylum threw its weight into a more regional laboratory scheme, based in the west of Scotland.<sup>48</sup>

Similar to the campaign conducted by the general medico-scientific research community to gain research funding, Ford Robertson lobbied the pages of the medical press to find benevolent donations. Throughout the early twentieth century, Ford Robertson campaigned in the *Scottish Medical and Surgical Journal* in an effort to gain extra money for SCALS. Ford Robertson highlighted that unless the SCAL scheme received more permanent funding and expansion, then Scotland would lag behind the rest of the world in research work.

...In Scotland we are not doing our just share in the great work of advancing the pathology of insanity and that large quantities of most valuable material is being allowed to go unutilized.<sup>49</sup>

In 1903, Ford Robertson issued a memorandum outlining his suggestions for the future of SCALS. Ford Robertson's main proposals were the removal of the laboratory to a large Scottish asylum and the establishment of two separate departments within the laboratory. Ford Robertson believed that a closer connection between the scheme and an asylum would be conducive in developing research by gaining easier access to clinical material.

Ford Robertson ultimately aimed for a Central Laboratory Endowment Fund, 'as if the need for it became known the public might subscribe to it so liberally as to make it independent of contributions from the asylum boards'.<sup>50</sup>

In 1900, the *Scottish Medical and Surgical Journal* made a plea for donors.

If any of our readers have influence with the millionaires who would be glad of advice as to how to dispose of some of their capital in such a way as to be a lasting benefit to mankind, this laboratory and similar schemes might be pressed upon their notice, for they would be enormously strengthened by liberal endowments.<sup>51</sup>

Ford Robertson's campaign was successful in that it caught the attention of the press. The *Glasgow Herald* declared in 1900 that 'the object they [SCALS] aim at is of a public kind and should receive public support'.<sup>52</sup> Such campaigns were in keeping with public calls for funding by the general medical community.

The endowment scheme never materialized. However, SCALS did receive occasional grants from the Carnegie Trust and Treasury of Medical Research through the General Board of Control for Scotland. Relying on voluntary contributions from asylums and

the efforts of one main pathologist, the scheme had little hope of competing in research terms with its London, European and New York contemporaries.

#### Scientific Research at Local Asylums

Although the central policy of hospitalisation recommended the construction of laboratories, decision making was left up to local interest. Although the boards were willing to pay for the construction of laboratories, District Boards were unwilling or unable to go the additional mile and fund additional staff. Consequently, many asylums were forced to rely on the abilities of over-stretched medical officers to conduct research.

Table 16 outlines the extent of qualified and unqualified pathologists and dispensers at the thirteen largest Scottish asylums in 1910. The previously unpublished hand written table was compiled by Easterbrook and is inserted into the CRI's Minute Books. Of the thirteen asylums, only four employed a separate pathologist. These asylums were the CRI, REA, Gartloch and Stirling District Asylum. Woodilee had a pathologist but 'gave him up'. Alternatively, medical officers (generally unqualified in laboratory research) were left to conduct post-mortems and original research in addition to dispensing drugs. Asylums were not legally obliged to employ a qualified pathologist or dispenser as a part of their staff.



Table 16  
 Pathology and Drug Dispensing at Scotland's Thirteen  
 Largest Asylums, (1910)

NAME OF ASYLUM	AVERAGE DAILY RESIDENT	AVERAGE ANNUAL ADMITTED	NUMBER MEDICAL OFFICERS	NUMBER OF PATHOLOGISTS	NUMBER OF DISPENSERS	DETAILS
ABERDEEN ROYAL ASYLUM	795	171	3	0	0	Medical Officers conduct research, post mortems and dispense drugs.
AYR DISTRICT ASYLUM	533	149	2	0	0	Medical Officers conduct post mortems and dispense drugs. Had a dispenser but gave him up.
BANGOUR VILLAGE ASYLUM	745	207	3	0	0	Medical Officers dispense drugs. Third medical officer conducts post mortems.
CRICHTON ROYAL INSTITUTION	808	136	3	1	1	Also one Crichton Fellow and one dispenser. Medical Officers conduct post mortems.
EDINBURGH ROYAL ASYLUM	738	182	4	1	1	Also one dispenser (£60 per annum).
FIFE DISTRICT ASYLUM	624	143	2	0	0	Medical Officers conduct post mortems and dispense drugs.
GARTLOCH DISTRICT ASYLUM	770	261	3	1	1	One unqualified dispenser paid £60 per annum. Also one pathologist.
GOVAN DISTRICT ASYLUM	607	224	2	0	0	Medical Officers conduct post mortems and dispense drugs.
WOODILEE DISTRICT ASYLUM (GLASGOW)	1096	306	4	0	1	One unqualified dispenser paid £40 per annum. Had a pathologist but gave him up.

INVERNESS DISTRICT ASYLUM	717	153	2	0	0	Medical Officers conduct post mortems and dispense drugs.
LANARK DISTRICT ASYLUM	915	219	3	0	0	Medical Officers conduct post mortems and dispense drugs.
MONTROSE ROYAL ASYLUM	664	129	2	0	0	Medical Officers conduct post mortems and second Medical Officer dispense drugs.
STIRLING DISTRICT ASYLUM	716	213	2	1	0	Medical Officers dispense drugs.

Source: *Report by the physician superintendent of the present position of the Crichton Research Laboratory Scheme, 16/6/10 in Minute Book Board Minutes and Special Reports etc (1908-1912).*

The financial objection of District Boards to the employment of pathologists was an obvious drawback for asylum heads interested in pursuing research. Woodilee is an example of an asylum that developed facilities but did not employ the necessary research workers. When Hamilton Marr became Medical Superintendent in 1902, further expansions in scientific research were made. Marr had worked as a medical officer at the CRI in the 1890s. In the early 1900s, Marr campaigned for a new laboratory to be built at Woodilee. The District and General Boards approved the plans and in 1904, the new laboratory was opened.

The laboratory was connected to a new mortuary and post-mortem room and had rooms for microscopical, bacteriological and chemical investigation. In addition, the laboratory was also supplied with accommodation for special research work, a biological test room, rooms for photographic purposes and a museum and library. After the laboratory's opening, Lunacy Commissioners regarded the laboratory as perhaps the most complete and best-equipped institution for nervous pathology in the UK.

Yet despite these new facilities, there was no trained staff to conduct the research work. Woodilee had employed a pathologist in earlier years but he was unqualified and was also expected to contribute to general medical duties. James Hogg Macdonald became assistant medical officer and unqualified pathologist to Woodilee in 1900. As Woodilee's pathologist, Macdonald received a salary (inclusive of board and lodgings) of £100 per annum. Macdonald remained at Woodilee for one year and throughout this period conducted all routine post-mortem and pursued new methods in pathological research.

Of most significance was Macdonald's development of a method for the preparation of Golgi Sublimate Microscopic sections. This was the examination of specimen sections through high power lenses. Camillo Golgi first introduced a new stain for central nervous system tissue using silver chromate. The new stain highlighted the nerve cell clearly and allowed further dendrites to be seen for the first time. In 1901, Macdonald published his research with Ford Robertson in the *JMS*.<sup>53</sup> Macdonald's work was reflective of the contemporary interest taken in microscopical research work.

When Macdonald left Woodilee at the end of 1900 to pursue his psychiatric career, he was not replaced. The unwillingness of the District Board to pay for additional staff is influential in this decision. The Visiting Commissioners commented on this inadequacy in 1904.

The District Board must still consider the question of providing an adequate scientific staff...Otherwise there is the alternative to be faced that they have erected and equipped a costly scientific establishment, which is confining itself to work which might easily have been accomplished with much simpler and less costly means.<sup>54</sup>

However, this 'scientific staff' did not materialise and the staff of four medical

officers continued to act as the institution's pathologists.

Impetus for scientific research was therefore reliant on the personal interest of individual asylum doctors and time constraints of asylum staff. As earlier shown, Bruce was a superintendent who worked closely with Ford Robertson at the SCALS. Independent of the SCALS, Bruce pursued his interests at the PDA. His continual attempt to catch the scientific community's eye feasibly stems from setbacks in his career. After Thomas Clouston's resignation from the Royal Edinburgh Asylum in the early twentieth century, Bruce had applied for the position of medical superintendent. To his disappointment, Bruce was side-stepped in favour of George Robertson (who Bruce had succeeded at the PDA). Bruce remained as superintendent of the PDA until his retirement in 1936. Bruce was no means an international player in the research community and was criticised by contemporaries.<sup>55</sup> However, his research publications denote that scientific research was pursued if individual doctors showed a personal interest in research, rather than as a result of the implementation of a central policy.

Bruce was the first recorded medical superintendent to introduce the thyroid treatment of the insane in Scotland. From the 1870s a series of clinical experimentation had established that the thyroid gland was essential to life. Research had found that total removal of the thyroid from an animal would lead to its death, yet this could be avoided if the gland was transplanted elsewhere. From this discovery came the idea of injecting thyroid tissue as treatment. By the 1890s, injections and oral preparations of the thyroid gland were used in humans whose thyroid gland had been removed or whose thyroid was deemed inactive. These developments were concurrent with the inference that conditions such as cretinism, goitre and myxoedema<sup>56</sup> were the result of thyroid failure. In the 1890s, thousands of underachieving children were put on



thyroid extract and it was also recommended for a range of symptoms in adults including constipation, tiredness, obesity and depression.<sup>57</sup>

These developments in physiology and thyroid treatment manifested themselves in asylum treatment. Bruce was interested in the connection between the function of the thyroid and mental illness.

There is ample evidence that disturbances of the function of the thyroid leads to mental disorder altogether apart from the mental changes noted in exophthalmos and myxoedemia, and there is, I am certain, abundant matter for most valuable research into these conditions of disordered thyroid secretion in so far as they affect mental health.<sup>58</sup>

Bruce presented examples of treatment by thyroid extract in an article to the *EMJ* in 1910. The following example is of a young girl who had been re-admitted to the PDA on three occasions and who presented with 'attacks of stupor' that could last for up to 6 months.

The second attack of stupor or sleep came on like the first during a meal. This attack had been in progress about four weeks when it was noted that the thyroid gland had markedly diminished in size. It then occurred to me that this was an unusual case of thyroid deficiency...They [the symptoms] looked more like prolonged attacks of sleep, and excessive sleepiness is a common symptom of thyroid deficiency. She was accordingly treated by means of thyroid extract, 45 grains of the dry extract being given daily for seven days. Upon the sixth day after treatment was commenced, the patient became suddenly conscious and again had no knowledge of what had happened during the attack. She was kept in bed a week and then allowed to move around the ward and do light work...For about three months she took 5 grain doses of the extract 2 or 3 times a week, but after that the treatment was entirely discontinued. From that day to this the patient has never had a return of these attacks of prolonged sleep.<sup>59</sup>

The use of treating asylum patient by extracts of thyroid treatment depended on the support of the individual doctor. Aside from Bruce, one or two Scottish asylum

doctors produced research on the subject in the 1890s.<sup>60</sup> At Gartloch, thyroid extract was used for cases of 'stupor'. Thyroid extract was used on the patient E.M. admitted to Gartloch in 1901(see Case E, Appendix three). Classed to be suffering from 'adolescent insanity', the patient's behaviour had swung between one of 'stupor' to 'often destructive, restless, vain and erotic and cannot be got to employ herself in useful work'. Various 'treatments' were attempted including blistering the neck and drugs. In September 1901 thyroid extract was administered and this was deemed to have a good effect.

There were significant problems in using thyroid extract and Landel Oswald, first medical superintendent of Gartloch in Glasgow was not completely impressed by the outcome of using thyroid extract.

While the exact mode of action of some of the new methods of treatment is not clearly understood they were carefully tried. The treatment of certain insanities by animal extract has not with us given us the same good results it has with others.<sup>61</sup>

As with all new drug treatment, accuracy of dose (or knowing how much to use) was a problem for doctors. The male patient A.M. was admitted to Gartloch in April 1909. On admission the notes recorded of his mental condition that 'it is difficult to say whether he is in a state of temporary mental confusion or whether he is demented'.

Dec 5<sup>th</sup> 1909      He has been in this Infirmary ward for some time, has been left continually in bed, and has to be cared for in every way. His stupor has of anything has increased and he practically never speaks at all. With the intention of relieving the stupor he was put on thyroid extract for a short time. The dose was 8 v. for a few days. This was more than was intended and after a few days during which the mistake escaped notice the dose was reduced to 8 iv, the one originally intended. There was an increase in pulse rate and a slight rise in temperature, which before that had been subnormal and consistent troublesome diarrhoea which resisted treatment for some weeks.

Jan 5<sup>th</sup> 1910      The diarrhoea has been controlled with opium and starch enema and an a contingent mixture internally but the emaciation has continued along with a dry cough suggestive of phthisis. He has been twice tested with tubercular. On first occasion the result was negative, on the second occasion with double the dose there was a slight rise of temperature which had been up as high however the day before.<sup>62</sup>

The entry suggests an automatic assumption that the patient was suffering from tuberculosis rather than the thought that the doctor's mistake had a detrimental effect. It is also interesting to note the continued use of opium into the twentieth century as a medical treatment. The patient died however on the 5<sup>th</sup> January. The post-mortem revealed that 'no pthithis pulmonalsis was found' but oedema (or dropsy) of the lung.

The microbiological revolution launched by Koch and Pasteur brought immunology to the forefront of medicine. In 1890, Emil von Behring proclaimed that the blood serum of an animal rendered immune to tetanus or diphtheria by the injection of a relevant toxin could treat another animal that had been exposed to the bacilli. This became known as serum therapy and was introduced for diseases such as tetanus, the plague, cholera and diphtheria in the 1890s.

Serum therapy was also transferred to asylum culture. Bruce's enthusiasm for vaccine therapy led him to publish on the subject and to introduce it at the PDA. In 1904, Bruce documented the experimental use of anti-serums for acute insanity.

Anti-streptococcus serum was administered orally to five patients suffering from fully developed acute mania in doses ranging from 10 to 20 c.c., without any benefit; and in any case of acute mental disease where the symptoms are severe, serum treatment is of no value. In two cases however, which threatened to relapse, 10 c.c. of anti-streptococcus serum reduced the pulse 10 to twelve beats per minute, lowered the temperature a degree

and apparently cut short the attack...Both patients benefited by the treatment; their pulses did not show the evening rise, there was less restlessness and both made rapid recoveries.<sup>63</sup>

However, the application of serum treatment was notoriously problematic. Supplies varied in strength and purity and at worst could cause death or the side effect 'serum sickness' (fever, rashes and joint pains). Public distaste at the use of animal extracts in treatment also hindered serum therapy's use as a treatment.<sup>64</sup> The Commissioners produced no guidelines and the therapies were little if at all commented upon in their reports. As such, the use of thyroid and serum treatment remained experimental in asylums and introduced on the initiative of individual medical superintendents.

Douglas McRae (another REA disciple) took his interest in scientific research to the rurally situated Ayr District Asylum. McRae was employed as the REA's pathologist throughout the 1890s and also worked with Ford Robertson on investigations into general paralysis.<sup>65</sup> In 1908, McRae was appointed medical superintendent of the ADA in 1908 and in the following year, applied to register the Ayr asylum as a centre that could conduct experiments on live animals. McRae aimed to continue with research work that he had pursued in earlier years at the REA.

For the purposes of continuing scientific research on the lines, which I have previously worked it, would be necessary to employ various animals. I would strongly urge the desirability of having the institution registered for such experimental investigations. It is chiefly by the pursuit of such methods that we can ever hope to obtain a true knowledge of the cause and cure, or prevention of mental diseases.<sup>66</sup>

After receiving approval from both the General and District Boards, application was made to the Home Office. In 1909, the ADA was sanctioned as a registered place for experimentation.<sup>67</sup> Yet the amount of research work produced as a result does not



seem extensive. According to the *Medical Directory*, McRae did not appear to produce any published papers as a result of his research. It also has not been possible to gain further details of the type of research work conducted at the ADA.

### Dominance of the Royal Asylums

The dominance of Edinburgh and Glasgow scientific research community is useful in contrasting the difficulties faced by medical superintendents outside the university centres. Jonathan Andrews rightly suggests that mental pathology was mainly conducted at Edinburgh and Glasgow and was debated in both cities' Medical Chirurgical societies and their *Medical Journals*.<sup>68</sup>

In Glasgow, Gartnavel established the Scottish Western Asylums Research Institute (SWARI) in 1909. SWARI aimed to encourage co-ordinate and guide research work in the west of Scotland. It was during Landel Oswald's superintendence at Gartnavel that the SWARI was established in the asylum's grounds.<sup>69</sup> The SWARI was similar to the Conjoint Scheme in Edinburgh because initially it was funded by voluntary contributions as table 17 shows.

Table 17:  
Associated Asylums of Scottish Western Asylums Research Institute, (1910)

<i>Contributing Asylums</i>	<i>Annual Contribution</i>
Glasgow Royal Asylum	£200
Gartloch Asylum	£50
Dykebar Asylum	£10, 10sh
Hawkhead Asylum	£30
Kirklands Asylum	£7, 10sh
Riccartsbar Asylum	£10, 10sh
Smithston Asylum	£10, 10sh
Woodilee Asylum	£50

The Institute benefited from a number of private donors, whose anonymity was maintained in the SWARI's annual reports.<sup>70</sup> The financial headaches of the SCALS were not shared by the SWARI in the long term. Although a substantial portion of

SWARI's finance rested on support from Gartnavel, contributions were made compulsory in 1913. Section 72 of the Mental Deficiency and Lunacy (Scotland) Act of 1913 made it for the first time lawful for District Lunacy Boards to contribute money to the SWARI. This legislation goes far in explaining the sounder financial footing of SWARI in comparison the voluntary scheme of SCALS.

The appointment of Dr Ivy Mackenzie as the Institute's director demonstrates the desire to have a professional body of research staff. It is likely that the more substantial funds of the Royal Asylums when compared with the rate aided District asylums was influential in this. Mackenzie had trained in pathology and bacteriology at the Western Infirmary Glasgow and had also conducted research work at the Royal College of Surgeons, London.<sup>71</sup> He was paid an annual salary of £225 and worked with one permanent assistant and a number of voluntary workers from the associated asylums. Iain Smith and Alan Swann argue that the SWARI was a diagnostic as well as a research institute and that the principle stimulus for the SWARI had been the discovery of the organism that was responsible for syphilis.<sup>72</sup> Consequently, much of the research at this time was going into the link between syphilis and insanity in a hope to discover potential cures for the condition. The results of the SWARI's researches into syphilis were published after further collaboration between Carl H. Browning and John Cruikshank.<sup>73</sup> These developments in diagnosis and treatment reflected the gradual links that were formed between the laboratory and the clinic.<sup>74</sup>

Outside Edinburgh and Glasgow, a lack of suitable (and willing) candidates for hindered provincial efforts to develop research work in Royal Asylums. The CRI's minute books detail the process of applications for the Crichton Fellowships. In place of using assistant medical officers as pathologists in the CRI, Easterbrook aimed to

employ three professional pathologists in the fields of (1) clinical neurology and psychiatry, (2) pathology and chemistry with special reference to the nervous system, (3) pathology and bacteriology with special reference to the nervous system.<sup>75</sup> The Fellowships were open to men who had already demonstrated potential for research through the publication of original research. Each Fellowship was to the value of £250 (with board and lodgings) or £300 without this allowance. This contrasted to the salary of £100 offered by Woodilee for a similar post.

Dr William J. Maloney was awarded the first fellowship in Clinical Psychiatry and Neurology in October 1909. As part of his fellowship, Maloney received training in neurology as a senior house physician to a national hospital in Queen's Square, London. He also attended training in experimental psychology under Dr Spearman at University College, London. In the following year, Maloney spent six months at the Royal Psychiatric Clinic in Munich, which included instruction in clinical psychiatry under Professor Kraepelin. Kraepelin was one of the world's most influential psychiatrists in the late nineteenth and early twentieth centuries and had developed a groundbreaking system of classification for mental illness.<sup>76</sup>

As a consequence of Maloney's training in Germany, he produced a wealth of joint and solo publications on modern methods of research in psychiatry, publishing articles in contemporary journals such as *Brain* and *Review of Neurology and Psychiatry*.<sup>77</sup> However, his thorough training did not long benefit the CRI. Maloney resigned his position from the Crichton in June 1911 on his appointment as the Chief of Clinic at the Neurological Institute, New York. Shortly after this, Maloney was promoted to Professor of Neurology at Fordham University, New York.

The Minute Books of the CRI highlight the difficulties in attracting interest in all the Fellowships. Only four candidates applied for the Fellowship in Clinical Psychiatry and Neurology. Maloney was awarded the post, yet of the other candidates, one was not medically trained and the other two candidates had produced no publications. Although three posts were initially advertised, it was recorded in 1909 that 'the two other Fellowships are not awarded meantime due to a dearth of eligible candidates'.<sup>78</sup>

In June 1910, Easterbrook commented in his report of the Laboratory Scheme that:

The primary scarcity is this – men having the requisite preliminary training for scientific and medical research and willingness to devote themselves to the special branch of nervous and mental pathology, the difficulty of attracting such men from the teaching centres, where lie their main chances of promotion.<sup>79</sup>

In 1911 Easterbrook highlighted that 'three advertisements in three successive years had not attract desirable candidates for the two vacant Fellowships and in this year, the remaining two Fellowships were dropped.

### Gender perspectives

With the gradual admission of females into the medical profession, the employment of female doctors was occasionally viewed as a more cost-effective option. Massie suggests that because psychiatry was afforded lower status in the medical profession, there was less competition for posts and as such produced opportunities for women in positions of junior doctors.<sup>80</sup> The CRI under James Rutherford employed female medical officers in the private female wards. However, this probably stemmed more from a reaction to female patient sensitivities and Victorian morals than a willingness to allow females to infiltrate the profession. Typically, female doctors were fighting against prejudices of contemporary society.



Mackenzie points out that local factors and individual preference influenced whether women were employed in posts as medical superintendents.<sup>81</sup> Landel Oswald (medical superintendent of Gartloch) had recommended the appointment of a female pathologist to the Glasgow District Board in 1900. There is no indication why Oswald favoured the appointment of a female. He may have anticipated that the District Board would be attracted by the lower wage of a female pathologist and more likely to fund her employment. In 1900, the Glasgow District Board appointed Mary Hannay to the post of pathologist at Gartloch.

It was unanimous resolved to recommend the appointment of Dr Mary Hannay for clinical and pathological work (of which she has made special study) at a salary of £90 per annum with board and lodgings.<sup>82</sup>

In comparison that year, the District Board employed a male pathologist at Woodilee at an annual salary of £125. Hannay graduated from Queen's Margaret College, Glasgow in 1896. Here, Hannay had gained experience in laboratory techniques. She had subsequently worked as a House Surgeon to the Glasgow Maternity Hospital. She then moved to Gartloch in 1900 and remained there for five years. Following this, Hannay was appointed as pathologist to the Glasgow Ophthalmic Institute and then as assistant pathologist in Glasgow Royal Infirmary. During her period, Hannay contributed articles on her research to the *Glasgow Medical Journal*.<sup>83</sup>

The efforts of medical superintendents to employ dispensers at their institutions caused the same financial headaches as pathologists. Only four of the largest Scottish asylums employed dispensers, namely the CRI, REA, Gartloch and Woodilee. In the main, these were the four asylums that also employed pathologists. Woodilee was the only asylum that had a dispenser but did not employ a pathologist. (Although it had employed a pathologist in earlier years). For the asylums that did not employ

dispensers, the assistant medical officers were expected to dispense drugs, along with research work and daily duties.

To employ a qualified pharmacist in an asylum cost on average between £40-70. Both the REA and Gartloch's pharmacists were paid an annual salary of £60 with board and lodgings. Woodilee's pharmacist cost £40 per year but was unqualified. Yet the use of an unqualified dispenser hardly amounted to professionalism and the implications of unqualified pathologists and drug dispensers do not need to be dwelt upon.

Like the cheaper employment of Hannay as pathologist, a feasible alternative was the use of a newly qualified female pharmacist. Easterbrook at the CRI considered this option when looking for a dispenser and sought advice from both a commercial druggist and a pathologist to the Royal Edinburgh Infirmary. The responses of these two men show up two opposing attitudes. Whereas the commercial manager James Ewing was driven by cost effectiveness and displayed compassion for the difficulties faced by female candidates in a male world, the RIE pathologist Alexander was prejudiced by the presence of female doctors in the traditional male domain.

James Ewing, manager of '*Duncan Flockhart and Co*', *Wholesale Export Druggist*. wrote

In reply to your letter a fair salary for a young qualified pharmacists with board and lodgings would be £70 per annum; for an unqualified, £50...I may suggest to you that you might probably get a qualified lady pharmacists... from £50-60 per annum with board and lodgings. A good number of young ladies have qualified in recent years but it is not easy for them to get situations in shops and they are glad to get a situation as you offer.<sup>84</sup>

The difficulties faced by females in finding positions is mirrored by Alexander at the RIE laboratory.

As regard the question whether a female should be thought of...they have as a rule no initiative and are only marking time for THE EVENT – Matrimony!<sup>85</sup>

Easterbrook appeared to be swayed by the opinions of Alexander. Perhaps concerned by the 'radical' nature of a female dispenser in an asylum and by Alexander's senior position in the medical community. Easterbrook's advert for a dispenser was thus placed in the *Chemist and Druggist* in 1910.

Dispenser – man, qualified (1) to dispense drugs, and (2) to assist with photographic and laboratory work; salary £52 a year with board, lodgings and laundry. Apply at once, stating age, training and experience and with copies of references to physician superintendent, CRI, Dumfries.<sup>86</sup>

Although not indicated in the records, it is likely that the asylum's Board was influential in setting the advertised salary. This highlights a clear reluctance by the asylum to pay for qualified laboratory staff. Although Ewing had stated the fair salary for a qualified male candidate to be £70, the CRI position only offered £52.

Perhaps the CRI should have gone with the female option recommended by Ewing. The likelihood that the Institution ended up with an under-qualified pharmacist is borne out by the termination of the pharmacist's position in 1911.

The experiment of a dispenser...has not proved a qualified success...there has been a considerable increase in the cost of drugs without any compensating advantage in an increase of efficiency in the treatment of patients...<sup>87</sup>

Easterbrook continued:

One cannot expect to attract or retain the services of an experienced qualified pharmacist and competent businessman in the dispensary of an asylum'.<sup>88</sup>

This outcome should hardly be seen as a surprise. This is especially in light of the aforementioned difficulties in attracting pathologists away from university centres to asylums and even more so in view of the advertised salary being £18 below the average.

## Conclusion

With the development of a scientific basis in medical education and advances made by the British scientific community it is unsurprising that asylums aimed to follow this lead. Evidently, general scientific medicine was subject to divisions and lagged behind Europe and America in terms of education and funding. However, these restrictions are also useful in paralleling the difficulties faced by scientific research into mental illness.

Due to a lack of funding and staff, the SCAL scheme failed to compete with national and international scientific medicine. With no permanent funding and only one pathologist there is no wonder that the scheme's ambitions were largely unrealised. Although the Conjoint Scheme provided training for a number of asylum doctors, it is evident that this training did not generate further investigations and publications. When this scheme is compared with the scant funding received by general scientific research in the universities it hardly seems surprising that the scheme did not achieve formal funding and success.

Current literature focuses primarily on developments in the main centres of Edinburgh and Glasgow. This chapter has highlighted that some initiatives were made in scientific research in asylums outside the main centres of Edinburgh and Glasgow. Despite the increased emphasis on a science based curriculum, the pursuit of original research work came far down the list of priorities for the overworked medical staff.

Although there were attempts to extend scientific medicine to the clinical bedside, such as dabbling in thyroid and serum treatment, such scientific practice was at the instigation of individual doctors. The REA background of doctors with an interest in



research shows up the influence of the Edinburgh asylum. Although it is perhaps too strong to refer to a "Clouston-mafia" in terms of medico-scientific psychiatry, it is undeniable that of the asylum heads that promoted research work, all had worked under this asylum head at the REA.

The Royal Asylums were in a securer financial position to employ professional qualified pathologists who had experience in general hospitals. Easterbrook's Fellowships were unusual in that they provided training under contemporary figureheads like Kraepelin. However, even Maloney left the CRI and went to work abroad. Even if medical superintendents secured the interest and to employ experienced pathologists and dispensers, superintendents were caught in a vicious circle of attracting suitable staff to their institutions. Pathologists and dispensers were attracted by the bright lights of the city hospitals and universities that gradually received funding for scientific research. With the marked difficulties faced by scientific research in general medicine, it is not surprising that Scotland (and British psychiatry) was unable to compete in the international field of research.

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<sup>1</sup> 'The Laboratory of the Scottish Asylums', *Occasional Notes of the Quarter, Journal of Mental Science*, 44 (1898), p.106.

<sup>2</sup> J. Andrews, in 'A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry: part 2', *History of Psychiatry* 8 (1997) and A. Beveridge, 'Thomas Clouston' in G.E. Berrios & H. Freeman, *150 Years of British Psychiatry 1841-1991*, (Gaskell, 1991).

<sup>3</sup> Andrews, 'A Failure to Flourish part 2', p.349.

<sup>4</sup> Beveridge, 'Thomas Clouston', p.380.

<sup>5</sup> Andrews, 'A Failure to Flourish part 2', p.349.

<sup>6</sup> C. Lawrence, *Medicine in the Making of Modern Britain 1700-1920*, (Routledge, 1994), p.72-73.

<sup>7</sup> J. Jenkinson, *Scottish Medical Societies 1731-1939 Their History and Records*, (Edinburgh University Press, 1993), p.65.

<sup>8</sup> *Ibid.*, p.41.

<sup>9</sup> S. Jacyna, 'Theory of Medicine, Science of Life: The Place of Physiology in the Edinburgh Medical Curriculum', in V. Nutton & R. Porter (ed), *The History of Medical Education in Britain*, (Rodopi, 1995), p.141 & 150.

<sup>10</sup> Lawrence, *Medicine in the Making of Modern Britain*, p.72.

<sup>11</sup> Lawrence, 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914', *Journal of Contemporary History*, 20 (1985), p.509.

<sup>12</sup> W.F. Bynum, *Science and the Practice of Medicine in the Nineteenth century*, (Cambridge University Press, 1994), p.181.

<sup>13</sup> R. Porter, *The Greatest Benefit to Mankind*, (HarperCollins, 1997), p.532.

- <sup>14</sup> E. Shorter, *A History of Psychiatry From the Era of the Asylum to the Age of Prozac*, (John Wiley and Sons, 1997), p.35.
- <sup>15</sup> Porter, *The Greatest Benefit to Mankind*, p.532.
- <sup>16</sup> Beveridge, 'Thomas Clouston', p.380.
- <sup>17</sup> Shorter, *A History of Psychiatry*, p.35 & 71.
- <sup>18</sup> F.W. Mott, *Archives of Neurology from the Pathological Laboratory of the London County Asylums Vol. I*, (1899), p.x.
- <sup>19</sup> D. Millet, 'Illustrating a Revolution: An Unrecognised Contribution to the 'Golden Era' of Cerebral Localisation', *Notes and Records of the Royal Society of London*, 52 (1998), p.284.
- <sup>20</sup> D. Henderson, *The Evolution of Psychiatry in Scotland*, (E & S Livingstone, 1964), p.122.
- <sup>21</sup> *American Journal of Insanity*, 56 (1900), p.772.
- <sup>22</sup> see for example L.S. Jacyna, 'The Laboratory and the Clinic: The Impact of Pathology on Surgical Diagnosis in the Glasgow Western Infirmary, 1875-1910', *Bulletin of the History of Medicine*, 69/3 (1988).
- <sup>23</sup> Andrews provides a comprehensive overview of this group's work in 'A Failure to Flourish? Part 2', p.333-360.
- <sup>24</sup> Beveridge, 'Thomas Clouston', p.381-2.
- <sup>25</sup> Beveridge, 'Life in the Asylum: patient letters from Morningside, 1873-1908', *History of Psychiatry*, 9 (1998), p.432.
- <sup>26</sup> Appendix one outlines the careers of these men.
- <sup>27</sup> Beveridge, 'Thomas Clouston', p.380.
- <sup>28</sup> David Skae is best known for his classification of insanity, outlined in 'On the Classification of the various types of insanity' published in the *JMS*, 9 (1863).
- <sup>29</sup> J. Batty Tuke, *A Plea for the Scientific Study of Insanity*, (Young J. Pentland, 1891), p.5.
- <sup>30</sup> *Edinburgh Medical Journal*, (1892), p.652.
- <sup>31</sup> *Occasional Notes of the Quarter, JMS*, 44 (1898), p.105.
- <sup>32</sup> *Ibid.*, p.1115.
- <sup>33</sup> J. Ritchie, *History of the Laboratory of the Royal College of Physicians*, (Royal College Physicians Edinburgh, 1953), p.25.
- <sup>34</sup> *Occasional Notes, JMS*, 45 (1899), p.125.
- <sup>35</sup> *Annual Report of the Royal Edinburgh Asylum*, (1901), LHB7/7/10.
- <sup>36</sup> E. Winters (ed), *The Collected Papers of Adolf Meyer Vol. 2: Psychiatry*, (The John Hopkins Press, 1951), p.77.
- <sup>37</sup> *Lancet*, (5 April 1902), p.976.
- <sup>38</sup> W. F. Robertson, *A Textbook of Pathology in Relation to Mental Disorders*, (William F Clay, 1900), p.viii.
- <sup>39</sup> 'The Laboratory of the Scottish Asylums', *Scottish Medical and Surgical Journal*, 6 (1900), p.437.
- <sup>40</sup> *Lancet*, (28 Jan. 1905), p.245.
- <sup>41</sup> D.L. Gardner and J. Bennett, 'Henry Wade 1876-1955: The early life of a pioneer of cancer research', *Unpublished paper, Royal College of Surgeons of Edinburgh and the Castle Museum, Norwich, 2000*, p.8-9.
- <sup>42</sup> *An. Rep. of the REA*, (1903), LHB7/7/10.
- <sup>43</sup> *54<sup>th</sup> Report of the Commissioners in Lunacy for Scotland*, (1911), GD17/5/23.
- <sup>44</sup> *Minute Book of the Ayrshire District Lunacy Board*, (1901-1903), AA17/4/4.
- <sup>45</sup> *Ibid.* (1903-1906), AA17/4/5.
- <sup>46</sup> *49<sup>th</sup> Rep. of the Com. in Lun. for Scot.*, (1907), GD17/5/22.
- <sup>47</sup> *Ibid.*
- <sup>48</sup> *Minutes of Glasgow District Lunacy Board*, (1909), HB30/1/6.
- <sup>49</sup> *SMSJ*, 4 (1900), p.441.
- <sup>50</sup> *British Medical Journal*, 13 June 1903, p.1399.
- <sup>51</sup> *SMSJ*, 4 (1900), p.437.
- <sup>52</sup> *Glasgow Herald*, (16 March 1900) in *Presscuttings Book 1893-1903*, LHB7/12/5.
- <sup>53</sup> J. Macdonald and W.F. Robertson, 'Methods of Rendering Golgi Sublimate Preparations Permanent by Platinum Substitution', *JMS*, 47 (1901).
- <sup>54</sup> *47<sup>th</sup> Rep. of the Com. in Lun. for Scot.*, (1905), GD17/5/21.
- <sup>55</sup> Bruce's textbook *Studies in Clinical Psychiatry*, (1907) received mixed reviews. The *Journal of Nervous and Mental Diseases* dismissed it as 'one of the more "faddy" outlooks in a field that is so in need of cultivation', *JNMD* 35 (1907), p.124. See also *Scottish Medical and Surgical Journal* 20 (1907), p.95-96 and *Review of Neurology and Psychiatry*, 5 (1907), p.77-80.
- <sup>56</sup> Termed by William Gull in 1873. Used to describe a 'cretinoid condition' in adult women, associated with obesity and sluggishness. See Porter, *Greatest Benefit to Mankind*, p.564.
- <sup>57</sup> Bynum, *Science and the Practice of Medicine*, p.171.

- <sup>58</sup> L.C. Bruce, 'The Value of Physical Examination in Mental Disease', *Edinburgh Medical Journal*, (1910), p.530.
- <sup>59</sup> *Ibid.*
- <sup>60</sup> See for example, H.C. Marr, 'Case of Myxoedema with Insanity treated by Thyroid Feeding and Thyroid Extract', *Glasgow Medical Journal*, (1893) and J. Macpherson 'Notes on a case of Myxoedema Treated by Thyroid Grafting', *JMS*, (1892).
- <sup>61</sup> *2nd An. Rep. of Gartloch District Asylum and Hospital*, (1898-98), HB1/6/2.
- <sup>62</sup> *Gartloch Casebook of Male Admissions*, (1909), HB1/14/20.
- <sup>63</sup> Bruce, 'On the Experimental Use of the Anti-serums in Acute Insanity' in *Review of Neurology and Psychiatry*, 2 (1904), p.482-3.
- <sup>64</sup> Bynum, *Science and the practice of medicine*, p.161.
- <sup>65</sup> W.F. Robertson, D. McRae and J. Jeffrey, 'Bacteriological Investigations into the Pathology of General Paralysis of the Insane', *Review of Neurology and Psychiatry*, 1 (1903).
- <sup>66</sup> *Correspondence from the Com. in Lun. for Scot.*, (1869-1951), AA17/6/2.
- <sup>67</sup> *Ibid.*
- <sup>68</sup> J. Andrews and I. Smith, 'The Evolution of Psychiatry in Glasgow during the Nineteenth and early Twentieth Centuries', in G.E. Berrios and H. Freeman (ed), *150 Years of British Psychiatry 1841-1891*, (Gaskell, 1991), p.326.
- <sup>69</sup> Andrews, 'A Failure to Flourish?: Part 2', p.352.
- <sup>70</sup> *1st An. Rep. of the Scottish Western Asylums Research Institute*, (1909-10), T PAR 1.16.
- <sup>71</sup> Henderson, *The Evolution of Psychiatry*, p.130.
- <sup>72</sup> J. Andrews & I. Smith (ed), *Let There be Light Again: A History of Gartnavel Royal Hospital from Its Beginnings to its Present Day*, (Gartnavel Royal Press, 1992), p.66.
- <sup>73</sup> I. Mackenzie, C.H. Browning and J. Cruikshank, *Recent Methods in the Diagnosis and Treatment of Syphilis: the Wassermann Serum Reaction and Ehrlich's Salvarsan*, (Constable and Company, 1911).
- <sup>74</sup> . Jacyna, 'The Laboratory and the Clinic', p.403-04.
- <sup>75</sup> *EMJ*, 27 (1910), p.289.
- <sup>76</sup> Shorter, *A History of Psychiatry*, (1997), p.101.
- <sup>77</sup> C.C. Easterbrook, *Chronicle of Crichton A History of the Crichton Royal Institution*, (Dumfries Press, 1945), p.333.
- <sup>78</sup> *Ibid.*, p.326.
- <sup>79</sup> *CRI Minute Book Board Minutes and Special Reports etc.*, (1908-1912), DUM.CRI1989.307.
- <sup>80</sup> L. Massie, 'The role of women in mental health care in nineteenth century England', *International History of Nursing Journal*, 1/2 (1995), p.49.
- <sup>81</sup> C. Mackenzie, 'Women and psychiatric professionalisation', 1780-1914' in London Feminist History Group, *The Sexual Dynamics of Labour*, (Pluto, 1983), p.118.
- <sup>82</sup> *Min. of the Glas. Dist. Lun. Bd.*, (1900), HB30/1/3.
- <sup>83</sup> M. Hannay, 'Description of Porencephalic Brain', *Glasgow Medical Journal* (1904) and 'Case in which there were Attacks of Pulmonary Edema', *Ibid.*
- <sup>84</sup> *CRI Bd Min. and Spec. Rep. Etc.*, (1908-1912), DUM.CR1989.307.
- <sup>85</sup> *Ibid.*
- <sup>86</sup> *Chemist and Druggist*, (1910) in *CRI Bd Min. and Spec. Rep. Etc.*, (1908-1912), DUM.CR1989.307.
- <sup>87</sup> *CRI Bd Min. and Spec. Rep. Etc.*, (1908-1912), DUM.CR1989.307.
- <sup>88</sup> *Ibid.*



## Chapter eight

### Asylum nursing and professionalisation

#### Introduction

In the alignment of nursing to psychiatric practice, nursing was caught up in the changing theories and fashions of psychiatry in the nineteenth and twentieth centuries.

In the early nineteenth century, 'respectable' attendants were sought after as models of refining influence for patients. With the construction of asylum hospital wards in the process of hospitalisation, asylum staff were required to behave as exemplary general hospital staff.

The debate surrounding professionalisation and its association with professionalism remains an issue in nursing today. Historians have also projected the debate onto general and psychiatric nursing history in order to examine concepts of profession, working conditions and training. In turn, the issue of professionalism is caught up with the wider discussion surrounding the image and reality of nursing history. As is known, the Nightingale image that espoused progress and the nurse as the epitome of middle class respectability not only sits uncomfortably with psychiatric nursing history but also the wider general nursing model.

Attempts to raise asylum-nursing standards were linked to an attempt to improve the asylum's image and also as a reaction to a growing need for trained staff after the Medical Act of 1858. Unlike general nursing, developments did not come from individual asylum nurses within the occupation. Alternatively, medical superintendents imposed 'professionalisation' from above through the introduction of systematic training by the *MPA* and through emulation of the general nursing model. In line with general nursing, female nurses in Scotland ran and worked on the male wards of



hospital wards in asylums. The attempt by some doctors to use general hospital nurses as matron positions in asylums was also a bid to strengthen the patriarchal discipline and control of the distant medical superintendent.

Commissioners and medical superintendents widely supported the use of female nurses on male wards. At an early stage, George Robertson, medical superintendent of the Fife and Kinross (FKDA) and Stirling District Asylums (SDA) in the 1890s had promoted female nursing in male wards and had vocalised his support in contemporary journals. However, doctors were less enthusiastic about Robertson's suggestion for employing general hospital trained nursing staff in asylums.

In reality, asylum nursing remained characterised by superficial training, harsh discipline, poor pay and long hours. Medical superintendents and the Commissioners did not seriously address issues of pay and conditions in their bid to raise the status of asylum nursing. In order to address grievances, asylum staff adopted industrial unrest and trade unionism as an alternative strategy to 'professionalisation'. Although strike action did not spread across Scotland, this does not highlight staff contentment with conditions elsewhere. Asylums remained characterised by a high staff turnover well into the twentieth century.

The General Board of Lunacy was quick to look into in asylum nursing issues when it involved claims of patient abuse or malpractice. Such allegations often received coverage in the press and in an era of extensive asylum construction, Commissioners were keen to refute any negative images that were raised against the asylum. In terms of the daily lives of staff, Commissioners rarely intervened in issues of working

conditions and pay. Typically, changes at a local level were reactive rather than proactive and arose as a reaction to transient workforces or local stresses.

### Changing Terminology

During the eighteenth and early nineteenth century the term 'keeper' was applied to those entrusted with the care of the mentally ill. With the rise of a public asylum system after 1845 in England and 1857 in Scotland, the term attendant was used for both female and male asylum staff. Attendants were employed to look after their respective gender of patients. Attendants were responsible for controlling patients on a daily basis and organising the daily activities of the institution such as patient participation in occupations.

After the mid nineteenth century, the term female attendant changed to '*asylum nurse*'. By the 1900s, 'nurse' was a neutral term used for both males and females. In addition, a minority of *trained general hospital nurses* (who had undertaken a probationary period in a general infirmary) was employed within Scottish asylums. In 1923, 'mental nurse' became an official title for asylum staff with the establishment of the supplementary register for Mental Nursing under the General Nursing Council.

### Defining Professionalisation

The meaning of the term 'profession' suggests a different type of occupation from any other. Its meaning implies a superior type of work that is self-autonomous and requires greater formal entry requirement and levels of training than other occupations.<sup>1</sup> Modern day literature proposes that nursing still struggles to emerge as a profession. The lack of autonomy possessed by nurses when compared to the 'medical profession' does not adhere to a 'professional' status. Although nurses are typically left to run wards, the

ultimate authority in terms of patient treatment comes from the doctor.<sup>2</sup> If nursing is not a profession in the traditional sense, nursing can aspire to the goal of professionalism through the strategy of professionalisation.<sup>3</sup> Savage describes the strategy of professionalisation as a method of achieving better standards of working practice, higher entry requirements and training as well as increased individual autonomy.

Savage highlights that an elite can use professionalism in order to impose certain standards and moral codes on a lower ranking group. To be 'professional' assumes that professionalisation is the best approach to achieving an end. As such, supporters of professionalisation criticise unionisation as an alternative strategy to betterment and oppose industrial unrest due to a fear of losing control. Abel Smith argues that nurses did not strike in the nineteenth century because action went against the social aspirations of many in the profession.<sup>4</sup> As such, the image of the nurse was traditionally viewed as antithetical to the concept of trade unionism.

In the projection of professionalisation onto mental nursing history, Chatterton argues that the concept is divided between the perception of nursing as a career or as a means of earning a living.<sup>5</sup> Massie suggests that working conditions were so poor in asylum culture that those who became mental nurses did so as a last resort.<sup>6</sup> Mackenzie does not draw upon mental nursing in her study of women and psychiatric professionalisation between 1780 and 1914. Alternatively, she argues that the only means by which women could professionalise and gain authority in the asylum was through positions as asylum doctors.<sup>7</sup>

The professionalisation of nursing in history also takes into account regulation and training. Massie argues that training for asylum staff trailed behind developments in general nursing. Whereas general nursing introduced training from the mid nineteenth century, asylum nursing lagged until the 1890s.<sup>8</sup> General nursing also opposed any association with asylum nursing. For example, campaigners such as Mrs Bedford-Fenwick fiercely opposed the inclusion of asylum staff as nurses. Her opposition came primarily from a view that asylum training standards were inferior to those of general nursing.

### Realities of general nursing

The development of the medical profession after the 1858 Act coupled with an increasing body of medical knowledge generated a need for a trained nursing staff. The history of general nursing is traditionally narrated with Nightingale as the founder of the profession and its leaders and pioneers as white and middle class women. Nursing history was viewed as one of progress, with Nightingale and her reforms at the centre. Much of this history has centred on the reform of the nursing occupation and the training of nurses. Savage argues that nursing education propagated this image in order to reinforce certain standards and beliefs in the nursing tradition.<sup>9</sup>

In the past 20 years, recent literature has turned away from the traditional image of nursing history.<sup>10</sup> Only in the past two decades has the image of nursing shifted from the Nightingale icon to achieve a more multicultural and diverse representation.<sup>11</sup> Although Whig history propagated nursing to have high training standards, any female could be called a 'nurse' and many were employed with no training at all. Trained nurses remained in short supply as late as 1905. Of the 63,000 female nurses in England and Wales by this year, approximately 25,000 were considered 'trained'. Abel Smith



comments that the term 'trained' was taken in the loosest sense.<sup>12</sup> In Scotland, although nursing training was instigated in Edinburgh in 1872 and spread out of the centre, it is unlikely that such training filtered out consistently to the local areas.

Working conditions varied between the poor law infirmaries and voluntary hospitals and standards were diverse between individual institutions. Each hospital awarded its own certificates, which in turn reflected the competence of that hospital. For the larger urban based infirmaries, nursing care generally improved. Hospital governors rapidly realised that the introduction of training schools lowered staffing costs. Dingwall et al suggest that as probationers, recruits would be attracted by the prospect of training and in many hospitals, middle class recruits paid for their own training. In the smaller and more rural based infirmaries, the occupation was less attractive and characterised by long hours, poor wages and domestic chores as well as hospital duties.

Dean and Bolton posit that in the workhouse, efficient economy dictated that nursing was assigned to able-bodied paupers.<sup>13</sup> Although it was forbidden to employ pauper staff after 1887, the impact of these changes was not swift. Even by 1913, many institutions still employed untrained staff. This was certainly true of the rural poor law infirmaries where changes were made to job titles rather than the tasks given to pauper staff.<sup>14</sup> In 1913, untrained staff were finally banned from nursing practice unless accompanied by trained nurses. Yet even by the early twentieth century it remained difficult to attract experienced staff to posts in the provincial infirmaries.<sup>15</sup> As a result, nursing standards in poor law infirmaries remained low.

### Changing images of the attendant

The recognition of mental nursing as part of nursing history by many historians has helped deconstruct the Nightingale image.<sup>16</sup> Male attendants were also employed in asylums, a reality that sat uncomfortably with the image of the 'middle-class female nurse. In the early nineteenth century asylum, the ideal attendant was a member of the respectable working class. As such, medical superintendents attempted to recruit those motivated by a 'higher' vocational calling.<sup>17</sup> Foucault's analogy of the nineteenth century attendant is that he/she was an important player in moral management and as such was strongly tied to the application of moral restraint. According to the moral philosophy of the York Retreat,

The keeper intervenes, without weapons, without instruments of constraint, with observation and language only; he advances upon madness, deprived of all that could protect him or make him seem threatening...it is not as a concrete person that he confronts madness, but as a reasonable being.<sup>18</sup>

In Foucault's view, the role of the 'keeper' was therefore essential in the restoration of reason. As such it was important that the ideal attendant was of high moral fibre and respectability.

This image of the nineteenth century attendant is disputed by more recent literature. Carpenter suggests that medical superintendents often took what they could get.<sup>19</sup> Scull's emphasis on warehouses for the unwanted is supported by his remarks that the attendant was 'the unemployed of other professions'.<sup>20</sup> Sheehan has attempted to 'debunk the myth' by arguing that although attendants were not always caring and kind, neither were they always rough and unkind.<sup>21</sup>

The shift of the term female *attendant* to *nurse* was central to the late nineteenth century image of a 'medicalising' asylum.<sup>22</sup> In 1902, George Robertson alleged that the use of

female nurses was an intrinsic feature of the hospitalisation process. Robertson asserted that only with proper nursing care could an asylum aim to be a hospital proper for mental disease.

If any evidence were needed in addition to the defective care of the insane at night to indicate how far behind that of general hospitals medical practice in asylums is, the fact that in almost all asylums the sick and infirm on the male side are nursed by men would demonstrate it sufficiently. If we are to be influenced by the highest medical ideals, it is necessary that these defects should be remedied.<sup>23</sup>

Certainly, such as the shift of term to *nurse*, and the presence of female nurses on male wards appeared in tune with contemporary medical ideals. However, the presence of female nurses did not mean that training standards had risen.

Asylums utilised photography to propagate the image of a woman in uniform caring for the sick. It became common practice for asylum annual reports to include photographic images of their hospital wards and staff. Illustrations 1 to 4 in chapter 6 propagates the image of the female hospital nurse on the verandahs of the Gartloch and Ayr asylums' hospital wards. Fox and Lawrence argue that nurses were essential to the image of the asylum and were used to depict moral and material order in the institution.<sup>24</sup> Illustration 3 in chapter 6 of Gartloch verandah depicts a nurse reading during her work, possibly in a bid to depict the training and educational standards of the institution.

### Working Conditions

The reality of working conditions in the asylum sat uncomfortably with the image of a 'professionalising' group. Chatterton argues that mental nursing continued to be characterised by arduous discipline and poor working conditions into the twentieth century.<sup>25</sup> As such, doctors demanded high standards of 'professionalism' without the reward of reasonable pay and conditions.<sup>26</sup>

The detailed annual reports of Douglas McRae, Ayr District Asylum's (ADA) medical superintendent provides some insight into staff wages at asylums. In wages, married attendants received free board and a wage of £50, which increased annually by £1. Unmarried attendants received £28 with board. Female nurses' salaries were unsurprisingly lower. Their wages (including board) began at £16, rising to £17 after 6 month's service and to £18 after one year's satisfactory service. The maximum annual wage for a nurse was £38. The Matron, Alison, received over £70 per annum.<sup>27</sup> Such discrepancies in wages could only have generated antagonisms between asylum and hospital trained staff.

At Gartloch, the Wages Book gives indication of salaries although the source has unfortunately suffered some water damage. As table 18 highlights, the matron earned £110 per annum by 1910. The matron had been a hospital trained nurse and it is interesting that she earned more than the head attendant. In comparison to the ADA, the matron salary was at a higher level and this may be due to the larger size of Gartloch.

Table 18: Gartloch nursing and attendant salaries (1905 and 1910)

	1905	1910
	£	£
matron	105	110
assistant matron	38	40
charge nurse	NIL*	35-23
nurse	35 - 10	23 -16
head attendant	98	108
deputy attendant	72	88
charge attendant	42 - 56	44 - 78

\*Position of charge nurse did not exist as a separate salary band in 1905.

\*\*average figure (water damaged pages)

There was however a stark contrast with the wages of the nurses. Nurses who were in their first year at Gartloch earned £10 per annum. A nursing training scheme was introduced to Woodilee and Gartloch in 1905. In year one, nurses received £10 per



annum. This rose to £15 in year two of training, and thereafter rose at approximately £5 per year until the salary was capped in year seven at £40 (depending if the unlikely outcome of an assistant matron post had been achieved). Wages had risen by 1910 as the above table shows. It is significant that the greatest improvement had occurred for the year one nurses earning £10. In 1906, the Gartloch Wage Book indicates that the 25 nurses who earned just £10 in 1905 had been paid arrears and their wages increased to £16 per annum. For example, Martha Baird who worked at Gartloch from 22 June 1904 received £7 in arrears. This was not an insignificant increase considering that her original annual wage was £10. Despite the increases, nurse wages remained at a low for the rank and file nurse. In comparison, the Gartloch wage book also shows the salaries for non-nursing staff. In 1906, a housemaid earned £16 per year, the dairymaid earned £26 and the laundry maid received £20 per year.<sup>28</sup>

It is useful to make some comparisons with wage levels for other groups. Current nursing history literature is not littered with information relating to pay and conditions. What can be suggested is that pay and conditions for general nurses were diverse and varied between type of hospital and locality. Certainly, pay and conditions in poor law infirmaries remained at a lower level than the voluntary hospitals. White points to a small upturn in wages for poor law infirmary nurses in the late nineteenth century. By 1870, a nurse could expect to earn £20-30 per annum, a ward sister £50 and a matron £100.<sup>29</sup> Improvements in wages were coupled with a slow improvement in working conditions. However, conditions and pay would have varied significantly between rural and urban poor law institutions.

Although hard to find reliable wage data for this period, Smout provides information relating to the first systematic wage census, held in 1886. On average, a shipyard worker

could expect to earn £70 per annum, a female teacher between £72 – 90 and a male teacher between £121 – 143. A printer worker might take home £46 p.a. and a building worker £62.<sup>30</sup> It is evident then that unless promoted to the position of matron (approximately £70 p.a.) asylum authorities were not generous employers. Carpenter likens the wages of asylum nurses and attendants to those of agricultural labourers and domestic service.<sup>31</sup>

Another bone of contention was the long working hours for asylum staff. In the last quarter of the nineteenth century, there was considerable agitation in society to decrease the length of working week. Smout suggests that the campaign for a statutory 8-hour day was one of the most popular issues in the labour movement after 1880.<sup>32</sup> Certainly the lengths of day for different workforces varied across the board well into the twentieth century, with retail, chemical and transport workers continuing to work in excess of 12 hours. However, there were some legislative successes in terms of factory and miners' hours.

In contrast, asylum staff often worked in excess of 70 hours per week. In a survey conducted by the National Asylum Workers' Union (NAWA) in 1912, it was uncovered that staff of 29 out of 31 asylums researched in England and Scotland worked in excess of 70 hours. Admittedly, the bias of the NAWA must be kept in mind. However, when nurses in Gartloch and Woodilee went on strike in the early twentieth century this was because working hours were in excess of 80 hours per week. In a letter to the *Scotsman* in 1903, an anonymous correspondent listed 'length of hours on duty without a break' to be one of the main grievances of Scottish attendants and nurses.<sup>33</sup>

Unlike the distant medical superintendent, nursing staff were in daily contact with patients and could be subjected to violence. Case G. in appendix three was admitted to Woodilee in 1905. In October 1905, it is noted of the patient,

Has been giving trouble again. On Monday morning when she came back from tea she was using abusive language to the patients. Nurse Anderson asked her to be quiet and she flew at her, tore off her cap, pulled down her hair and gave her a blow on the mouth. A few days before this she attacked Nurse Morrow and scratched her face. When asked for reason for doing these things she always says that it is the nurses who attack her and that she never struck them. On Monday evening another patient Mrs M. was present at the time of the attack and corroborates Nurse Anderson's statement. Had it not been for this patient's help Nurse Anderson would have fared badly.<sup>34</sup>

The final sentence of the quote indicates the side of the patient taken over the nursing staff. However, the notes do not indicate how the nurses reacted to the situation in order for the nurse to have potentially 'fared badly' in terms of disciplinary action.

Far from possessing autonomy, asylum staff were subject to strict discipline, which practically mirrored the patients' experiences. Chatterton argues that asylum nurses were subjected to the 'same complex of rules and expectation of obedience' as the patients.<sup>35</sup> Attendants and nurses were often required to sign Obligation Forms acknowledging the ultimate rights of the superintendent. Daily life was also strictly controlled. Asylums included homes for nurses and cottages for attendants within the institution's grounds. Sleeping arrangements for staff also meant bedrooms were attached to patient wards. Staff could not leave asylum grounds without permission. Staff also required an order from the medical superintendent if they invited a visitor to the asylum, or wanted to bring in books and newspapers.<sup>36</sup> Carpenter argues that the medical superintendent regarded off duty time as an act of generosity rather than a right.<sup>37</sup> In 1905, nurses at

Gartloch complained that they were subject to unnecessary discipline' and were 'not allowed to make 'a pleasant use of their leisure time and they are locked in at 8.30 for the night'.<sup>38</sup>

The natural consequence of poor working/living conditions and wages was a highly transient workforce. In a letter to the *Scotsman* in 1903, Clouston pointed out the difficulty of retaining an asylum staff.

In the Scottish district institutions there is no provision for pensions as there is in England and Ireland and when they are fully trained some of the best of our staffs are apt to go into private mental nursing.<sup>39</sup>

Clouston realised that conditions needed to change in order to retain a workforce. Commissioners in Lunacy were also in favour of improvements. The repeated comment in their annual reports spelt out

...We think it deserving of careful consideration by the administrators of those institutions where changes occur frequently, whether some addition to the wages or some increase to the comfort of the attendants is not desirable.<sup>40</sup>

Table 19 shows the turnover of Scottish asylum staff in 1896. In this year, 73% of attendants and nurses left their institution in 1896. Moreover, the medical superintendents dismissed over 18% of staff for misconduct or incompetence. These categories could mean, 'drunkenness, 'leaving the asylum without leave', 'carelessness or neglect of duty', 'ill-treatment of a patient', 'dishonesty' and impropriety of conduct'.

Table 19  
Staff turnover in Scottish asylums (1896)

Left voluntarily	484	73.0
ill health	39	5.9
died	7	1.1
absconded	9	1.4
incompetence	35	5.3
misconduct	89	13.4
no longer required	0	0.0
Total	663	100.0



Sheehan highlights that in view of the low wages, harsh discipline and poor training, it is hardly surprising that nurses did not remain loyal to their employers.<sup>41</sup> Scottish asylum culture remained characterised by poor levels of pay and harsh conditions of work and the central authority made little to no effort to enforce change. As such, attempts to 'professionalise' nursing were made against a backdrop of significant staff discontent.

### Female nurses in male wards

The process of 'professionalisation' can be enacted in order to strengthen the control of certain groups. In relation to this, Carpenter suggests that any move to 'professionalise' asylum nursing was done to enhance the image of asylumdom in relation to general medicine and also to strengthen the control of the medical superintendents.<sup>42</sup> In Scotland, the model of general hospital nursing was emulated in a bid to strengthen the position of psychiatry.

In Scotland, female nurses operated a number of male hospital wards in Scottish asylums by 1914. This is an interesting development because in England, the first reported use of female nurses in male wards was not until World War One. Certainly, the Scottish Commissioners stated that female nursing was not a complete system in Scotland by 1913

Even at the present time the system is not either general or thorough, and although the asylums in which female nursing in the male wards has not been introduced at all are conspicuously rare, there are many institutions in which it is only partially employed...<sup>43</sup>

In 1900, within all Scottish asylums, there were 29 female nurses working in male wards, yet this figure had risen to 125 by 1913.

Only with the drastic shortages of male asylum workers in World War One did English superintendents contemplate employing female nurses in male wards. The employment of female nurses on male wards of English asylums did not become widespread until the war because of the resistance of male members of the National Asylum Workers union (NAWU).

George Robertson was a vocal supporter of female nursing on male wards. From the 1890s, Robertson made several appeals in the *Journal of Mental Science*, which called for the employment of female nurses on male wards. Table 20 is taken from the Stirling District Asylum annual report for 1904. It shows that females were in complete charge of the sickroom and infirm wards. Male nurses continued to staff the non-hospital accommodation (i.e. day rooms, wards for patients with epilepsy and industrial wards).

Table 20  
SDA patient and staff ratio in male department (1904)

	Patients	Attendants	Nurses	Charge Attendant	<u>Charge</u> <u>Nurse</u>	Assistant matron
1. Dayroom	24	4	0	1	0	0
2. Sickroom	33	0	3	0	1	1
Chronic infirm	95	0	8	0	1	1
Epileptic	44	4	0	1	0	0
Industrial	181	10	0	1	0	0
Total	377	18	11	3	2	2

Many other asylum medical heads followed suit. In 1896, Turnball, medical head of the Fife and Kinross District Asylum placed a ward containing 30 male hospital patients under the charge of female nurses throughout the day. Similar arrangements were then introduced to other Scottish asylums including Woodilee District Asylum (Woodilee), Gartloch District Asylum (Gartloch) and the Perth District Asylum (PDA). One possible motive is reasons of economy. Carpenter suggests that female nurses were

cheaper to employ and doctors could therefore improve staff ratio as they could afford to employ more nurses.<sup>44</sup>

Another possible reason for the employment of female nurses in male wards was that male patients were more likely to co-operate with female nurses, thereby strengthening discipline in the institution. In a lecture made in 1916, George Robertson argued that the 'presence of a good woman always has a refining influence on male society'.<sup>45</sup> The view of the 'good woman' ties in with a link made by Gamanrikow' between the 'good nurse' and society's perception of characteristics desirable in a 'good woman'.<sup>46</sup> As such, Robertson's belief here in the female nurse appears to have more to do with 'vocation and moral traits rather than medical training.

The manners and behaviour of an insane person, like those of a child are, to a very large extent what they are made, and from the influence of the gentler sex much good is certain to result among male patients.<sup>47</sup>

Such analogies also tie in with Foucault's belief in the use of attendants and nurses as part of moral management in the asylum. The thesis has also highlighted George Robertson's continued support for the importance of moral approaches in chapter three.

George Robertson also advocated the employment of nurses in asylums who had trained in general hospitals. Nolan argues that to have general hospital trained nurses on asylum wards helped doctors to convince themselves and the public that mental health nursing was a skilled profession.<sup>48</sup> Robertson asserted in 1902

A trained hospital nurse, is I consider, absolutely necessary if we aim at high ideals, and the hospital of a large asylum without a certified nurse is as retrograde an arrangement as would be that of the asylum with a layman as the superintendent...<sup>49</sup>

They are usually older than the average asylum nurse. These facts, in conjunction

with the prestige attached to hospital training, have at once given them great authority and have commanded respect.<sup>50</sup>

Robertson and a small minority of other medical superintendents employed general nurses in positions of responsibility in asylums, such as matron or sister posts.

The detachment of such employees from the rest of the asylum nurses could be used to wrest back the authority of the remote medical superintendent. Hospital nurses might be more likely to report misdemeanours to the medical superintendent. This group of nurses possessed extensive autonomy and higher wages in comparison to the rank and file asylum nurses. In 1901, Alison, then charge matron of the SDA's female wards became charge matron of female wards at Ayr District Asylum (ADA). Appointed at a salary of £78 per annum, her responsibilities included 'charge of the female patients and...control over the female attendants and servants'.<sup>51</sup> In 1904, an assistant matron was appointed to the ADA. Miss Binning assisted Alison and had been trained at the Glasgow Royal Infirmary.<sup>52</sup> Robertson argued that the old system of charge nurses was dissatisfactory because 'as she was one of themselves [asylum nurses] she had deficient authority over the asylum nurses, and perhaps sympathised with them. The result was poor discipline'.<sup>53</sup> By appointing hospital nurses as assistant matrons he believed that the distance of assistant matrons could be maintained from other nurses.

She has greater authority and maintains stricter discipline and because she keeps herself socially a little apart from the other nurses and attendants she feels less difficulty in reporting her juniors for breach of discipline.<sup>54</sup>

Another possibility is that doctors believed general trained nurses would be more likely to reject trade union activity and strike action.<sup>55</sup>

The support of Robertson for general hospital trained nurses was not shared by a majority of medical superintendents in Scotland. There were individual asylums such as



Gartloch, Woodilee, Ayr and Stirling who employed one or two general hospital trained nurses. Typically though, medical superintendents were not convinced by the practice and this is illustrated by a debate held at a *Medico Psychological Association* meeting in 1902. Some of the doctors present had tried using general nurses but reported unsatisfactory results. Lewis Bruce of Perth agreed with Robertson's use of female nursing in male wards but argued that 'Dr Robertson was off the line...when he put hospital nurses in charge of his nurses'. At the PDA, Lewis Bruce attempted to use general nurses but had found that 'the truth was that the hospital nurse gained her knowledge by a considerable amount of trouble and she did not care to pass that knowledge on to someone else for nothing'.<sup>56</sup> As a result, Bruce had abandoned the use of general nurses after a year's experience. As a promotion of 'female virtues', David Yellowlees argued that it was Robertson's selection of 'good women' rather than 'hospital training' that created 'very superior female officers'.<sup>57</sup>

Although not all asylums employed female asylum nurses it was widely supported as it projected an image that the psychiatric profession were emulating general medicine and their hospitals. The employment of general hospital nurses were less enthusiastically received, possibly because asylum doctors feared that general medicine would perceive their use as an admission of asylum culture's incompetence. In turn, this might suggest that the medical superintendents' provision of training and own profession was not up to standard.

### Training

Despite the emphasis on a asylum nursing staff, the training standards of asylum staff remained far from ideal. Early training of attendants had been at the discretion of the individual medical superintendent. WAF Browne at the Crichton Royal was the first to

provide an organised course of training for attendants and nurses in Britain. In 1854-55 he delivered a course of 30 lectures in mental disease and their management to staff at the institution. Thomas Clouston was also a Scottish proponent of asylum attendant training. In a published article for the *Journal of Mental Science* in 1876, Clouston proposed that staff training and improved standards were a method of stabilising the asylum workforce in Scotland.

Can we not devise and elaborate a systematic professional training for attendants in all our large asylums...the comfort and assistance of having reliable men and women would far more than repay all the trouble it would give us.<sup>58</sup>

Thomas Clouston was to become involved in the development of training for staff through the *MPA*.

In the late 1880s, the *MPA* introduced systematic training for attendants and nurses. The first step towards training was the publication of a *Handbook for Attendants on the Insane*. This appeared in the 1880s and was divided into chapters such as the general functions of the body; nursing of the sick; mind and its disorders; the care of the insane and the general duties of attendants. In 1889, both systematic training and registration was introduced. Prior to registration, attendants and nurses undertook a 3-month probationary period, followed by two years training and service in the asylum. At end of the two-year period, the *MPA* examination was taken. If successful, nurses and attendants were then certified and registered by the *MPA*. Individual asylums were required to provide lectures and demonstrations for their staff. In the first year of *MPA* examinations (1891) 8 candidates from the SDA passed the Certificate. At Woodilee, systematic training was established in 1894. Between this date and 1908, 99 nurses and attendants attained the *MPA* certificate.<sup>59</sup>

Examinations were held twice a year in the asylums where the candidates worked. Extract 5 is taken from the *MPA* examination paper for 1904. The extract was included in Woodilee annual report for this year. Many asylums included example questions of the examination paper and published the figures of staff who had passed the examination in their reports. Again, like the photographic images of nurses that were included in annual reports, the examination paper was intended to promote the asylum as a 'medicalising' environment.

Extract 5

MPA Examination Paper 1904

Medico Psychological Nursing Certificate

The list of questions which appeared on the paper at the may examination is as follows:-

- 1) What signs would lead you to expect that a patient is going to have a fit? What precautions would you take when you witness these signs?
- 2) What is dropsy? Where is it most common? How would you recognise it?
- 3) What is seclusion? What are the rules to be observed about it?
- 4) What are the principle parts of the nervous system? Of what parts is the brain composed? Describe briefly the functions of the cerebrum.
- 5) What is the urine? What is its daily normal quantity? What particulars should be noted by a nurse with regard to the urine?
- 6) What should you do in the following emergencies?
  - A patient while walking in the grounds follows a quantity of yew leaves, which you know to be poisonous.
  - A patient falls in the ward and sustains a simple fracture of the femur
  - A patient thrusts his hand through a pane of glass and severs the radial artery.
- 7) Give six examples of occasions when you would consider it your duty to make an immediate report to a medical officer.
- 8) What are the chief differences between treating a case of mental disorder in the patient's home, and in an institution. How would you act if sent to take charge of a insane patient in a private house
- 9) How would you keep patients clean who are confined to bed? Describe carefully the process of sponging a patient.
- 10) What do you understand by the term "insane ear" (haematoma auris)? Give an account of any case of this you have seen from its commencement to its termination.

Source: *29<sup>th</sup> Annual Report of Woodilee District Asylum, (1904)*

Nolan argues that the training was designed to give attendants an understanding of bodily structure and function that would enable them to perform first aid.<sup>60</sup> The emphasis on bodily functions and first aid is demonstrated in questions 5 and 6. Question 5 for example tied in with the increased emphasis placed on the physical condition of patients. The question paper also highlights the practice of seclusion (question 3) and bed rest (question 9). Of interest is the inclusion of a question relating to staff discipline. Question 7 asked the candidate to give no less than 'six examples of occasions when you would consider it your duty to make an immediate report to a medical officer'.

Some individual doctors made attempts to extend training. However, these efforts were often a reaction to local requirements rather than being introduced as a systematic training programme. For example, in 1905, the Glasgow District Lunacy Board introduced a nursing training scheme that linked training in asylums to experience in local poor law infirmaries. One of the main aims of this scheme was to try and stabilise the asylum workforce in the local area and to train staff for the poor law hospitals. Test examinations held at end of each year's training and nurses who passed third year's examination were admitted for work experience at a poor law infirmary in Glasgow. At the end of this experience, nurses were subjected to further examination and if successful, received a certificate in nursing signed by the local medical superintendents of the hospital and asylum. The apparent aim of the scheme was 'to improve the training of our asylum nurses by enlarging their experience of ordinary surgical and medical nursing. However, as a requirement of joining the scheme was to 'sign an engagement to serve for three years', it is realistic that developing a stabilised workforce was of more interest than developing any medical skills.



### Failure of Training

Training and registration made staff more accountable for their actions. Russell suggests that blaming staff for problems in the system was preferable to facing up to the ineffectiveness of training and psychiatry.<sup>61</sup> Nolan makes the point that it was unfair to demand professionalism from attendants who were not only underpaid and overworked.<sup>62</sup>

The investigation of abuses (although not all were ever uncovered) was one way in which the General Board input unqualified control. After the introduction of registration of asylum nurses, a log of all dismissals was maintained and circulated by the General Board of Lunacy.

We register the name of every attendant and servant dismissed from an asylum for misconduct and when any name so registered re-appears among the notices of engagement transmitted to use, we intimate the facts to the superintendent by whom the engagement has been made.<sup>63</sup>

However, due to the high turn over and shortage of staffs it was noted that

When the fault concealed has been serious dismissal usually follows,  
but when it has not been of a grave nature another chance is usually given.<sup>64</sup>

Where instances and allegations of abuse arose, the District and General Board were quick to intervene. In an age of growing medical regulation, Commissioners aimed to mitigate allegations of poor management.

The reality of standards is most often uncovered by scandal. Events at the Dundee District Asylum in 1903 are an illustration of the ongoing ineffectuality in nursing care and patient management. In October 1903, the District Lunacy Board of Dundee expressed concerns over the management of the Westgreen District Asylum. As a result, a committee from the District Board was formed in October 1903 to investigate

and report into the asylum's management. The concerns expressed in their report were based upon two main premises. Firstly, the treatment of medical staff by the medical head James Rorie, but more importantly, the ambiguous death of a patient at the asylum. The Dundee scandal highlights three issues relevant to this chapter. Namely, poor management of institutions; discontent expressed by staff with their working environment; and the poor nursing standards within the institution.

The committee's report brought to light discontent felt by Dr Tauch, the senior medical assistant. Tauch had dismissed a Westgreen attendant for going home without leave. However, Rorie had later re-appointed the attendant, claiming that Tauch had dealt too harshly with the employee. In response, Tauch felt aggravated because 'the re-engagement of the attendant would be an irreparable injury to the discipline of the institution...and that it would weaken his influence over the subordinate officials'.<sup>65</sup> In response to Tauch's complaints, the committee found that

it was at least a very serious error of judgement on the part of Dr Rorie, the effect of which, if matters were allowed to remain as they are, must be detrimental to the maintenance of proper discipline in the institution.<sup>66</sup>

This discontent was not reserved for one disgruntled employee. In addition, the matron and junior medical assistant had handed in resignations within recent months. The matron refused to comment on why she had resigned because she did not wish to be involved in an inquiry. In contrast, the junior asylum doctor happily aired his grievances.

He considered the latter's [Rorie] treatment of his assistants unjust, unfair and intolerable; that during the short time he had been in service he had been repeatedly ignored; and that he discovered that the head male attendant was Dr Rorie's medium of information regarding patients in the division particularly under his (the junior assistant) supervision, viz., the male division.<sup>67</sup>

The assistant doctor's comments again reflect how this group felt undermined by the asylum head. This, in turn highlighted discontent with staff working conditions.

The most disturbing section of the report concerned the suspicious death of a patient. A male patient admitted in August 1903 was found dead at the asylum in September 1903. The cause of death after post mortem report was reported to be double pleurisy, caused by an injury to the chest. After the fatality, the District Board had been informed by the superintendent that the patient was 'very restless and on several occasions had fallen out of bed'.<sup>68</sup> Rorie regarded this to be the most probable cause of death. Yet on investigation, the committee experienced great difficulty in obtaining information from the attendants as to the cause of death. The ambiguity was quoted as 'day attendants stated it [the death] must have been during the night and night attendants stating it must have been during the day'. The committee also suspected that the strapping down of the patient had in fact caused the death.<sup>69</sup>

The issue was of evident embarrassment to both the District and General Board. Unrelated to the incident, a Commissioner in Lunacy 1900 report of restraint in Scottish asylums had commented

It is remarkable that Dr Rorie Medical Superintendent of Dundee...did not find it necessary to resort to either restraint or seclusion in any one instance during the 5 year to which the returns refer.<sup>70</sup>

These comments suggest that Rorie had either lied about his practice of restraint at the asylum or was not systematically filling out the register. Either way, it is likely that the Commissioners were dubious about the lack of restraint or seclusion ever being used at the asylum.

In response to the alleged malpractice at Westgreen, the district board committee highlighted their lack of confidence in Rorie's management.

they are not satisfied that they [the injuries] were caused by his falling out of bed...the committee are of opinion that there should have been a fuller and more searching inquiry by Dr Rorie'.<sup>71</sup>

Further to the District Board's report, the General Board of Lunacy formed a committee to make a full and independent inquiry.

The report by the General Board uncovered the likely mistreatment of the dead patient by the asylum staff.

there is some evidence that they [the injuries] were not due to the patient falling out of bed, but to blows or pressure directly applied to the chest by some person or persons unknown.<sup>72</sup>

The committee also went on to reveal the ineptness of Rorie by suggesting:

Had he made anything like a proper inquiry he would have discovered - as the Board did at their inquiry that another patient had been tied down about a fortnight before the patient received his injury and at least some suspicion that the same thing had happened in the case of the patient who died.<sup>73</sup>

Finally, the General Board drew attention to Rorie's practice of using inexperienced, low-grade staff to treat the most acutely ill patients in the institution. When the Westgreen patient died in September 1903, the four male attendants in charge of the sickroom had less than three months experience each, and two of these attendants had been employed at the asylum for less than four weeks. Although Rorie defended this practice as 'affording training in nursing to new attendants', it was strongly condemned by the General Board as not only a 'source of danger' and against official procedures.

Contrary to their circular of 14 January 1901 in which they recommended patients difficult to manage should be placed in charge of "attendants specially selected for their long experience, good service, good temper and general trustworthiness."<sup>74</sup>



Rorie resigned due to the scandal. His career was not too harshly affected as within a year he had obtained a lectureship in mental disease at St Andrew's University.

The majority of literature written on asylum staff focuses upon the individual medical superintendent or the largely anonymous group of nurses and attendants. In the process, the conditions of assistant asylum doctors have often been overlooked. Richard Russell provides a brief overview of medical officers (also termed assistant doctors). Russell argues that medical officers also had grievances over pay and conditions. Medical officers also were required to double for the medical superintendent and cope with clerical duties.<sup>75</sup> As the previous chapter highlighted medical officers were often overworked and were expected to carry out scientific research as well as postmortem duties. The Dundee events demonstrate that this group often felt undermined by the actions of medical superintendents.

The poor management, discontent of staff and maltreatment of patients at Dundee should not be considered uniform with all Scottish asylums. However, the scandal does outline the severe shortcomings of training for asylum nursing and the clear gaps that remained. The incidence is also reflective of the antagonisms felt by the assistant doctors, a group who are often overlooked as an anonymous group in much of nursing and psychiatric history's literature.

#### Militancy and Strikes: An alternative strategy

The use of strike action or trade union activity was an alternative strategy to professionalisation. Carpenter suggests that just because asylum nurses were subject to objectionable discipline, this did not mean that asylum nurses would always adhere to it.<sup>76</sup> Chatterton suggests that alongside professionalisation, unionisation was an equally

important theme for mental nursing in this period.<sup>77</sup> Although Scottish asylum workers did not flock to trade unions before world war one, Scottish nurses were involved in strike action in the early twentieth century. This is interesting because the Scottish asylum strikes predate any similar strikes in England that have been referred to in the current literature.<sup>78</sup>

In the broader context, unionism and strike action was an integrated part of the occupational landscape by the 1890s. Although trade unions had existed throughout the nineteenth century, the late century saw the emergence of 'new style' unions. These unions were catered largely for unskilled and poorly paid manual workers and depended upon aggressive strike action in order to achieve benefits.<sup>79</sup> Unions also took root among non-manual workers, including teaching, shop work, clerical work and nursing. For example, the National Union of Teachers included 80% of certified teachers by 1914 and the National Amalgamated Union of Shop Workers was formed in 1891.<sup>80</sup> Growing political disenchantment and industrial militancy also continued to spread throughout the Edwardian period.

The first association of asylum workers was the Asylum Workers Association in 1895. However, medical superintendents working via the *MPA* formed the AWA. As such, Carpenter suggests that the AWA was similar to a 'company union', because its establishers aimed to prevent an independent organisation by rank and file workers.<sup>81</sup> Although the AWA achieved a membership of 5,000 at its peak, this was probably more due to the lack of suitable union alternatives.

Male asylum workers in Lancashire, England formed the National Asylum Workers Union (NAWU) in 1911. In Scotland, membership of the NAWU remained low

compared to England and membership did not spread across the whole of Scotland until after 1918. Speculatively, the lack of membership in Scottish asylums may be due to the strict opposition to trade union activity by medical superintendents. Certainly, conditions in Scottish asylums for staff were no better than their English counterpart. The lack of interest by female nurses in the NAWU may have resulted from NAWU opposition to the employment of females in male wards. The NAWU was strongly opposed to this practice, suggesting that it undercut the price of male labour and exposed females to sexual danger.<sup>82</sup> This was the standard trade union attitude to female workers. However, only Scottish asylums employed female nurses in male wards at this point.

Gordon argues for the period 1859 to 1914 that although women in Scotland were not involved to any formal degree in trade unions, they did participate in over 300 employment disputes.<sup>83</sup> In this context, the participation of female nursing staff in strike action is not out of character. A strike of Glasgow's female asylum nurses in 1905 highlights far-reaching discontent with their working conditions. At Gartloch in this year, a petition signed by an impressive 62 of 66 nurses was sent to medical superintendent Parker in protest about reduced staff numbers and increased working hours.

We the undersigned refuse to come on duty when the short leave comes into force.

We are now working 84 hours per week, exclusive of extra duty, which amounts to about 91 hours and we refuse to work an hour longer than we are doing at present.<sup>84</sup>

In turn, the protest had a knock on effect at Gartloch's sister asylum of Woodilee. Woodilee nurses were ordered to sign an Obligation to the medical superintendent, which stated that they would not strike. One Woodilee nurse refused to sign the agreement and was promptly dismissed. At Gartloch, Parker immediately dismissed 5

head nurses suspected of being the ringleaders. In turn, the dismissals lead to the joint resignation of the other 57 nurses who had signed the original petition.

The protest had been apparently influenced by strike action in London County Asylums, where nurses attempted to establish trade unions in the 1890s. The strike action failed although London asylum workers continued to put pressure on the authorities and this culminated in a petition for reduced working hours submitted jointly by male and female asylum workers. While this action was not taken up, some small attempts were made to improve conditions in London.

The nurses' strike action demonstrates the continued strict discipline held over asylum staff well into the twentieth century. What is also of interest is the noticeable absence of the male attendants. On the one hand this may have been due to the difficulties of spreading the strike to the male side. Alternatively as Gordon suggests, women were often prepared to take action when the men refused.<sup>85</sup> The dismissal of nurses at Gartloch and Woodilee led to the intervention of the Glasgow Trade's Council (GTC). At a meeting of the Parish Council, the leader of a deputation sent by the GTC suggested that while 'discipline ought always be maintained in these institutions, they considered that discipline might be carried out to the length of tyranny'.<sup>86</sup> Also at the meeting was Mr Motion, Glasgow Inspector of Poor. When Motion proclaimed that the nurses ought to have known better than 'raise this revolution', an ex-member of the Parish Council, Alexander Haddow helpfully pointed out that while Motion enjoyed a 30 hour week, nurses worked over 70 hours.<sup>87</sup> As a result of the GTC's intervention, all of the nurses were reinstated.



## Conclusion

In the asylum, any attempt to 'professionalise' asylum nursing was far removed from the aspirations of the attendants and nurses. Working conditions remained harsh for the rank and file and wages were low. The superficial training was minimal and served to make the psychiatric profession appear progressive. Similarly, the introduction of female nurses to male wards was an effort to 'medicalise' the institution as well as improve image of failing psychiatric profession in the context of general medicine.

Yet the model that asylum doctors sought to emulate was far from ideal. In this context, the concept of 'professionalisation' also sits uncomfortably with the nineteenth century general nursing model. Only in the recent decades has the level of reform implemented in hospital been properly challenged. The Nightingale model was not reflective of continuing practice in poor law infirmaries and local hospitals. Neither were the reforms of Nightingale as far reaching as has been proposed by many traditional historians.

It is untrue to liken Scull's analogy of the 'unemployable' of other professions to asylum staff in the late nineteenth century. The action of staff in unionisation and strikes reflects a desire to improve their conditions rather than seek alternative employment. Certainly, wages were low and comparable with agricultural labour or domestic service. However, the wages were also similar to the rank and file nurses working in poor law infirmaries.

If the doctor's concept of improvement did not include improvements to the attendants' and nurses' daily life, then this process was of little use to the attendants and nurses. As a result, asylum staff sought alternative strategies. Collectively across

Scotland, this meant leaving asylum service. While trade union activity and strike action did not fully escalate until after 1918, Scottish asylum staff played their part in setting the scene at a local level. As the twentieth century unveiled, female nurses in Glasgow attacked the iron rod grip of the medical superintendent and achieved some public recognition for their situation. Ironically for the doctors, this was the very group of staff that medical superintendents hoped would strengthen their own medical supremacy.

<sup>1</sup> S. Taylor & D. Field (ed), *Sociology of Health and Health Care*, (Blackwell Scientific Publications, 1993), p.213.

<sup>2</sup> M. Furness, 'A personal perspective of nursing history,' *International History of Nursing Journal*, 4/2 (1998-99), p.37.

<sup>3</sup> J. Salvage, *The Politics of Nursing*, (Heinemann, 1985), p.93.

<sup>4</sup> B. Abel Smith, *A History of the Nursing Profession*, (Heinemann, 1960), p.132.

<sup>5</sup> C. Chatterton, 'Women in mental health nursing: angels or custodians?', *International History of Nursing Journal*, 5/2 (2000), p.15.

<sup>6</sup> L. Massie, 'The role of women in mental health care in 19<sup>th</sup> century England', *IHNI*, 1/2 (1995), p.47-48.

<sup>7</sup> C. MacKenzie, 'Women and psychiatric professionalism' in London Feminist History Group, *The Sexual Dynamics of Labour*, (Pluto, 1983), p.117.

<sup>8</sup> Massie, 'The role of women in mental health care in 19<sup>th</sup> century England', p.47.

<sup>9</sup> Salvage, *Politics of Nursing*, p.33.

<sup>10</sup> See for example, C. Davies (ed), *Re-writing Nursing History*, (Croom Helm, 1980), R. Dingwall et al, *An Introduction to the Social History of Nursing*, (Routledge, 1991) and C. Maggs (ed), *Nursing History: The State of the Art*, (Croom Helm, 1987).

<sup>11</sup> J.E. Brooks, 'Ghost of the past: capturing history and the history of nursing', *IHNI*, 5/2 (2000), p.36.

<sup>12</sup> B. Abel Smith, *A History of the Nursing Profession*, p.57.

<sup>13</sup> M. Dean and G. Bolton, 'The Administration of Poverty and the Development of Nursing Practice in Nineteenth Century England', in *Rewriting Nursing History*, p.85-6.

<sup>14</sup> Dingwall et al, *An Introduction to the Social History of Nursing*, p.67.

<sup>15</sup> *Ibid.*

<sup>16</sup> Chatterton, 'Women in mental health nursing: angels or custodians?'; M. Carpenter, *Working for Health*, (Lawrence & Wishart Ltd, 1988), J. Sheehan, 'The Role and Rewards of Asylum Attendants in Victorian England', *IHNI*, 3/4 (1998), Sheehan, 'A second look at nursing history', *IHNI*, 3/1 (1997).

<sup>17</sup> M. Carpenter, 'Asylum Nursing before 1914: A chapter in the history of labour', in Davies, *Rewriting Nursing History*, p.135.

<sup>18</sup> M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, (Routledge, 1961), p.251-2.

<sup>19</sup> Carpenter, 'Asylum Nursing before 1914' in Davies, *Re-writing Nursing History*, p.136.

<sup>20</sup> A. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England*, (Penguin, 1979), p.122.

<sup>21</sup> Sheehan, 'A second look at nursing history', p.48 &50.

<sup>22</sup> O.M. Church, 'The Emergence of Training Programmes for Asylum Nursing at the Turn of the century', in Maggs, *Nursing History*, p.109.

<sup>23</sup> G. Robertson, 'Hospital Ideals in the Care of the Insane: a statement of certain methods in use at the Stirling District Asylum', *JMS*, 48 (1902), p. 265.

<sup>24</sup> D.M. Fox & C. Lawrence, *Photographing Medicine Images and Power in Britain and America since 1840*, (Greenwood Press, 1988), p.45.

<sup>25</sup> Chatterton, 'Women in mental health nursing', p.13.

<sup>26</sup> Boston Nurses' group, *The False Promise: professionalism in nursing*, (New England Free Press, 1978), p.1.

<sup>27</sup> *33<sup>rd</sup> Annual Report of the Ayr District Asylum*, (1904), AA17/7.

<sup>28</sup> *Gartloch Wage Book 1897 - 1907*, HB1/5/56.

<sup>29</sup> R. White, *Social Change and the Development of the Nursing Profession*, (Henry Kimpton, 1978), p.74.

<sup>30</sup> T.C. Smout, *A Century of the Scottish People 1830-1950*, (Fontana press, 1986), p.112.

<sup>31</sup> Carpenter, *Working for Health*, p.75.

- <sup>32</sup> Smout, *Century of the Scottish People*, p.103.
- <sup>33</sup> *Scotsman* (2/12/03) in *Presscuttings Book 1903-1917*, HB7/12/6.
- <sup>34</sup> See Case G, Appendix three.
- <sup>35</sup> Chatterton, 'Women in Mental Health Nursing', p.13.
- <sup>36</sup> Sheehan, 'The role and rewards of asylum attendants in Victorian England', p. 26.
- <sup>37</sup> Carpenter, *Working for Health*, p.25.
- <sup>38</sup> *Scotsman*, (13 Dec 1905) in *Presscuttings Book 1903-1917*, HB7/12/6.
- <sup>39</sup> *Scotsman*, (25 Nov 1903) in *Ibid.*
- <sup>40</sup> *23<sup>rd</sup> Report of the Commissioners in Lunacy for Scotland*, (1882-83), GD17/5/12.
- <sup>41</sup> Sheehan, 'The role and rewards of asylum attendants in Victorian England', p.32.
- <sup>42</sup> Carpenter, *Working for Health*, p.31.
- <sup>43</sup> *56<sup>th</sup> Report of the Commissioners in Lunacy for Scotland*, (1913), GD17/5/24.
- <sup>44</sup> Carpenter, *Working for Health*, p.31.
- <sup>45</sup> *Nursing Mirror* (04 Mar 1916) in *Presscuttings Book 1903-1917*, HB7/12/6.
- <sup>46</sup> E. Gamanrikow in, 'Sexual division of labour: the case of nursing' in A. Kuhn & A. Wolpe (ed), *Feminism and Materialism: Women and Modes of Production*, (Routledge & Kegan Paul, 1978), p.97-98.
- <sup>47</sup> *30<sup>th</sup> An. Rep. of Stir. Dist. Lun. Bd.*, (1899-1900), GD17/1/36.
- <sup>48</sup> P. Nolan, *A History of Mental Health Nursing*, (Chapman and Hain, 1993), p.72.
- <sup>49</sup> Robertson, 'Hospital Ideals in the Care of the Insane', p. 266.
- <sup>50</sup> *Ibid.*, p.279.
- <sup>51</sup> *Min. Bk. of Ayr. Dist. Lun. Bd.*, (1901-1903), AA17/4/4.
- <sup>52</sup> *34<sup>th</sup> An. Rep. of ADA*, (1904), AA17/7.
- <sup>53</sup> *Ibid.*
- <sup>54</sup> *Scotsman*, (2 Dec 1903) in *Presscuttings Book 1903-1917*, HB7/12/6.
- <sup>55</sup> Carpenter, *Working for Health*, p.61.
- <sup>56</sup> *Discussion held at the MPA Scottish Divisional Meeting, JMS*, 48 (1902), p.282.
- <sup>57</sup> *Ibid.*
- <sup>58</sup> T.S. Clouston, 'On the Question of Getting, Training and Retaining the Services of Good Asylum Attendants', *JMS*, 22 (1876), p.388.
- <sup>59</sup> *Mins of Glas. Dist. Lun. Bd.*, (1908), HB30/1/6.
- <sup>60</sup> Nolan *A History of Mental Nursing*, p.66.
- <sup>61</sup> R. Russell, 'The lunacy profession and its staff in the second half of the nineteenth century, with special reference to the West Riding Lunatic Asylum', W.F. Bynum, R. Porter & M. Shepherd, *The Anatomy of Madness Volume Three*, (Routledge, 1988), p.311.
- <sup>62</sup> Nolan, *A History of Mental Nursing*, p.72.
- <sup>63</sup> *39<sup>th</sup> Rep. of the Com. in Lun. for Scot.*, (1896), GD17/5/17.
- <sup>64</sup> *Ibid.*
- <sup>65</sup> *Dundee Courier*, (23 Oct 1903) in *Presscuttings Book 1903-1917*, HB7/12/6.
- <sup>66</sup> *Ibid.*
- <sup>67</sup> *Ibid.*
- <sup>68</sup> *Scotsman*, (23 Oct 1903) in *Presscuttings Book 1903-1917*, HB7/12/6.
- <sup>69</sup> *Ibid.*
- <sup>70</sup> *43<sup>rd</sup> Rep. of the Com. in Lun. for Scot.*, (1900), GD17/5/19.
- <sup>71</sup> *Dundee Courier*, (24 Oct 1903) in *Presscuttings Book 1903-1917*, HB7/12/6.
- <sup>72</sup> *Scotsman*, (20 Nov 1903) in *Ibid.*
- <sup>73</sup> *Ibid.*
- <sup>74</sup> *Ibid.*
- <sup>75</sup> Russell, 'The lunacy profession and its staff', p.306.
- <sup>76</sup> Carpenter, 'Asylum Nursing before 1914', p.138-9.
- <sup>77</sup> Chatterton, 'Women in Mental Health Nursing', p.17.
- <sup>78</sup> Brian Abel Smith argues that the first strike did not occur until September 1918 at the Prestwich Asylum (see Abel Smith, *A History of the Nursing Profession*.) The most famous nurse strike commonly referred to by historians is the defeated Radcliffe Strike of 1922. For further details see Carpenter, *Working for Health*, p.84-91.
- <sup>79</sup> C. Maggs, *Exploring History An Introduction to Nursing's Past*, (Continuing Nurse Education Programme, 1989), p.91.
- <sup>80</sup> *Ibid.*, p.95.
- <sup>81</sup> Carpenter, *Working for Health*, p.38.
- <sup>82</sup> *Ibid.*, p.63.

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<sup>83</sup> E. Gordon, 'Women's Spheres' in W. Hamish Fraser & R.J. Morris (ed), *People and Society in Scotland*, (John Donald, 1995), p.221 & 223.

<sup>84</sup> *Glasgow Herald*, (10 Jan 1906), in *Presscuttings Book 1903-1917*, HB7/12/6.

<sup>85</sup> Gordon, 'Women's Spheres', p.223.

<sup>86</sup> *Ibid.*

<sup>87</sup> *Scotsman*, (14 Dec 1905) in *Presscuttings Book 1903-1917*, HB7/12/6.



## Chapter Nine Architecture

In Scotland, as in England, it seems difficult to persuade the benevolent  
builders of asylums and their architects that insanity is not treated by palaces,  
but by physicians; not by bricks, but by brains<sup>1</sup>

### Introduction

Much existing literature views the late nineteenth century asylum as a monolithic institution that shared custodial features akin to prison life.<sup>2</sup> Showalter highlights that English asylums originally built to house a hundred increased to accommodate thousands.<sup>3</sup> She suggests that the need to control large numbers of patients meant that moral therapy was replaced with disciplinary techniques, closer to the prison or workhouse regime.<sup>4</sup> This chapter suggests that it is incorrect to project this custodial image of the large English county asylum onto all Scottish asylums. Certainly there were a number of district asylums that fitted Scull's analogy of the oversized Victorian institution in Scotland. Typically however, the average size of the Scottish asylum was in the hundreds rather than thousands. Andrews argues that after 1857, Scottish Commissioners worked hard to mitigate the custodial aspects of the Royal asylums.<sup>5</sup>

Alternatively, this chapter shows that early nineteenth century principles of classification reemerged between 1880 and 1914 within the asylum and were ultimately realised in the 1900s village asylum. Within this system, patients were often classified and accommodated according to their behaviour and whether they were 'trustworthy', 'industrious', 'dirty and degraded' or 'quiet'. Although few asylums adopted the blueprint of the village asylum it is consistent throughout the asylums researched that superintendents aimed to adopt their own version of classification and the gradation of

accommodation privileges. The smaller size of Scottish asylums meant that they were able to develop principles of classification more extensively than England.

Revisionist work has stressed how institutions such as asylums, workhouses and prisons shared similar architectural features that subjected their inmates to a disciplined regimen of strict classification and surveillance. In *Discipline and Punish*, Foucault highlights that the observation and discipline of the inmate was symbolised by the architectural image of Bentham's panopticon, which was widespread in prisons from the 1830s.<sup>6</sup> Classification was crucial in the accommodation of different inmates and a ladder of progress allowed the recovering to ascend towards final discharge.<sup>7</sup>

Although arguing that architecture was reflective of a continuation in moral approaches, it is also suggested that classification must be viewed in the wider medical context. The construction of hospitals and classification of new patients and 'curable' cases in admission wards was an attempt to promote cure and raise the profile of psychiatry. In some individual asylums, doctors attempted to decrease the monolithic size of urban asylums by admissions through observation wards in poor law infirmaries. Scottish psychiatrists were also keen to emulate the concurrent European moves to link psychiatry with general hospitals. Nineteenth century theories such as degeneration and eugenics influenced the accommodation of persons with learning disabilities.

Although the propagation of asylum hospitals and village asylums became part of the official stance taken towards asylum construction, innovations resulted from the 'grass roots' of the doctors. The sheer cost of asylum construction meant that it engaged the attention of all authorities, including the Commissioners, District Boards and medical superintendents. Andrews suggests that more research is needed in order to understand

power relations between the local authorities and medical superintendents.<sup>8</sup> As much as medical superintendents and Commissioners pushed for hospital additions, the financial costs incurred by the District Board from building construction also influenced how far accommodation change was implemented.

#### Parallels between the prison and asylum

In the eighteenth and early nineteenth century, the architecture of the asylum was vital to its success. Porter argues that the York Retreat was a classic example of a design that combined security with the impression of a country house.<sup>9</sup> As such, the building was intended to relinquish the idea of confinement. Donnelly argues that despite the divergent purpose of asylums, prisons and hospitals, the plans of each institution shared remarkable similarities.<sup>10</sup> Blueprints plans did not always make their way into actual asylum construction. However, the extremity of the Glasgow Royal Asylum's panopticism was evident. Here, the architect William Stark produced a 'classificatory quarantine' whereby members from each class were prevented from mixing with undesirable and lower ranks.<sup>11</sup> Strict classification was also an aspect of WAF Browne's moral approach at the Crichton Royal in Dumfries.

With the evolution of a public asylum system in Britain, County and District Boards were unable to justify the extravagances of small homely institutions or strict classification that moral methods proposed. Stark's panoptic ideal was lost at Glasgow as Royal asylums in Scotland became overrun with pauper patients. After the 1845 Lunacy Act in England, asylums rapidly increased in size and were far removed from moral therapy's ideal of a domestic milieu. Asylums that originally were built for a few hundred had increased their capacity to the thousands.<sup>12</sup> Colney Hatch Asylum,

Middlesex (1851) was designed for more than 1,000 patients and by 1874 possessed accommodation for more than 2,000 patients.

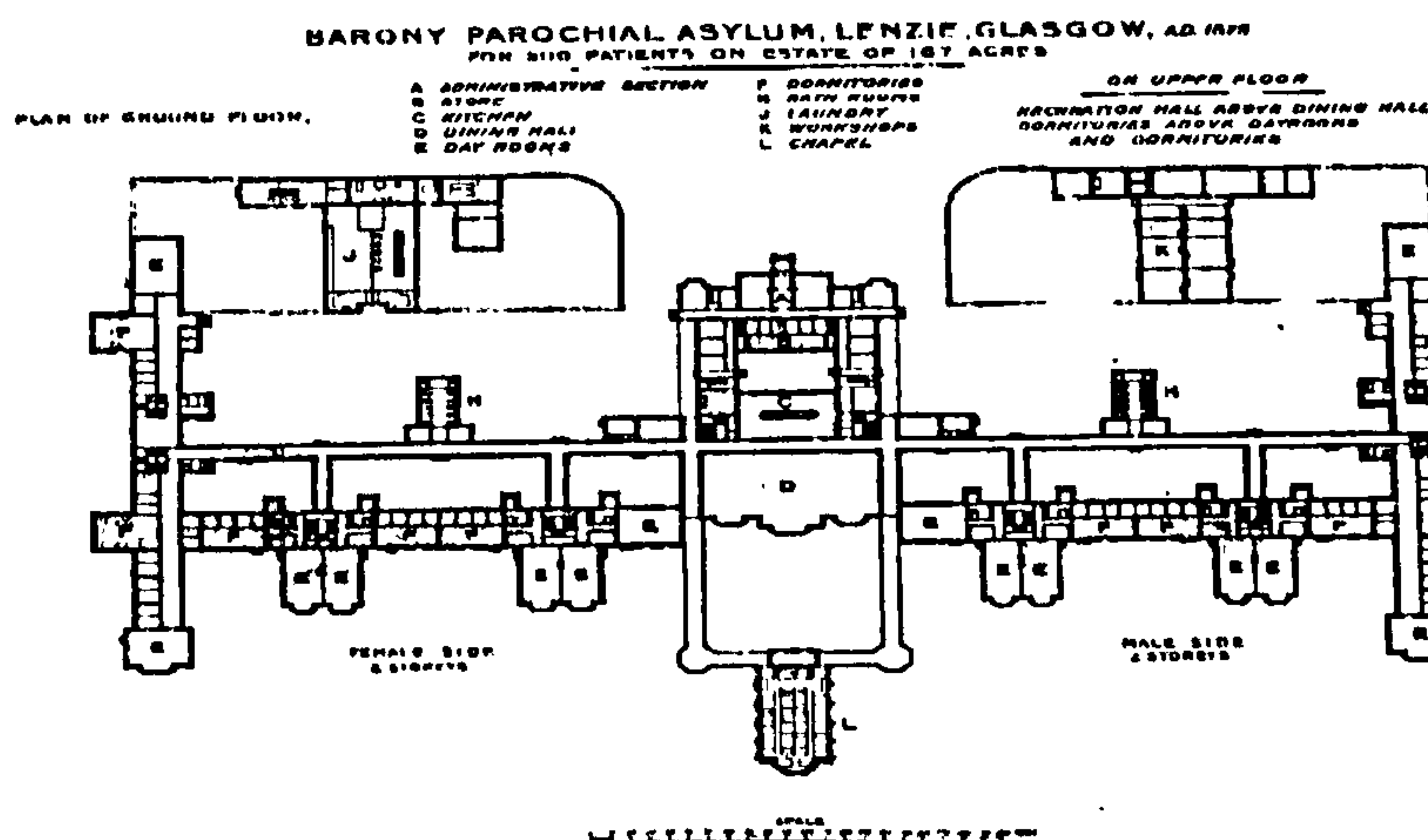
Many such asylums took on custodial characteristics of prisons and were in the design of the corridor style. The majority of asylums that had been built up until the mid to late nineteenth century were classed under this heading. Contemporaries noted that 'in this design, the "prison style" still hasn't lost its hold'.<sup>13</sup> Writing in 1892, Henry Burdett also criticised the lack of distinction between the asylum and other public institutions of the mid century.

The simplest form of corridor asylum is practically the same as that so often seen in general hospitals, and in large orphanages, charity schools, hotels etc.<sup>14</sup>

In Scotland, many asylums built up until the early 1870s were in this style.<sup>15</sup>

After the 1857 Act, Scottish Commissioners did aim to dampen the 'custodial' features of the new asylums. Commissioners aimed to remove high boundary walls and unlock the doors of asylums. When Woodilee (then Barony Parochial asylum), Glasgow opened in 1875, the Commissioners regarded it as a model institution (see plan 1).

Plan 1 Woodilee District Asylum, (1875)



Source J. Sibbald, *On the Plans of Modern Asylums for the Insane Poor*, (James Turner & Co, 1897)



The Glasgow architect James Salmon (1825-1888) designed Woodilee. Although the asylum was still constructed in the traditional corridor style it was less custodial than English asylums as it was built without airing courts and a boundary wall. Although built as one block, efforts were made to domesticate the accommodation as day rooms were on the ground, with sleeping accommodation on the first floor. Although built as a model of apparent liberty, the asylum was overrun with admissions by the late nineteenth century and as documented already, adopted a more custodial approach in its management.

### Nineteenth century hospital influences

Prior to the construction of asylum hospitals in Scotland, the pavilion type hospital had exerted an influence upon English asylum construction. 'Pavilion' described an edifice consisting of independent buildings (completely isolated or linked to each other through open galleries). Taylor argues that the pavilion style hospital was a response to the changing mix of social, sanitary and medical imperatives in the Victorian era.<sup>16</sup> The pavilion style emerged primarily due to the campaigns for ventilation and as a response to high hospital mortality rates and hospitalism.

The pavilion style was seen as an ideal model for tuberculosis sanatoria. The Royal Victoria Hospital in Edinburgh (discussed in chapter six) opened new pavilions in the 1900s that were completely separate from the main building. The Scottish architect Sydney Mitchell (son of the late Lunacy Commissioner Arthur Mitchell) designed the new units. Sydney Mitchell was also involved in the subsequent classification of accommodation at the CRI and is an example of how similarities arose between the architecture of different public institutions. Some English sanatoria also opened purpose built sanatoria that comprised of pavilion units. However, most sanatoria were

not purpose built and were often converted from hospitals, poorhouses and mansions.<sup>17</sup> In line with this, the RVH main hospital had been converted from Craighleith Poorhouse.

English asylum builders saw the pavilion style hospital as a convenient and cheap method of housing large numbers of pauper patients. The benefits of pavilions were perceived to be that the blocks could be of various architectural forms in order to suit different classes of patients. Secondly, the break up of patients into smaller blocks allegedly meant that the depressing effect of large crowds of patients was minimized. Pavilions also met asylum authorities requests to reduce infectious disease through proper ventilation and infectious disease blocks.

The move to include hospital accommodation in English asylums is evidenced by English architects' plans. The English architect William Dawes spoke to the Architectural Association in 1880 and had outlined his plans for a model asylum in the late Victorian period. Dawes suggested an asylum for 500 patients with a receiving block, infirm block, chronic block as well as central administrative offices and workshops for men and women. Similarly, George Thomas Hines, the Consulting Architect to the English Commissioners in Lunacy from 1897 designed and completed four major London County Council asylums (Claybury, (1893), Bexley (1898), Horton (1902) and Long Grove (1903-07) each housing approximately 2000 patients. The asylums' buildings made clear the increasing tendency by the 1900s to the dispersal of asylum buildings that included an acute hospital and main asylum building.<sup>18</sup> However, by 1901, the Claybury asylum accommodated almost 3,000 patients allowing for little realistic classification.

### Scottish Asylum Hospitals

The move to construct hospitals at Scottish asylums came primarily from individual superintendents which was then translated into official policy by the Commissioners. The conversions undertaken by Clouston at the Royal Edinburgh Asylum in the 1880s were the first practical steps taken by a superintendent towards the construction of a separate hospital. Between 1877 and 1882, Clouston worked with Mitchell to make extensive alterations to the asylum. Co-incidentally, Sydney Mitchell was the chief architectural advisor to the General Board in Scotland and in 1880, was asked to prepare plans for a model Scottish asylum. Although this model was never adopted in full, the plans also incorporated the separate construction of a hospital block from the asylum buildings.<sup>19</sup>

Craig House, comprised of two blocks, which were situated at a considerable distance from the main institution. In 1896, the then Commissioner John Macpherson described the new detached hospital at the REA as ‘the gem of the [Asylum-Hospital] Movement’.<sup>20</sup> The dominant hospital building at Craighouse was constructed in the popular Victorian ‘Francois premiere’ style of architecture. The application of this ornate architectural style is reflective of the contemporary Victorian fascination with architecture of the past.

Stirling District Asylum (SDA) was the first district asylum to open a separate hospital block and took place at the instigation of the superintendent in charge. Its then superintendent John Macpherson pressed for additional accommodation at the SDA in the 1890s and in 1892, a hospital was opened in its grounds. The new accommodation divided the SDA into three distinct building types. Firstly, the hospital blocks provided 24% of the asylum’s accommodation with 120 beds (see plan 2) and accommodated







Plan 4  
SDA Chronic Block, (1894)

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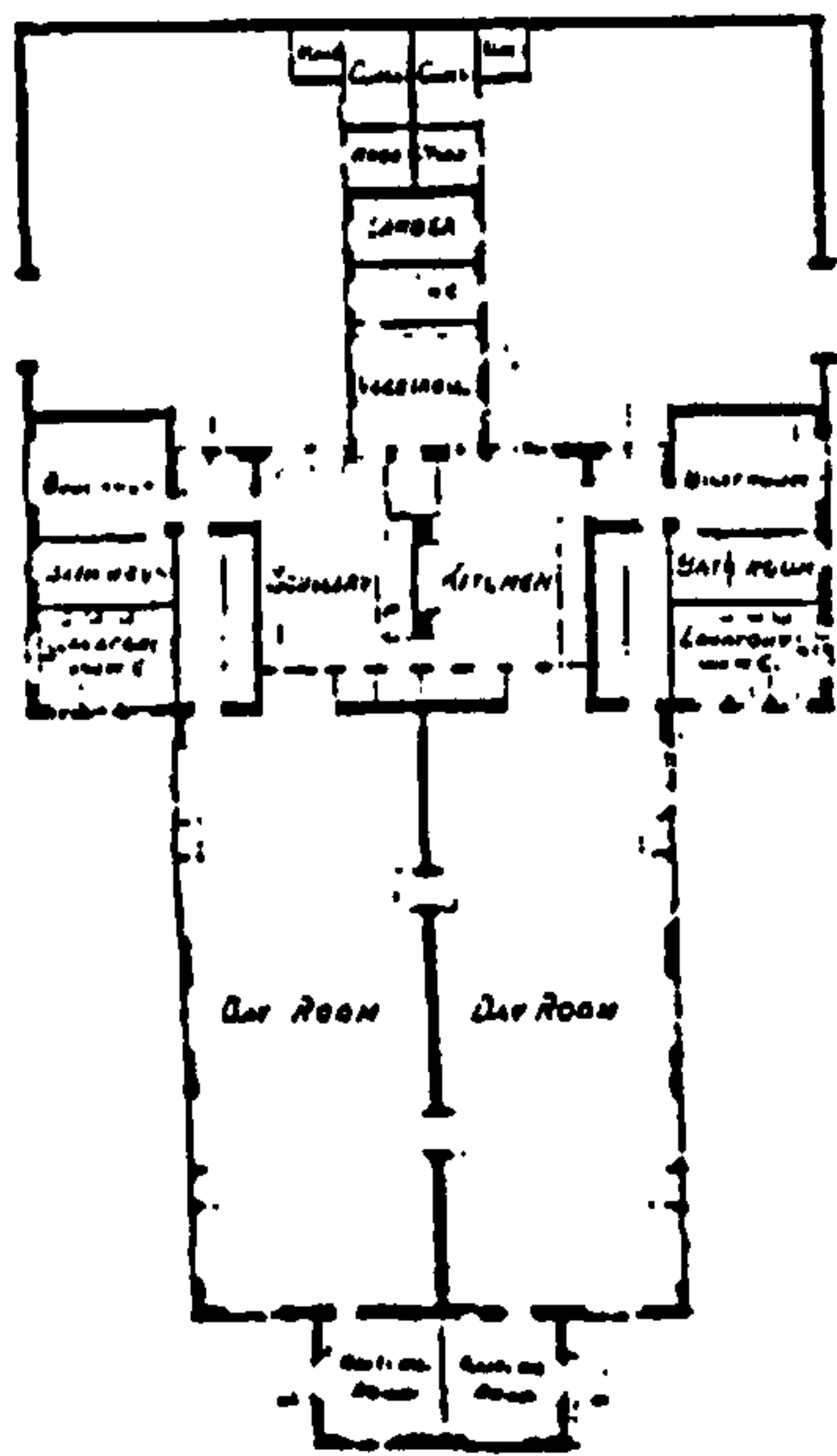
Side Elevation



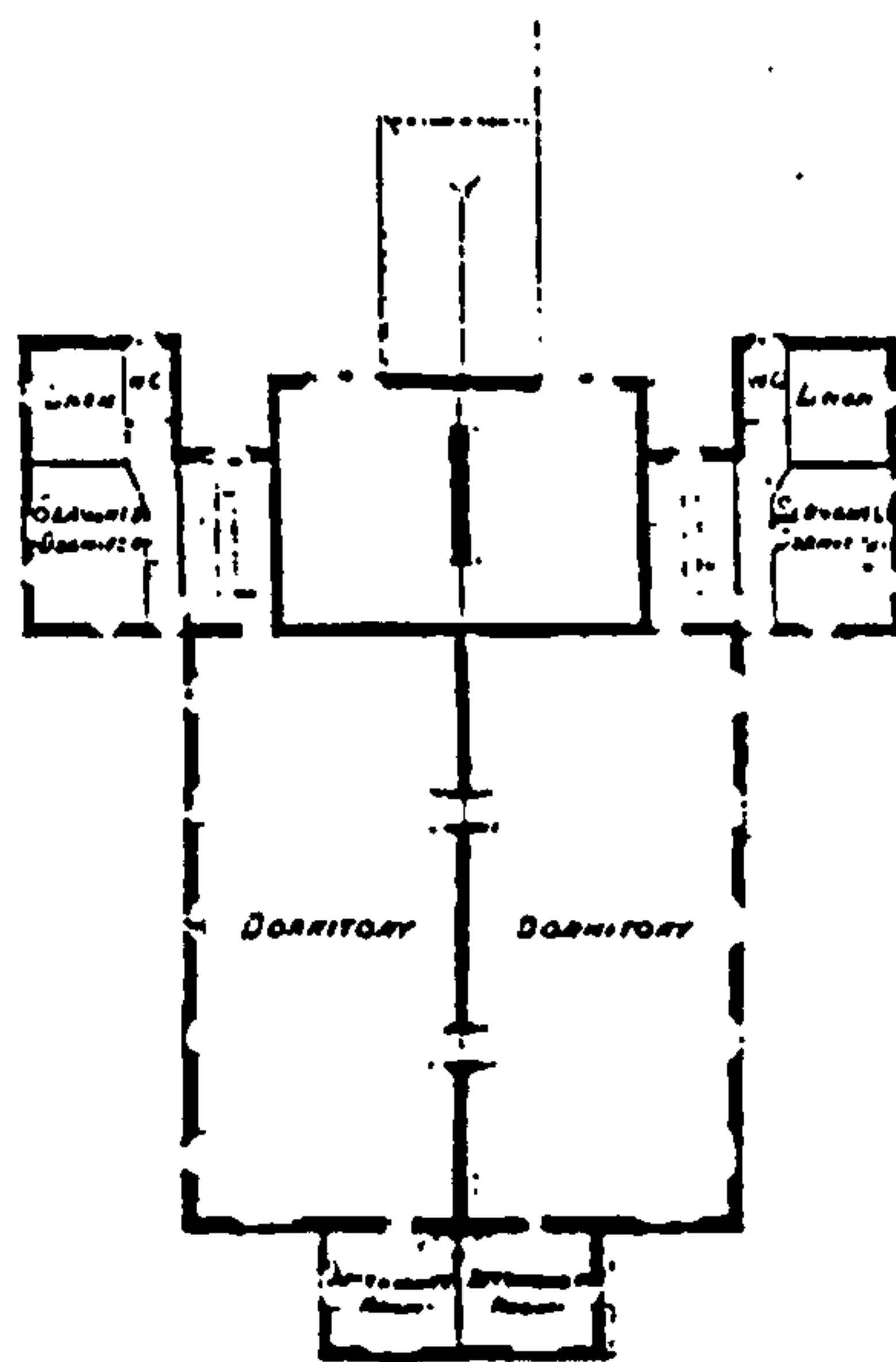
Front Elevation



Cross Section



Ground Floor

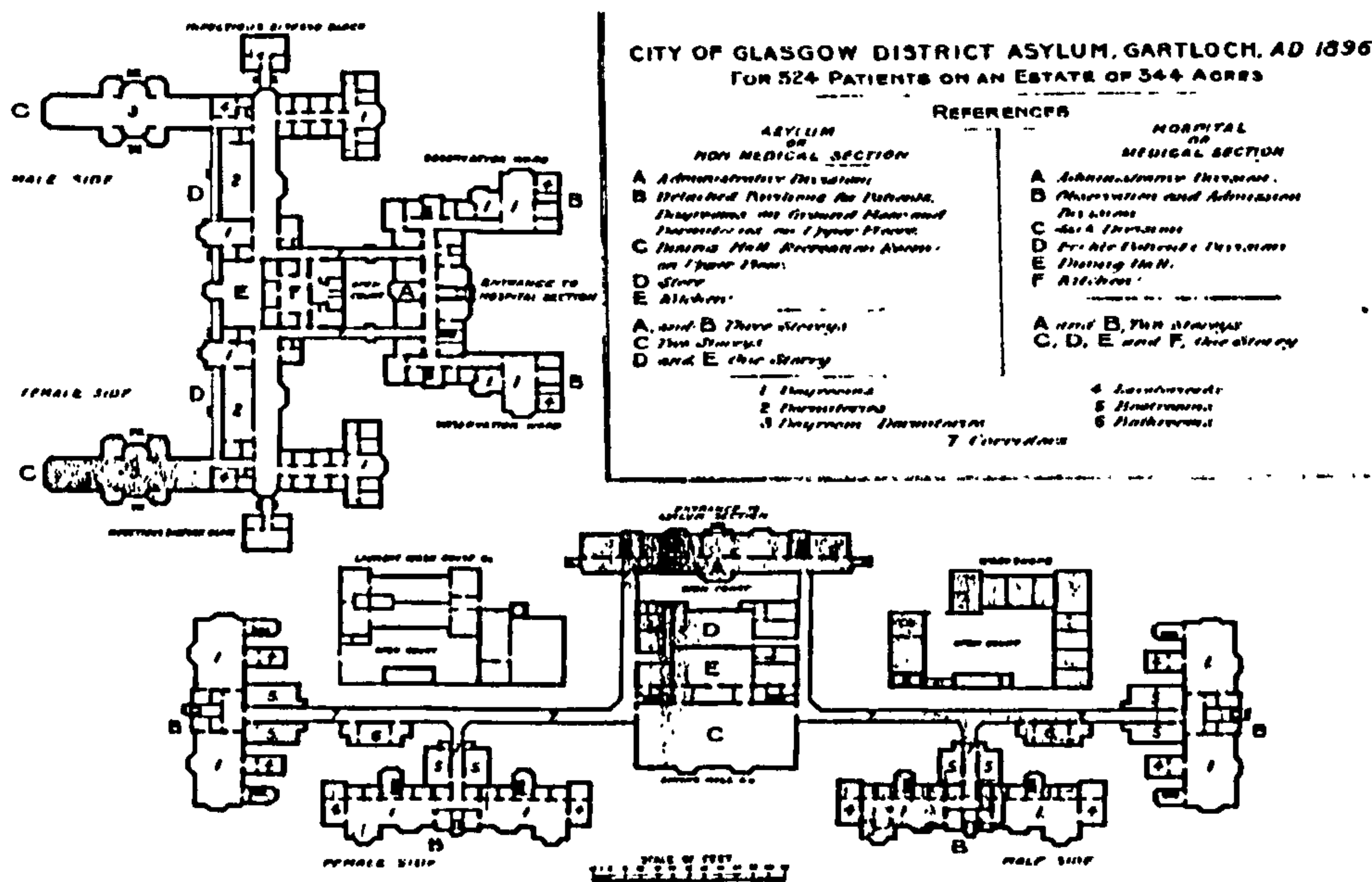


Upper Floor Plan

Source: 24<sup>th</sup> Annual report of Stirling District Asylum Lunacy Board, (1893-94), GD17/1/30.

Macpherson's support for hospitalisation was to influence the General Board when he became Commissioner in 1894. It is likely that the General Board was also impressed by Mitchell and Clouston's work at Craig House. The ensuing result was Gartloch Mental Hospital and Asylum opened in 1896. The asylum was the first to be purpose built with a separate hospital in its grounds. Gartloch adopted the principles of the pavilion hospital and was seen by Commissioners to be a 'model' asylum in its construction with separate groupings of buildings, namely 'hospital' and 'asylum' (see plan 5). The formidability of Gartloch was akin to the sizeable institutions built in England at the time and the Craighouse hospital at the REA and was again constructed in the 'Francois Premier style'. The Glasgow architects Sandilands and Thomson were well known in the city for their French influenced design such as 'Beaux Arts'<sup>21</sup> and had won the contract for the design.

Plan 5 Gartloch District Asylum and Hospital, (1896)



Source J. Sibbald, *On the Plans of Modern Asylums for the Insane Poor*, (James Turner & Co, 1897)

The hospital could accommodate up to 30% of the asylum population. It was divided into two subsections, namely the admission and observation wards for 25 patients of each sex and the sick rooms and infirmary wards for 60 patients of each sex. A new development in the asylum hospital was its use of observation and admission wards for the newly admitted patients. However this move to separate the seemingly more curable from the chronic and enduring cases generated some criticism. Steen spoke out against the plan arguing that 'there seems to be some danger that the two sections of the institution will be used to separate the curable from incurable.'<sup>22</sup>

The asylum (or industrial) section at Gartloch provided 70% of the institution's total accommodation and was three storeyed. Within this, the buildings were divided into two subsections and based on the English pavilion style. The supervision wards (for patients not permitted the privilege of parole or probation) accommodated 95 patients of each sex. Meanwhile, the industrial wards had beds for 100 patients of each sex. Patients requiring the least supervision were placed in the industrial wards and those that were deemed less 'trustworthy' were accommodated in the supervision wards. Trustworthy industrious patients were sent to the industrial wards, denoting the link made between mental improvement and occupation.

The ostentatious architecture of Craighouse and Gartloch reflected 'model' asylum hospitals. Both hospitals provided a dramatic imprint on the landscape and adopted the modern fashions in architectural design. Superintendents built both Craig House at the REA and the SDA as a result of individual impetus. These developments were then to influence policy in the construction of future asylums such as Gartloch. Influence for hospitalisation had come also from general medicine and English hospitalisation. From this point, no new asylum was built with out hospital accommodation. However, as the



majority of existing asylums were hard pressed to finance imposing buildings, hospitalisation of architecture was negotiated at a local level between the district boards, medical superintendents and commissioners.

### Hospitalisation in the Localities

Medical superintendents adopted hospital buildings that were most suited to the locality and their own treatment practices. In the early twentieth century, Easterbrook adopted the cottage hospital for Ayr District Asylum's (ADA) new hospital.<sup>23</sup> The asylum was suffering from overcrowding, which had in part been caused by conflict between the local asylum authority and parish council. Under duress from a visiting Commissioner, the District Board was urged to provide additional accommodation.

Unless the asylum authorities and some of the parish councils in the district can co-operate in removing from the asylum a number of cases...there seems to be no course left but to add to the male accommodation.<sup>24</sup>

In 1903 the asylum still remained overcrowded and Macpherson commented

the infirm wards in both divisions are seriously over-crowded, and this, coupled with the fact that the proportion of patients sent during recent years to the Asylum who require hospital treatment, is large, clearly indicates the character of the new accommodation called for.<sup>25</sup>

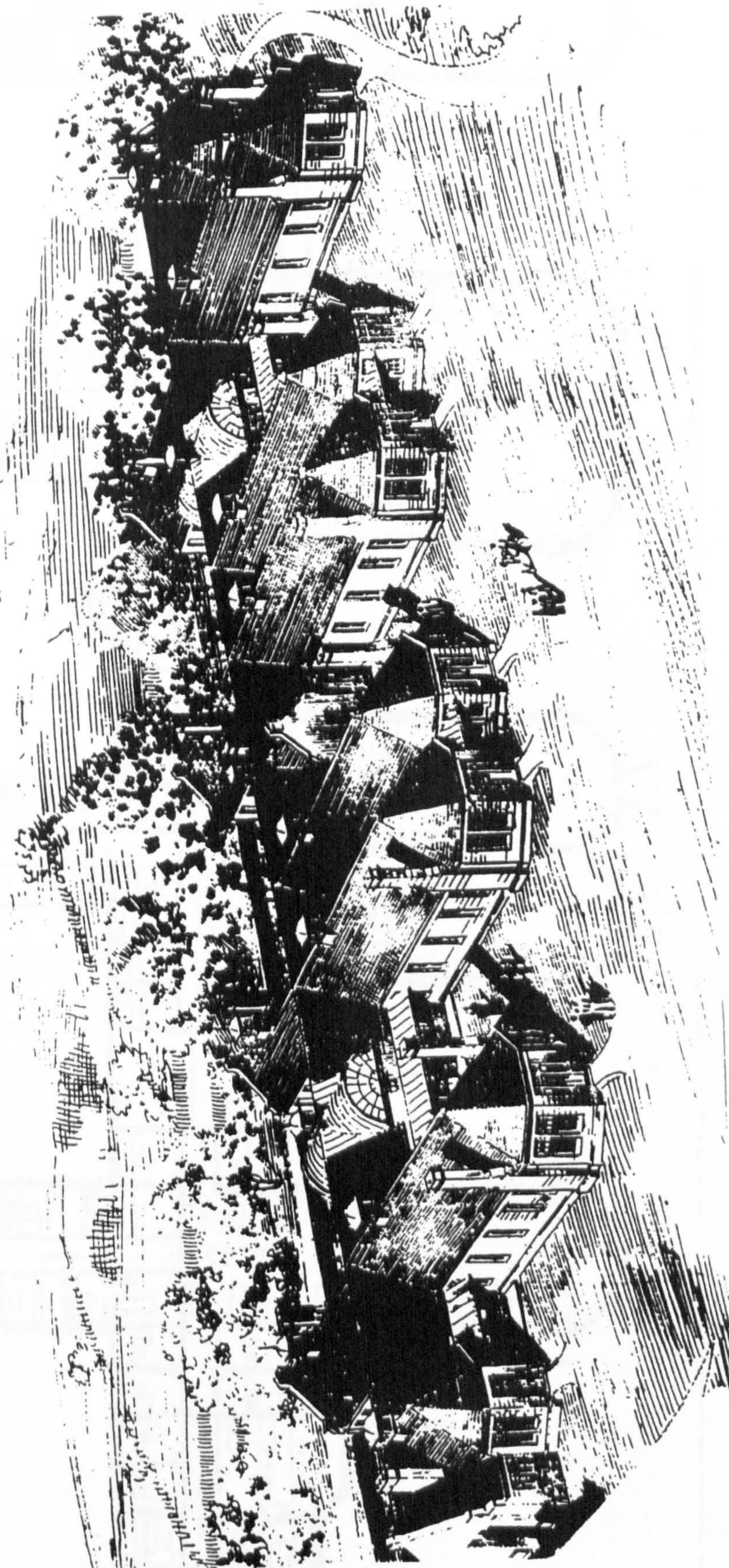
In response, the Ayr District Lunacy Board commissioned Easterbrook to visit hospitals at other asylums and to draw up plans for a possible hospital at Ayr.

Unconvinced by the imposing Gartloch and the REA styles, Easterbrook decided on a cottage style hospital (see illustration 5 and plan 6). The adoption of this style is not wholly surprising and fitted developments in general hospitals. While many hospitals in urban localities were vast pavilion style infirmaries, smaller local hospitals adhered to more traditional styles such as the cottage hospital. Traditionally built with



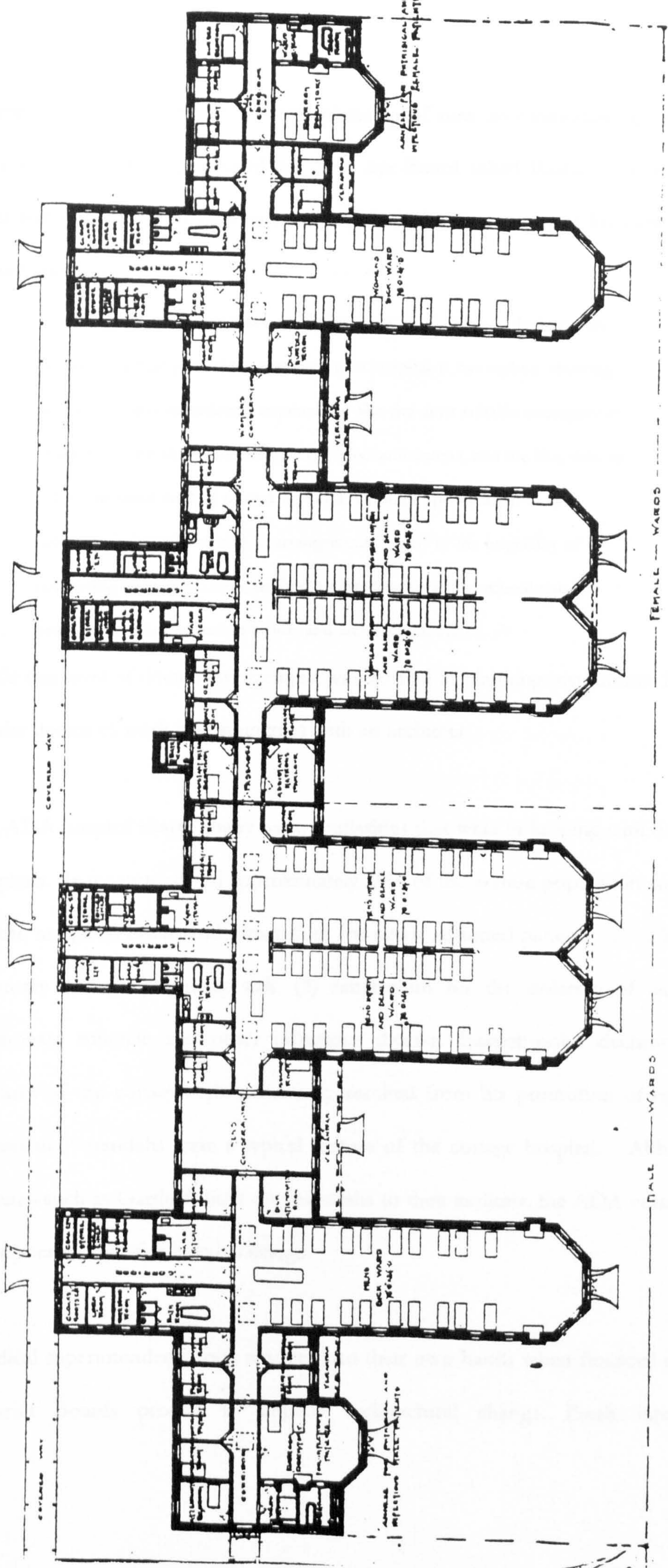
approximately 20 beds, late nineteenth century cottage hospitals often had over 100 beds. The larger cottage hospitals did adopt some features of pavilion wards but usually remained one storeyed.

Illustration 5  
Ayr District Asylum Hospital, (1906)



*Source: C.C. Easterbrook, 'The new hospital at Ayr asylum', JMS*  
*53 (1907).*





Plan 6  
 ADA Hospital Plan (1906)  
 Source: C.C. Easterbrook, 'The new hospital at Ayr asylum', *JMS* 53 (1907).



District Boards had little to do with planning of new accommodation, preferring to leave this up to the superintendent. The Ayr Board asked Easterbrook to draw up plans and as such the hospital was designed in order to incorporate his view of what an asylum should be.

I considered at this point that it would be more satisfactory, in the long run, to make an actual plan of the proposed new hospital at Ayr asylum, showing not only the accommodation required but also the most suitable arrangement of wards, observation bedrooms, verandahs, bath-rooms, and the like, than to follow the usual method of making out in writing a specification of the accommodation and leaving its arrangements largely to the originality of the competing architects...who, further, are pardonably apt to subordinate the principle of utility to that of beauty and architectural effect...<sup>26</sup>

While this level of doctor involvement was normal in planning institutions, it was usual for the doctor to work in conjunction with an architect.

The ADA hospital shared many basic similarities that were in keeping with other asylum hospitals. It accommodated approximately 20% of the asylum population and served as (1) the reception house and sanatorium for newly admitted patients, (2) sick room and infirmary for the physically sick, (3) sanatorium for the isolation of patients with pulmonary tubercle and other infectious disease. Easterbrook's decision to adopt features of the cottage style potentially resulted from his promotion of open-air rest treatment. Verandahs were a typical feature of the cottage hospital. Although other asylums such as Gartloch built on verandahs to their asylums, the ADA verandahs were incorporated specifically in his design.

Medical superintendents took matters into their own hands when financial concerns of District Boards proved to impede architectural change. Fresh into his first



superintendent position at the PDA in 1892, George Robertson was a strong supporter of hospitalisation and was in later years, Clouston's successor at the REA. Like the ADA, it took an overcrowded asylum to persuade the District Board to make architectural changes. The Commissioners consistently had referred to the overcrowded state of the asylum and had consistently urged the District Board to build new accommodation. It was noted in 1893 that 'the principal defect of the asylum structure at the present time is that its size is not adequate for the numbers it contains'.<sup>27</sup>

Only after the loans from the asylum's initial construction had been paid off could the board be persuaded to go ahead with change. At a meeting of the District Board in 1894,

Mr Atholl Macgregor referred to the overcrowding of the asylum and the necessity which had arisen for providing extra accommodation. He also explained the present position of the providing account and that in respect of the original loans being paid off, the accommodation could now be provided without increasing the rates.<sup>28</sup>

As a result of the meeting, the Board asked George Robertson to draw up plans for new accommodation. His comments on construction highlight the necessity of balancing favour with the Commissioners' (and his) ideals with the financial constraints of the District Board. Robertson continuously referred to the need to keeping costs low in description of the new accommodation in his reports.

Impressed by hospital buildings constructed at asylums like the SDA, Robertson put forward plans for hospital accommodation and a convalescent block at the PDA. He also recognised that in order for the District Board to accept any such plan, it would be necessary to provide this at minimum costs.

we were strongly recommended to build a detached hospital block...I however came to the conclusion that such a large detached building was not specially adaptable for a small asylum, as it would be inconvenient to divide a small staff of officials into two; moreover its administration would be expensive and it would be necessary to appoint several new officials...It was found possible however, to remodel a wing on each side of the house at a very trifling expenditure,..<sup>29</sup>

Robertson also proposed that a Convalescent House be built for 50 patients of each sex who required the least care and attention. The cost for two of these buildings was estimated at well under £7,500 as 'accommodation required for this class scarcely needs to differ from that of an ordinary house...[and] should be...as much like a home and as little like an asylum as possible'.<sup>30</sup> This provision of separate accommodation denotes the increasing tendency towards classification of patients on an architectural ladder towards recovery.

Medical superintendents supported the provision of hospital accommodation and no objection by doctors was uncovered in the research. The ardent supporters of hospitalisation such as Robertson and Easterbrook did not believe it appropriate to construct overtly expensive buildings. A significant barrier to architectural change was the District Board who only permitted adaptation in circumstances of overcrowding. As a result, the timing of hospital construction was sporadic and reactionary to the accommodation pressures of individual asylums.

### Classification and medical views

Classification of the asylum patients through segregated asylum accommodation tied in with concurrent theories in psychiatry. The direction taken in classification was influenced by discoveries in disease classification and the theory that different types of

illness required different methods of treatment. Emil Kraepelin, a professor at the Heidelberg University clinic in Germany wrought a breakthrough in disease concepts and classification in the late nineteenth century. Although the Kraepelin system in Britain did not take off until the twentieth century, it highlights the approach towards a more medically based model of treatment for mental illness.

Britain looked abroad to Germany for new models of asylum care. In addition to producing figures such as Kraepelin, Germany had established links between asylums and general hospitals as early as the 1860s. Shorter argues that by 1900 the German asylums were the best run in the world because they were generously supported by the German states.<sup>31</sup> Germany had introduced clinics and psychiatric wards in general hospitals in order to enhance teaching at the University's medical school. These developments made an impact on the Commissioner John Sibbald when he visited Berlin in 1867.<sup>32</sup> Sibbald also became interested in Griesinger's work when translating a Griesinger lecture for the *Journal of Mental Science*.<sup>33</sup>

Asylums in Britain moved towards the classification of new and acute cases of insanity through the use of reception wards in their hospitals. These wards were an integral part of asylum accommodation by the early twentieth century and also impacted on the increased use of rest in the institution. The reception wards were attached to the hospital and their principle was to ascertain the nature of the patient's illness before sending him/her to the most appropriate ward of the institution. Burdett detailed Gartloch's admission procedure in his overview of asylum architecture.

The wards called special observation wards are on each side of the administrative section. It is in these wards that all patients are to be placed on first arriving at the asylum...patients may be kept in the observation wards

for any amount of time, but generally however they will remain only a short period...to allow the medical superintendent to ascertain the nature of each case ...they are then sent to the subsection of the asylum or hospital for which they seem most suited.<sup>34</sup>

Although still within the asylum walls, admission to a reception ward meant that patients suffering from temporary relapses might be discharged from the asylum without admission to the main body of the institution.

The reception house at Woodilee opened in December 1902 and was the first in Scotland to be built entirely separate from the rest of the asylum buildings. The House consisted of two wards, six single bedrooms and could accommodate 10 patients of each sex. In its first year of opening, the reception house admitted 373 patients to its wards. Of that number, its superintendent Hamilton C Marr boasted that 130 patients (35%) were apparently discharged recovered without admission to the main asylum buildings.<sup>35</sup>

However, an ultimate ideal of hospitalisation by the 1900s was that new and curable cases of mental illness should be treated in separate hospital surrounds and that the proper function of the asylum was for long term, chronic and incurable patients. The thesis highlighted earlier how English psychiatry rejected the move to construct a separate hospital for new and acute cases of insanity in London during the 1890s. Only in 1907 was the London County Council persuaded to build a separate hospital for acute cases after Henry Maudsley donated £30,000 to the cause.

In Scotland, the topic of separate hospitals and wards was raised at *Medico-Psychological Association (MPA)* discussions. Articles on the topic by Clouston, Sibbald and Urquhart were also published in the *Journal of Mental Science* and *American Journal of Insanity*.<sup>36</sup> Doctors



believed that the establishment of psychiatric wards would assist recovery rates and possibly lead to fewer asylum admissions. Sibbald argued in 1902 that

I desire to press as strongly as I can that the need for these wards is urgent.

In establishing them I think that provision would be made...for the treatment of a class of patients now exceptionally neglected [new acute cases].<sup>37</sup>

A further effect was the improvement of teaching psychiatric medicine, as this would allow students closer proximity to patients. The present system meant that Edinburgh University medical students often traveled to Royal Edinburgh Asylum or an institution in Larbert<sup>38</sup> to conduct clinical observations.

In the early 1900s, Clouston called repeatedly for a link to be made with the city's Infirmary. This was a shift from his objection to the extensive use of indoor bed rest for the treatment of mental illness.

...we should then have in Edinburgh four means of treating brain diseases that produce mental disturbances and defects, viz: 1) the Royal Infirmary for the incipient cases, 2) the Queen Alexandra for the acute, 3) Bangour for the more prolonged and the chronic, 4) the boarding out system for more easily managed.<sup>39</sup>

The attempt by Clouston et al to establish a ward in connection with the Royal Infirmary in Edinburgh culminated with a proposal made at an Edinburgh Medico-Chirurgical Society Meeting in February 1902.

the meeting urges strongly on the managers of the Royal Infirmary to consider the expediency of providing within or in the immediate vicinity of the institution for the treatment of incipient, transitory and recent case of insanity.<sup>40</sup>

In Clouston's concluding remarks to the *MPA* annual meeting in October 1902, he proclaimed 'I hope that when we meet next year the experiment will actually be at work in the wards of the Royal Infirmary at Edinburgh'.<sup>41</sup> Clouston and his contemporaries' aspirations to penetrate Scotland's Royal Infirmaries and establish separate hospitals for acute cases were unrealised.<sup>42</sup> The Edinburgh Infirmary managers were not the only

opponents to the scheme. Like the English opposition to the London hospital, asylum superintendents shared concerns about the removal of their powers to general medicine.

The opening of observation wards in poor law hospitals for new cases of insanity were heralded as a further shift towards the medical treatment of the mentally ill. However, the presence of these wards had more to do with the attempt to reduce spiralling asylum admission rates at Glasgow's Woodilee and Gartloch asylums and to filter out patients more suited to the poorhouse. In 1904, the Corporation of the city of Glasgow provided beds for 50 patients at the Duke Street General Hospital. John Carswell, Lecturer in Psychiatry at Glasgow University persuaded the Glasgow Parish Council to establish wards for new cases of mental disease at the Barnhill poorhouse hospital. Carswell took charge of two wards at Duke Street for the treatment of non-certified patients. Ivy Mackenzie<sup>43</sup> succeeded him in 1910 when Carswell was promoted to the post of Lunacy Commissioner.

The wards came to be used as a holding place for people suffering from alcohol related mental illness. Chapter four touched on how medical superintendents such as Marr and Clouston objected to the use of asylums for such cases. The use of observation wards was seen to be a preferable place to retain cases of alcohol related insanity. Commenting on the Glasgow scheme, A.R. Urquhart, medical head of the Perth Royal Asylum suggested

No doubt many of these cases are alcoholic, of transient nature; but their maladies are properly treated without legal certification and all that entails.<sup>44</sup>

In the Glasgow District Lunacy Board minutes in April 1903 it was noted

Of 565 admissions to the two asylum [Woodilee and Gartloch] and 213 to observation wards during 12 months, 259 cases have become chargeable to the parish through alcohol indulgence.<sup>45</sup>

Although observation wards and poor law hospitals were far from ideal for patients with alcohol dependency or mental health problems, the wards did achieve the doctors' aim of removing a significant proportion of alcohol related cases.

### Segregation and classification: a return to a 'panoptic' ideal?

Classification of non-hospital accommodation in the asylum harked back to the days of moral management and drew some analogy with the Foucauldian prison and asylum regime. At the York Retreat, classification had been an intrinsic feature of the rewards/punishment system.<sup>46</sup> Scull suggests that classification was central to the implementation of moral treatment.<sup>47</sup> In the panopticon ideal, men were separated from the women, incurables from curable, the violent from the harmless, the clean from the dirty and a ladder of progress established for the improving to progress towards final recovery and discharge.<sup>48</sup>

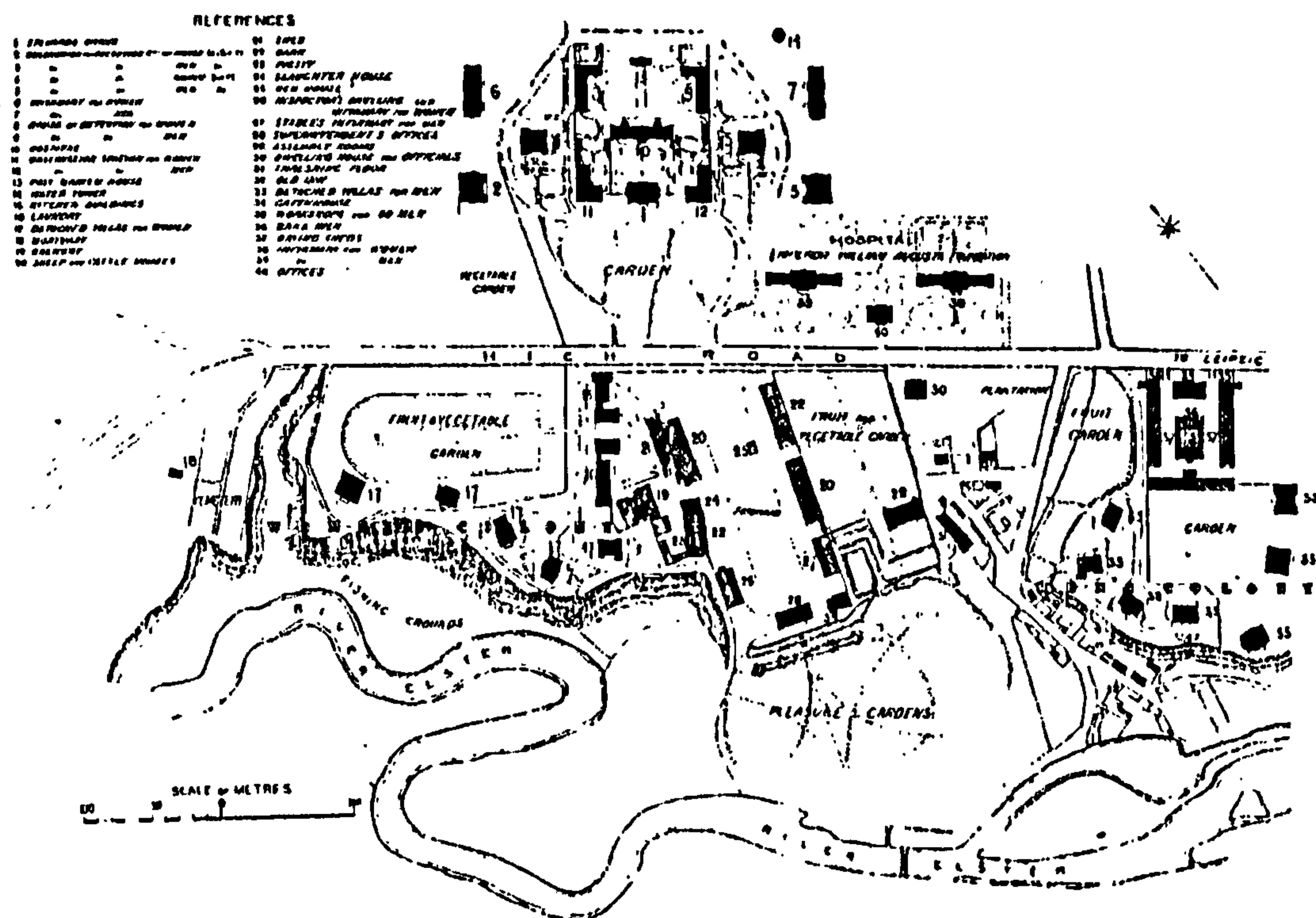
These classificatory ideals were realised to some extent in the model village asylums of the 1900s. Commissioners were heavily involved in the construction of model village asylums. German developments once again influenced the Commissioners in their plans for patients retained within the traditional 'asylum' section. An example of the village style is Alt Scherbitz, near Leipzig. John Sibbald had visited this asylum and in his pamphlet *On the Plans of Modern Asylums for the Insane Poor* (1897) recommended that future District Boards should adopt the village asylum type.<sup>49</sup>

An aim of Alt Scherbitz was to make it both 'non-institutional' and akin to countryside living. Alt Scherbitz had opened in 1885 and accommodated approximately 900 private and pauper patients.

The idea at the basis of the whole scheme of its construction and administration is to endeavour to make as far as possible...the conditions of life of the patients as far as possible to those of a sane person in a rural community.<sup>50</sup>

Plan 7 shows the division of patient groups into two main sections, namely medical and industrial. At Alt Scherbitz, 80% of patients were occupied on the asylum farm in 1900.

Plan 7  
Alt Scherbitz Village Asylum, (1891)



Source J. Sibbald, *On the Plans of Modern Asylums for the Insane Poor*, (James Turner & Co, 1897)



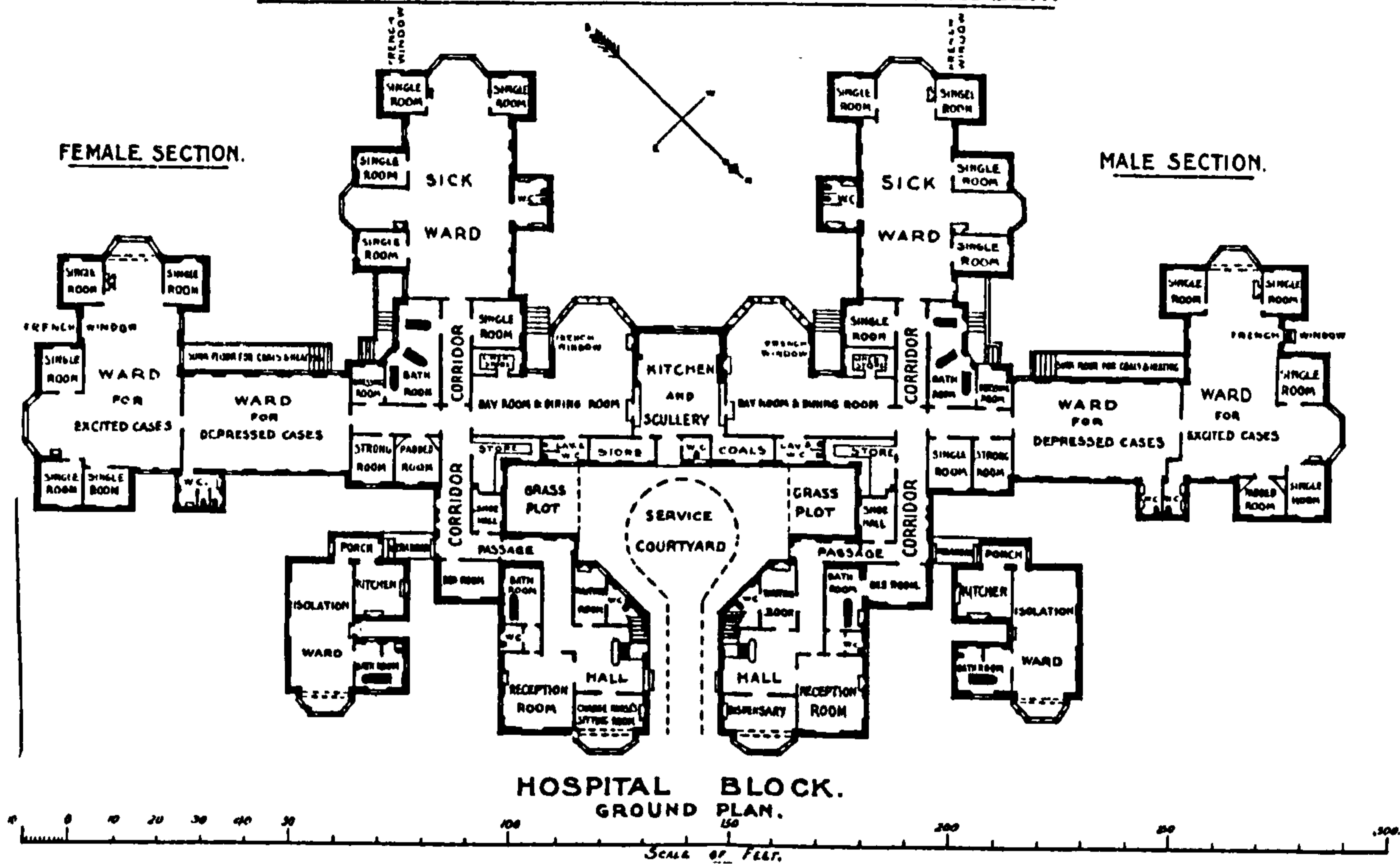
In 1904, the Kingseat Village Asylum, Aberdeen was the first village asylum to open in Britain. The impetus for a new asylum had come after an 1898 inquiry by the General Board into the increase of lunacy in the north east of Scotland. The asylum was built with a separate hospital (see plan 8) and this along with the other features of Kingseat's accommodation are highlighted in table 21.

Table 21: Classification and Accommodation at Kingseat Village Asylum (1906)

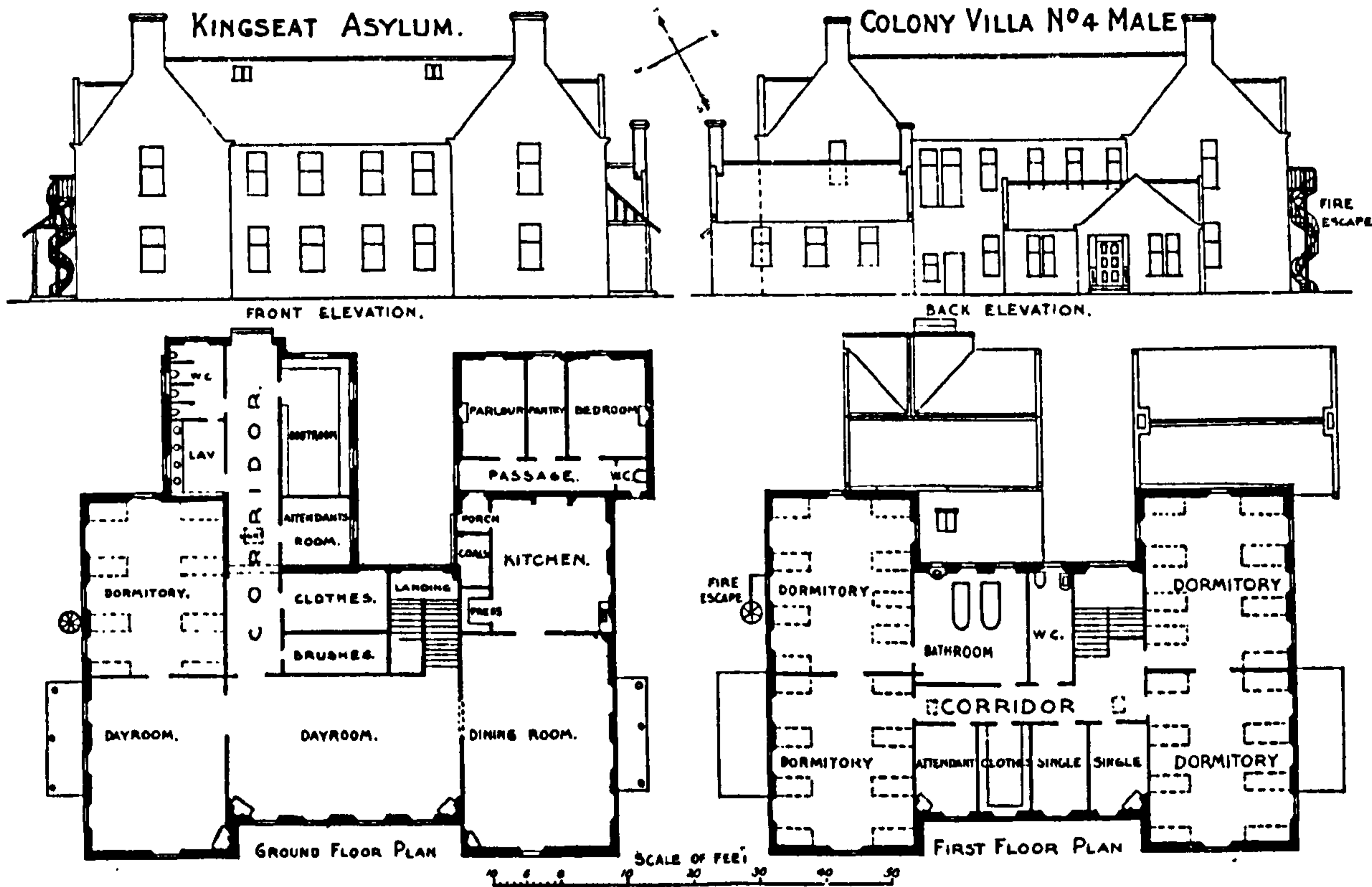
MALE	FEMALE
<p>HOSPITAL- (52 beds, 4 attendants and 3 nurses)</p> <ul style="list-style-type: none"> <li>- New Admissions</li> <li>- Acute cases</li> <li>- Cases requiring special supervision</li> <li>- Convalescent cases</li> <li>- The physically ill</li> </ul> <p>(continuous night supervision by staff)</p>	<p>HOSPITAL (52 beds, 6 nurses)</p> <ul style="list-style-type: none"> <li>- New Admissions</li> <li>- Acute cases</li> <li>- Cases requiring special supervision</li> <li>- Convalescent cases</li> <li>- The physically ill</li> </ul> <p>(continuous night supervision by staff)</p>
<p>VILLA I (41 beds, 4 attendants) Epileptics and impulsive</p> <p>(continuous night supervision by staff)</p>	<p>VILLA I (42 beds)</p> <p>Presently unoccupied</p>
<p>VILLA II (36 beds, 3 attendants) Incurable cases who work but require observation.</p> <p>(continuous night supervision by staff)</p>	<p>VILLA II (33 beds, 3 nurses)</p> <ul style="list-style-type: none"> <li>- Epileptics</li> <li>- Impulsive cases</li> </ul> <p>(continuous night supervision by staff)</p>
<p>VILLA III (42 beds, 3 attendants) Incurable cases requiring less observation than those in Villa II</p> <p>(patrol night supervision by staff)</p>	<p>VILLA III (42 beds, 4 nurses) Quiet epileptic and incurable cases who work but require observation.</p> <p>(continuous night supervision by staff)</p>
<p>VILLA IV (46 beds, 1 attendant, 1 nurse) Parole Villa admits: Convalescent and chronic patients who work on farm and garden</p> <p>(patrol night supervision by staff)</p>	<p>VILLA IV (46 beds, 1 sewing nurse, 2 nurses) Parole and Sewing Villa Admits convalescent cases</p> <p>(patrol night supervision by staff)</p>
<p>PAROLE VILLA V (32 beds, 2 nurses) Chronic cases who work in the grounds and in workshops</p> <p>(night parole supervision by staff)</p>	<p>PAROLE VILLA V (34 beds, 2 nurses) Laundry and kitchen workers</p> <p>(parole night supervision by staff)</p>

Plan 8  
Kingseat Asylum Hospital (1905)

KINGSEAT ASYLUM, NEWMACHAR ABERDEEN.



Plan 9  
Kingseat Male Colony Villa No. 4 (1905)



Both Sources: 1<sup>st</sup> Annual report of Kingseat District Asylum, (1905), GD17/1/41.

The description of Kingseat's accommodation clearly denotes a ladder of progress whereby the patients moved from the reception wards to parole and eventual recovery and discharge. Of the ten villas, two were kept constantly locked throughout the day and were occupied by patients deemed untrustworthy and requiring special supervision. Patients deemed disruptive were kept separate from the remainder of the asylum population.

Patients with special characteristics of mental disease such as epileptics, paralytics and those of faulty habit are separated from those whose habits and taste in their personal tidiness are unimpaired.<sup>51</sup>

As such, the 'violent' were separated from the 'quiet' and the 'dirty from the unclean' and the 'curable' from the 'incurable'.

The final ladder of stay was the parole villa that permitted open doors and less supervision. Villa 4 for the male patients accommodated 46 beds with a staff ratio of one nurse and one attendant. These were patients who were convalescent and chronic patients who work on farm and garden. Accommodation in these villas made domestic with the sleeping arrangements on the top storey and living quarters on the ground floor (see plan 9). Doors were unlocked throughout the day and routine of work remained intrinsic in the control of this group.<sup>52</sup>

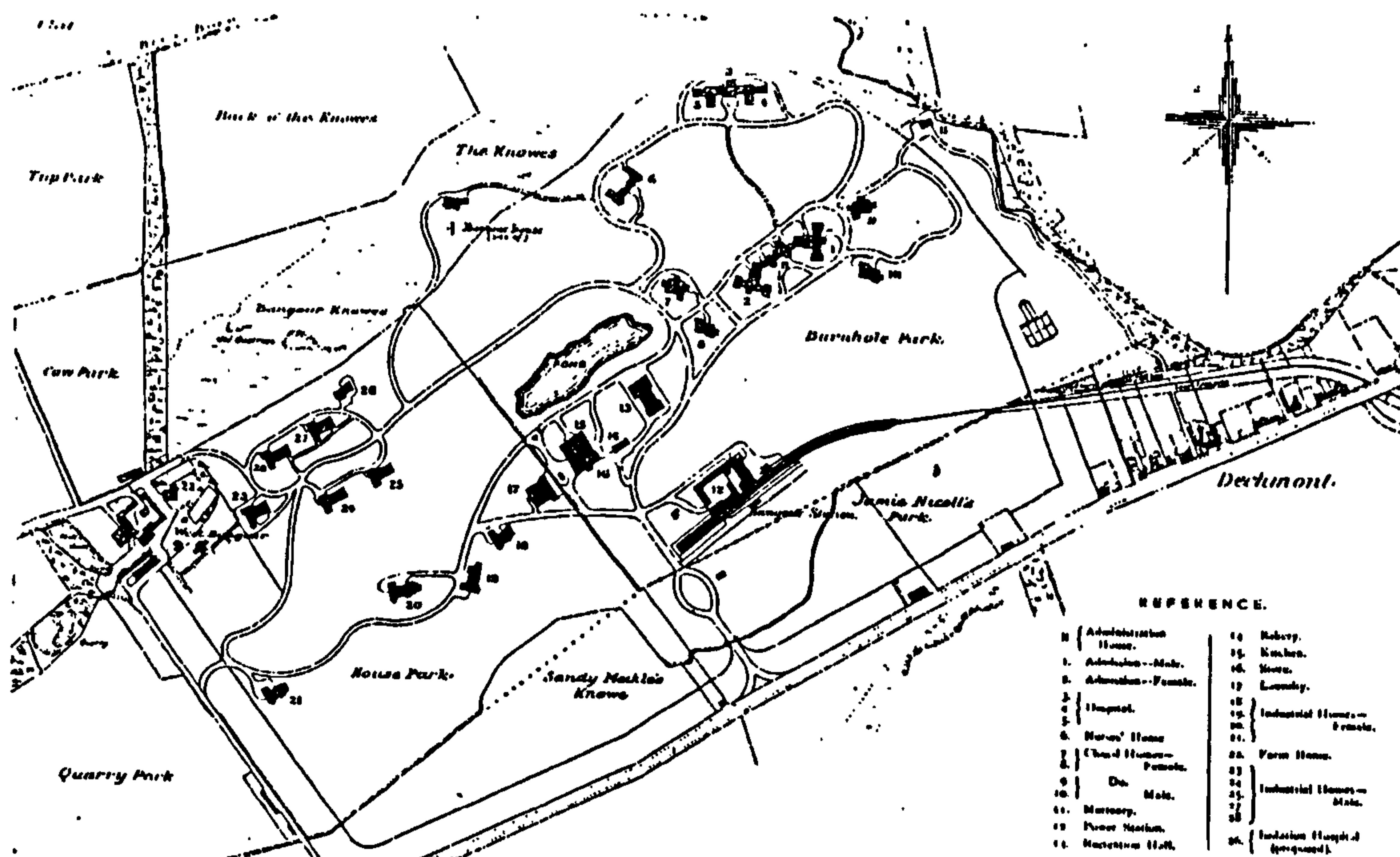
Commissioners (in particular John Sibbald) were also influential in persuading the Edinburgh District Lunacy board to construct a village style asylum. In 1904, Bangour Village Asylum open in Broxburn. Like Kingseat, Bangour was divided into two Medical and Industrial sections (see plan 10). The Medical Section accommodated 314 male and female patients and was divided into three parts for each sex. The admission ward and



administration house was contained in the same building and contained all recently admitted patients.

Plan 10

Bangour Village Asylum, Edinburgh, (1904)



Source J. Sibbald, *On the Plans of Modern Asylums for the Insane Poor*, (James Turner & Co, 1897)

Like Kingseat, clear distinctions were made between the grades of patients. Two closed villas for each sex accommodated acute and recent cases. In these villas, the doors were locked and patients were under constant observation. The hospital contained 2 wards on the ground floor and one ward on the first floor for each sex with several side rooms, totaling 90 beds. In the industrial section, 5 male homes, 4 female homes and a farmhouse included beds for 440 patients. Each home accommodated approximately 50 patients. Both the male and female homes were designed for trustworthy patients employed in asylum work.<sup>53</sup>



While Sibbald and the Lunacy Board were at the forefront of the village style, it is apparent that superintendents were already making these moves prior to the Commissioners. At Perth and Stirling for example, classification of accommodation was introduced concurrently with hospital accommodation. Even Sibbald admitted that 'the two villas recently erected at the Perth District Asylum at Murthly might be accepted as examples of what the houses should be in the section of the institution corresponding to that which is called the "Colony" at Alt Scherbitz'.<sup>54</sup>

In the 1880s, Rutherford had adopted a somewhat segregated style of accommodation at the CRI. Rutherford established a series of villas and farmhouses for private and pauper patients after he became medical superintendent in 1883. In 1884, Rutherford purchased two cottages at Spittalfields, near the CRI. This had primarily been done in an attempt to reduce the numbers of pauper patients at the institution. The cottages housed up to 12 female patients and were designed for those who did not require asylum treatment but were unable to live outside the asylum alone.

Some patients then sent out were returned to the asylum as unmanageable in private dwellings and for some others Guardians willing to take them could not be found. To show practically that these patients did not really require the skilled attention and costly accommodation of the asylum, was my object in making the experiment.<sup>55</sup>

These patients lived alone and without an attendant although an older patient did take principal control of the cottages. What is unusual in this case was that patients were trusted without any supervision. They were also not part of a systematic ladder of accommodation as the cottages were only intended for incurable patients whose care provision was problematic within the local system of 'community' care.

The Spitalfields project prompted Rutherford to develop a number of additional cottages for patients of all classes. These villas were more in line with graded accommodation and were used as a parole incentive for private patients. Fourteen women from the private class occupied Maryfield, and Midpark provided accommodation for 10 - 12 male 'gentlemen of a quiet or convalescent class'. In the 1890s additions were made with the farmhouses of Brownhall for pauper patients as well as Rosehall and Rosebank for private patients. Like Spitalfields, Brownhall was primarily used to reduce overcrowding or for pauper patients who were unsuited to boarding out. Unlike Spitalfields, the villas and farmhouses had two or three attendants in residence.

With his existing interest in separated accommodation and his support for moral methods in treatment, Rutherford became interested in German asylumdom and subsequently visited the Alt Scherbitz asylum with a deputation from the CRI Director's Board in the 1890s. Drawing on this European influence and the accommodation already in place at the CRI, Sydney Mitchell was commissioned to expand the nature of segregate accommodation. By 1906, the accommodation was based on the reward scale, ranging from the reception house to the open and closed villas (see table 22). This included 1) separate sex divisions; 2) a hospital for the newly admitted, physically ill and old and infirm; 3) convalescent or 'open' wards for the trustworthy and 4) closed wards for those requiring supervision (i.e. suicidal or the untrustworthy). The converted homes (Brownhall and Maidenbower) continued to be used for trustworthy females on parole. The highest percentage (33%) of patients were housed in the farm and laundry annexes, namely the 'Industrial Section'.

Table 22  
Pauper Accommodation at the CRI (1906)

MEDICAL SECTION	Male	Female
Reception House	6	6
Female Intermediate House	0	45
Male Intermediate House	40	0
Infirmary	14	14
Closed Villa	30	0
Closed Villa	0	30
Brownhall (parole house)	0	12
Maidenbower (parole house)	0	16
Sanatorium	9	9
INDUSTRIAL SECTION		
Farm Annex	60	0
Johnstone House (Laundry Block)	0	52
<i>Total</i>	159	184

Easterbrook developed a classificatory scheme at the ADA, alongside the new cottage hospital. His descriptions provide a detailed insight in the contemporary perception of mental illness and the necessity for classifying its various types. The first four categories were housed in the 'colony section (1) *Trustworthy able-bodied patients* were harmless chronic cases and convalescent curable patients. All of this category participated in work, were granted parole of the grounds and lived in wards with open doors by day and slept without supervision at night. (2) *Untrustworthy able-bodied patients* also worked, but did so under the immediate eye of their attendant or nurse. Patients lived in wards with locked doors and slept under observation. (3) *Epileptic patients* were grouped in a day ward and a night dormitory on each side of the house, as 'it is in keeping with the modern tendency of providing for this unfortunate class of sufferers in 'epileptic colonies'. (4) *Degenerate and degraded* included all those patients were destructive or noisy. "They are for this reason best segregated from other patients and placed under continuous day and night supervision for the purposes of correcting their depraved habits'.<sup>56</sup>

The final two categories of Easterbrook's segregate system covered those patients requiring 'hospital' treatment. Category 5 included the *infirm, old and bedridden*. Easterbrook charmingly described this group as 'senile wrecks of humanity', the lame, the blind, and the paralysed and those who are the subjects of chronic debilitating diseases. (6) The final category was made up of *recent, relapsing and bodily ill* cases and any patients already in the asylum who was suffering a mental relapse. The group also included the suicidal and violent.

By the 1900s, existing asylums had developed clear systems of classification in their accommodation. Commissioners had most influence over the new village style asylums and aspired to the progress made by German asylums. In existing institutions, it was more difficult for Commissioners to make an impact and change was ultimately reliant on the input of the individual medical superintendent. It is evident too that moves towards classification predated the influence of the Commissioners on design. The principles of classification in the asylum also denote the persistence of moral approaches in the use of accommodation privileges.

#### Classification: Learning Disabilities

Early twentieth century classification also took into account the concurrent theories surrounding learning disability. The 1857 Lunacy Act had not differentiated between mental illnesses and learning disabilities and as such, most asylums treated the group alongside each other. Prior to 1857, people with learning disabilities were boarded out in the community or were in institutions such as the Royal Asylums and poorhouses. The Baldovan Asylum for the treatment of 'Idiot and Imbecile Children' opened in 1855 as a philanthropic venture. The 'Scottish Institution for the Education of Imbecile Children' opened in 1863. Although intended for children of 6 to 12 years of age,



children below and above this age were admitted due to the lack of alternative accommodation.

Woodilee in Glasgow was unusual in its decision to construct a home for children with mental disabilities as part of the asylum in 1901. The Home housed a small number of children. In its first year of opening, 21 girls and boys were admitted although only one female was discharged from the Home in 1901. Adults with learning disabilities were not provided for and were typically admitted to the main asylums, although the Stoneyetts Hospital, Glasgow provided institutional care for adults from 1912.

Although the beginnings of institutional care of people with learning disabilities should be understood in the mass institutional expansion of Victorian society, ideas of 'idiocy' and 'cretinism' were inextricably linked to concurrent 'scientific' debate. Progressive degeneration was forwarded by Morel from the 1850s. This theory proposed that mental disability was caused by a series of inherited defects that had been transferred through the generations. Scottish doctors such as Thomas Clouston were supportive of this doctrine.

Anderson and Langa suggest that it is unsurprising that writers like Scull refer to the expansion of asylum care as a method of social control.<sup>57</sup> Doctors proposed radical steps such as compulsory sterilization and a ban on marriage in order to reduce numbers of people with learning disabilities. Andrews argues that the support of John Macpherson and other Commissioners for theories that linked insanity with degeneration were reflective of the wider medical community.<sup>58</sup> Scottish Commissioners played a significant role in framing the Mentally Deficient (Scotland) Act (1913) which

consequently resulted in sped up the institutionalization of people with learning disabilities.

### Conclusion

To conclude, this chapter has show that Scottish asylums did not always share the analogies of the vast 'warehouse'. While the chapter disputes the 'custodial' similarity between the prison and asylum, it does acknowledge that asylums adopted graded accommodation privileges and classification. The move towards classification was also influenced by more contemporary developments, such as the threat of degeneration and European progress. The move to distinguish and separately treat new and acute cases, which had been devised in the 'asylum hospital' and reception house, extended to the attempt to link asylums with general hospitals.

However, the blue print of 'Asylum Hospitals' and 'Village Asylums' did not filter down to exact replicas at a local level. Few asylums introduced the grand design of Gartloch and the REA preferring to adapt existing accommodation or smaller scale hospitals. Although hospitalisation became a grand architectural movement of the Commissioners, the inspiration had come from innovations earlier moves such as Rutherford, Clouston and Macpherson.

Too much power should not be attached to the medical superintendent in their ability to generate change. Where an asylum already existed, medical superintendents (and the Commissioners) faced the task of persuading district boards to embrace change. It is apparent that Boards were willing to adopt hospitalisation usually as a by-product of necessary asylum expansion. As such, the lack of power to inflict architectural change

that the medical superintendent possessed, represented the limitations imposed on modernisers by the localities.

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<sup>1</sup> *Occasional Notes, Journal of Mental Science*, 48 (1902), p.540.

<sup>2</sup> A. Scull, *Museums of Madness The Social Organisation of Insanity in Nineteenth century England*, (Penguin, 1979), p.194.

<sup>3</sup> E. Showalter, *The Female Malady Women, Madness and English Culture 1830-1980*, (Virago, 1987), p.102.

<sup>4</sup> *Ibidem*.

<sup>5</sup> J. Andrews, 'They're in the Trade... of Lunacy They 'cannot interfere' – they say": *The Scottish Lunacy Commissioners and Lunacy Reform in Nineteenth-Century Scotland*, (Occasional Publications, The Wellcome Trust, 1998), p.59.

<sup>6</sup> M. Foucault, *Discipline and Punish The Birth of the Prison*, (Penguin, 1977), p.249.

<sup>7</sup> *Ibid.*, see especially p.195-228.

<sup>8</sup> Andrews, 'Raising the Tone of Asylumdon' in J. Melling and B. Forsythe (ed), *Insanity, Institutions and Society 1880 – 1914: A Social History of Madness in Comparative Perspective*, (Routledge, 1999), p.217.

<sup>9</sup> R. Porter, *Mind-Forg'd Manacles A History of Madness in England from the Restoration to the Regency*, (Penguin, 1987), p.147.

<sup>10</sup> M. Donnelly, *Managing the Mind: A study of medical psychology in early nineteenth century Britain*, (Tavistock, 1983), p.56.

<sup>11</sup> Andrews, 'Raising the Tone of Asylumdon', p.201.

<sup>12</sup> Showalter, *The Female Malady*, p.102.

<sup>13</sup> R.H. Steen, 'The evolution of asylum architecture and the principles which ought to control modern construction', *JMS*, 46 (1900), p.89.

<sup>14</sup> H.C. Burdett, *Hospitals and Asylums of the World*, (London Scientific Press, 1891), p.66.

<sup>15</sup> Ayr (1869), Fife and Kinross (1866), Haddington, (1866) Midlothian and Peebles (1874), Perth (1863), and Roxburgh, Berwick and Selkirk, (1872).

<sup>16</sup> J. Taylor, *Hospital and Asylum Architecture in England 1840-1914*, (Mansell Publishing Limited, 1991), p.7.

<sup>17</sup> L. Bryder, *Below the Magic Mountain. A Social History of Tuberculosis in the 20<sup>th</sup> Century*, (Oxford University Press, 1988), p.50.

<sup>18</sup> Taylor, *Hospital and Asylum Architecture*, p.152-53.

<sup>19</sup> J. Macpherson, 'The Hospital Treatment of the Insane in Asylums', *JMS*, 42 (1896), p.779.

<sup>20</sup> *Ibid.*

<sup>21</sup> [www.sherbrooke.co.uk/history.htm](http://www.sherbrooke.co.uk/history.htm)

<sup>22</sup> Steen, 'The evolution of asylum architecture', p.91.

<sup>23</sup> C.C. Easterbrook, 'The new hospital at Ayr asylum', *JMS* 53 (1907).

<sup>24</sup> *Minute Book of Ayr District Lunacy Board*, (1901-1903), AA17/4/4.

<sup>25</sup> *33<sup>rd</sup> Annual Report of Ayr District Asylum*, (1902-03), AA17/7.

<sup>26</sup> Easterbrook, 'The new Hospital at Ayr Asylum', p.3.

<sup>27</sup> *29<sup>th</sup> An. Re. Of the PDA*, (1893), GD17/1/29.

<sup>28</sup> *30<sup>th</sup> An. Re. Of the PDA*, (1894), GD17/1/30.

<sup>29</sup> *31<sup>st</sup> An. Rep. Of the PDA*, (1895), GD17/1/31.

<sup>30</sup> *Ibid.*

<sup>31</sup> E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the age of Prozac*, (John Wiley & Sons, 1997), p.66.

<sup>32</sup> J. Sibbald, 'The Treatment of Incipient Mental Disorder and its Clinical Teaching in the Wards of General Hospitals', *JMS*, 48 (1902), p.216.

<sup>33</sup> W. Griesinger, 'An Introductory Lecture Read at the Opening of the Clinique for Nervous and Mental Disease in the Royal Charité in Berlin 1<sup>st</sup> May 1866', trans. Sibbald, *JMS* 12 (1867).

<sup>34</sup> Burdett, *Hospitals and Asylums of the World*, p.67.

<sup>35</sup> *Min. of the Glas. Dist. Lun. Bd*, (1903), HB30/1/5.

<sup>36</sup> T. Clouston, 'The Possibility of providing Suitable Means of Treatment for Incipient and Transient Mental Diseases in our Great General Hospitals', *JMS*, 48 (1902); Sibbald, 'The Treatment of Incipient Mental Disorder'; and A.R. Urquhart, 'On the Treatment of the Insane in the great General Hospitals', *AJL*, 55 (1909).

<sup>37</sup> Sibbald, 'The Treatment of Incipient Mental Disorder', p.226.

<sup>38</sup> Royal Scottish Institution for the Care of the 'Feeble-Minded'.

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- <sup>39</sup> *Presscuttings Book 1893 – 1903*, LHB7/12/5.
- <sup>40</sup> *Ibid.*
- <sup>41</sup> Clouston, 'The Possibility of providing Suitable Means of Treatment for Incipient and Transient Mental Diseases in our Great General Hospitals', p.709.
- <sup>42</sup> A. Beveridge, 'Thomas Clouston' in *150 Years of British Psychiatry 1841 – 1991*, (Gaskell, 1991), p.481.
- <sup>43</sup> Former director of the Scottish Western Asylums Research Institute.
- <sup>44</sup> Urquhart, 'On the treatment of the Insane in the great General Hospitals', p.261.
- <sup>45</sup> *Min. of the Glas. Dist. Lun. Bd*, (1903), HB30/1/5.
- <sup>46</sup> A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat 1796 - 1914*, (Cambridge University Press, 1985), p.66-72.
- <sup>47</sup> Scull, *The Most Solitary of Afflictions Madness and Society 1700 -1900*, (Yale University Press, 1993), p.150.
- <sup>48</sup> R. Porter, *Madness A Brief History*, (Penguin, 2002), p.116-17.
- <sup>49</sup> J. Sibbald, *On the Plans of Modern Asylums for the Insane Poor*, (James Turner & Co, 1897), p.31 & 33.
- <sup>50</sup> *Edinburgh Evening News*, (1 Nov 1897), in *Presscuttings Book 1893 – 1903*, LHB7/12/5.
- <sup>51</sup> *1st An. Rep. of Kingseat Village Asylum*, (1904), GD17/1/41.
- <sup>52</sup> *Ibid.*
- <sup>53</sup> *1<sup>st</sup> An. Rep. of Bangour Village Asylum*, (1904).
- <sup>54</sup> Sibbald, *On Plans of Modern Asylums*, p.33.
- <sup>55</sup> *50<sup>th</sup> An. Rep. Of the CRI*, (1889), DUM.CRI1990.36.
- <sup>56</sup> *Min. Bk of Ayr. Dist. Lun. Bd* (1901-1903), AA17/4/4.
- <sup>57</sup> N. Anderson and A. Langa, 'The development of institutional care for 'idiots and imbeciles' in Scotland', *History of Psychiatry*, 8 (1997), p.261.
- <sup>58</sup> Andrews, *They're in the Trade...of Lunacy*, p.23.



## Chapter ten

### Conclusion

Fuelled by a more legislative and institutional solution to health care, the Scottish asylum system evolved after 1857 as the main response to mental illness. Such developments would not have occurred without the wider changes implemented within poor law reform and the subsequent breakaway of the asylum system from the Board of Supervision. While the Poor Law retained some autonomy in terms of pauper admissions and the lunacy grant, the direction taken in treatment was largely removed from parochial board hands. The declining influence of philanthropy and lay interest in the asylum must in part be reflective of a shift from an individualistic or local approach to a central response in health and welfare in Scottish society.

In the General Board of Lunacy's propagation of their new asylums, Commissioners initially forwarded a moral approach that advocated non-restraint, open doors and occupation. This was intended to mitigate the harsh criticisms of asylum care that arose from the 1855 Commission. As the century progressed, the hospitalisation of accommodation, support for scientific research and the employment of female nurses on male wards emerged as further features of Scottish asylum culture. By the 1900s then, the Scottish asylum gave the impression of a hub of social, medical and moral influences.

Of course, the reality of policies was less dramatic in practice and varied according to local interest and stressors. Although hospitalisation was promoted at a central level, the roots of hospitalisation arose from individual doctors. Edinburgh remained an important centre of innovation and many doctors who trained under Clouston took their hospitalisation practices to the localities when they achieved posts as

superintendents. In this context it is suggested that mentors such as Clouston had an equal impact on the direction of asylum care, as did the Commissioners in Lunacy. The involvement of former asylum doctors such as Sibbald and Macpherson on the General Board did mean that the General Board contributed to the direction of hospitalisation. District Boards were happy to listen to the Commissioners' recommendations as to asylum construction. Although Commissioners were vocal in their support or disapproval of aspects of asylum practice, like its Poor Law predecessor, the General Board generally left issues to be resolved at a local level.

Most doctors supported hospitalisation and were happy to argue that their institutions were at the cutting edge of modern care. From the asylums researched here it is clear that the rural ABDA made little direction in scientific research, hospitalisation of accommodation and female nursing. This could be taken to reflect the inability of centrally supported policies to impact on the localities. Yet in its day, the ABDA was a model asylum under John Sibbald and James Rutherford, and had led the way in the Commissioners' promotion of non-restraint after 1857. Similarly, PDA shows how this small and isolated institution was able to develop many features of hospitalisation under Robertson and Bruce. As such, the superintendent's interest was more important than the location of the asylum. The biggest diversity in rural and urban considerations was the impact of asylum's size on developments made in treatment. Whereas urban institutions were faced with a medley of social concerns and rising numbers, these were potentially less pressing in the rural localities.

New directions taken in mental health care received extensive discussion in the journals and similar to any medical debate was subject to divisions and disagreements. A shared characteristic of all doctors and Commissioners was the continued use of occupation

for asylum patients that went irrespective of their support for hospitalisation. Although the use of female asylum nursing on male wards proposed by George Robertson received support, other medical superintendents were less inclined to use general nurses who trained outside the asylum. The attempts by asylum doctors to promote rest, as a form of treatment for acute cases was less than well received by those in favour of occupation for this group. Only with the gradual acceptance of reception and admission wards was rest in bed perceived to be a more acceptable method in treatment by many doctors.

Attempts by up and coming doctors to impose an individualistic mark on treatment were subject to rigour from traditional figures such as Clouston and Yellowlees. Within the practice of open-air rest, most doctors adopted it for tuberculosis patients or those patients already receiving bed rest. However, the use of open-air rest by Easterbrook for fractious patients was not commonly adopted. The introduction of serum and thyroid-based treatments also remained at the discretion of medical superintendents and not widely practised. Disagreements arose over issues of liberty for patients. Although most medical superintendents continued to take the middle course in restraint, the 'open-door' policy polarized opinion in the medical press.

District Boards placed barriers against costly hospitalisation developments. Hospitalisation attempts through architecture were opportunistic and often occurred when District Boards were forced to make changes due to accommodation shortages. As such, changes were often reactive to local stressors. The ability of the Glasgow District Board to establish an observation ward system at the poor law hospital arose from a need to cut the admission rates at the local asylums. Funding was not available from District Boards to employ experienced pathologists. Although general medicine

was plagued by a lack of research funding, the increasing opportunities in this arena meant that qualified pathologists opted for posts outside the asylum. While asylum doctors received a more scientific based education, heavy workloads meant that there was little time to put technique into practice. Only with the 1913 Mental Deficiency (Scotland) Act were District Boards forced to contribute towards research programmes.

While hospitalisation arose from the doctors working within the asylum system, its existence represented an effort to catch up with the seemingly vast strides made in general medicine and science. The expansion of the medical profession and growth of hospital and surgical procedures generated need for a better trained hospital staff. Asylum doctors aimed to emulate this type of success in their new hospitals. Moves were made to evolve a clinical approach towards mental illness through casenote recording, physical examination and confinement to a hospital bed on admission. However, hospitalisation shared the set backs faced by general medicine such as the lack of funding opportunities for research and the somewhat trial and error nature of treatments.

Yet as much as hospitalisation was viewed as a 'modernising' force, asylum doctors found it impossible to extricate themselves from the association of insanity with its moral connotations. Increased concerns surrounding alcohol abuse and degeneration, particularly in cities like Glasgow only heightened the moralistic tendencies of the doctors who were challenged with tremendous inability to effect a cure. Rather than develop a clinical and dispassionate view of the patient, casenotes continued to reflect the personal disapproval of many patients' inappropriate lifestyles that had resulted in institutional care. As such the 1900s saw a re-emphasis of Foucauldian moral



approaches through the gradation of accommodation. The growing segregation of learning disability that shadowed policy making by the 1900s is reflective of the pessimism that Scull and others attach to the conclusion of the Victorian era.

In placing the asylum within the context of wider society, the Scottish asylum inevitably shared similar characteristics to other institutions that housed large numbers of people. The custodial analogy of the prison may also be attached to larger urban institutions such as Woodilee that declined from an apparent model institution to disciplined regime. A common feature of daily life in any public institution was an expectation of occupation, perhaps unsurprising in view of the concurrent Victorian ethos of respectability. As such, institutions shared similar features in the attempt to engage all people in work. This is important in the crossover of schemes such as the BES from the poorhouse to the asylum and the use of rewards and punishment to coerce work.

In the prison, the use of parole and probation, occupation and a ladder of privileges in the asylum were akin to the Foucauldian perception of a 'model' disciplinary regime. Of course, like the 'model' prison must not be taken as a blueprint, the use of parole and probation and other liberties was not consistent across all asylums. Similarly, the model village asylum and asylum hospital were implemented to varying degrees and the timing of construction was negotiated at a local level. Again, moves towards hospitalisation and classification predated the construction of the General Board's models of Gartloch and Bangour.

The model and reality also differed in the presentation of asylum staff. Pages of asylum annual reports were scattered with images of the female nurse in uniform, *MPA*

examination results and extracts from examination papers. It is little surprise that there was no propagation of the male nurse as an important member of the asylum staff. The concept of the 'total institution' suggests that staff were subjected to the same discipline as the inmates. Discipline was arduous for asylum nurses, attendants and the assistant doctors. However, the image of the non-fractionous nurse or doctor is unrealistic. This overlooks protests and resignations, as well as the willingness of some individual doctors to speak out against their autonomous medical superintendents.

A sub theme from the research that contests both Scull and Foucault's view of the asylum is the presence of patients who reacted against their incarceration. Certainly, the asylum staff were ultimately most influential in the patients journey through the asylum. However, patients often made life difficult for the medical superintendent and staff and this is indicated in the reactions of patients on admission, refusal to work and some hostility to open air rest. Voluntary patients (albeit a small percentage) tentatively denote other ways that admission was negotiated between various factors. Voluntary boarders are also evidence of further dissimilarities between the Scottish and English asylum system.

After all this, did the emergence of hospitalisation in asylum culture realistically have any noticeable effect? Statistics relating to admission, discharge and recovery taken from the reports of the Commissioners in Lunacy and were compared for the time period prior hospitalisation (1858 to 1879) with the years 1880 - 1914. Statistics for the Stirling District Asylum and Argyll and Bute District Asylum admission rates were collated between 1880 to 1914 to contrast an asylum that practised hospitalisation (SDA) with one that did not (ABDA).

For the period 1858 to 1879 the average annual admission rate for private patients was 465 and for pauper patients this was 1693. In the period 1880 - 1914 the average annual admission for private patients had only risen to 561. Alternatively this equated to 3033 for pauper patients. Without scratching the surface, it is plausible to allude the dramatic increase in pauper asylum admissions as reflective of the Foucauldian round up of society's destitute and misfits. However, the information collated on occupation (included in appendix two) demonstrates that asylum patients did not equate to Scull's description of destitute and unemployed.

In the period 1858 - 1879, recovery rates for both private and pauper patients averaged 41% of total discharges and deaths (see tables a & b, Appendix nine). Recovery rates for pauper patients fluctuated between 29 and 46% although there was no dramatic increase or decline in recovery (see table b, Appendix nine). The figure for private patients dropped more dramatically to 33% in this period, with a steady decline in recovery rates (see table c, Appendix nine). Comparatively there was only a slight decline in pauper patient recoveries to 39% in the period 1880 - 1914 (see table d, Appendix nine). These figures correspond with findings that also highlight a recovery rate of between 30 – 40%. Beveridge's study of the Royal Edinburgh Asylum population shows that up to 40% of private patients were discharged as recovered in the period 1873 to 1908.<sup>1</sup> Doody et al's analysis of the Fife and Kinross District Asylum population notes a recovery rate of 38% for the period 1874 - 1899.<sup>2</sup>

A high percentage of asylum patients were also discharged as 'unrecovered' from Scottish asylums between 1858 and 1914. Between 1858 and 1879 this group accounted for 39% of private patients and 33% of pauper patient discharges. In the following period, figures remained relatively consistent accounting for an average of

31% of paupers and 33% of private patients. However, it is unclear if the term 'unrecovered' is used here to describe asylum patients discharged as 'relieved'. The category of 'relieved' was retained in asylum statistics of discharged patients. The term 'relieved' generally applied to patients who were boarded out from the asylum. The loose meaning of the term allowed it to be used as a positive description of outcome even if total recovery had not been effected.

Comparisons were made in the admission and discharge rates of the Argyll and Bute District Asylum (who did not practise hospitalisation) and the Stirling District Asylum (that claimed to practise hospitalisation). There are evident differences between the admission and outcome of the two populations. The average admission rate to the ABDA in the years 1880 to 1908 was 76 patients. Table e in Appendix nine show that admissions underwent a decline in this period. The SDA admissions steadily increased in the same period and averaged 204 patients (see table f, Appendix nine).

There were differences in the suggested recovery rates of patients at the two institutions. Recoveries accounted for 47% of SDA discharges compared to 38% of ABDA discharges. Death rates at the ABDA were higher, approximating 37% of discharges. In 1906 alone, deaths accounted for over 50% of discharges at the institution. In comparison, death rates at the SDA accounted for 29% between 1880 and 1908.

At a first glance, it would suggest the SDA's higher recovery and lower death rates demonstrate a higher degree of success as a result of hospitalisation. The figures are unusual when compared with studies conducted by Beveridge at the REA (an asylum that practised hospitalisation under Clouston). The comparative figures for the



Gartloch asylum hospital for the decade 1899 to 1908 do show a high recovery rate too (see table 23). However, the asylum is less successful in its deaths in this period, possibly a reflection of the tuberculosis problem noted in chapter six.

Table 23: Gartloch District Asylum and Hospital Recovery, Discharge and Death (1899 - 1908)

	Ad.	Rec		Rel		Not imp		Died		Total
			% Rec		% Rel		% Not Imp		% Died	
1899	203	98	45%	79	37%	1	0.5%	38	18%	216
1900	211	77	43%	59	33%	0	0.0%	45	25%	181
1901	268	84	39%	56	26%	13	6.1%	60	28%	213
1902	262	107	50%	26	12%	29	13.6%	52	24%	214
1903	285	114	45%	37	15%	30	12.0%	70	28%	251
1904	251	84	39%	68	31%	0	0.0%	66	30%	218
1905	306	101	41%	51	20.9%	0	0.0%	92	38%	244
1906	288	114	40%	88	31%	0	0.0%	85	30%	287
1907	301	99	41%	60	25%	0	0.0%	81	34%	240
1908	300	119	40%	77	26%	4	1.4%	94	32%	294
Total	2675	997		601		77		683		2358

Statistics do not tell the whole truth and there is likely manipulation in terms of recovery and discharge in these figures. At face value is evident that the SDA and Gartloch achieved higher recovery rates compared to the ABDA. However, whether a patient was discharged as not improved, relieved or recovered was at the discretion of the doctor. Recovery also depended on contemporary nuances that linked insanity to disobedience and recovery with a willingness to work. Overall, the period 1880 - 1914 achieved a lower recovery rate and higher death rate than the preceding years denoting the overall failure of hospitalisation. What is clear is that although the district asylums were no more effective in cure for pauper patients, neither should the comparative abilities of the Royal Asylums be exaggerated for private care.

The move of psychiatric history towards the contextualisation of the asylum in society highlighted a need to utilise a range of source material. It is hoped that this thesis has provided some example of the diverse records available across Scotland's asylums.

Casenotes do remain as one of the closest links for the historian to the asylum patient's experience. Projects such as '*Finding the Right Clinical Casenotes*'<sup>3</sup> have helped promote and preserve personal health records in Scotland. Casenotes give impressions of why treatments were used as well as the doctor - patient relationship. The doctors' personal disapproval and even dislike of some patients denotes the continuation of a less 'medicalised' approach.

Asylum records outside Edinburgh and Glasgow are far from incomplete and include hidden gems such as the daily casebooks of the Perth District Asylum and the correspondence of the Lismore and Appin Parochial Board in Argyll and Bute. The often-researched Royal Edinburgh Asylum also retains undervalued sources such as the press cutting books. How better to compare and contrast the unpublished opinions of superintendents than through a perusal of the articles and newspaper cuttings that the doctors personally collected.

Hospitalisation may not have dramatically changed the nature and success of asylum care between 1880 to 1914 and pessimism and ineffectuality undeniably marked the period. However, movements need to take root in some time period and while hospitalisation is now positively far removed from today's ideals, the medicalisation of the asylum did eventually achieve prominence in the twentieth century. Much research remains to be done with the local Scottish asylum systems (that included the asylums, parochial boards, district boards, patients and community members). While Scotland's urban Royal Asylums are of course fascinating resources for the researcher with their wealth of records, it is perhaps the outlying areas that provide a truer reflection of Scotland's psychiatric legacy.

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<sup>1</sup> A. Beveridge, 'Life in the Asylum; patient letters from Morningside, 1873-1908', *History of Psychiatry*, 9 (1998), p.43.

<sup>2</sup> G.A. Doody., A. Beveridge and E.C. Johnstone, 'Poor and Mad: a study of patients admitted to the Fife and Kinross District Asylum between 1874 and 1899', *Psychological Medicine*, 26 (1996), p.890.

<sup>3</sup> [www.clinicalnotes.ac.uk](http://www.clinicalnotes.ac.uk)

## Appendix One

### Biographies of Medical Superintendents and Doctors

The appendix provides biographic histories of medical superintendents and doctors who are referred to throughout the thesis. The information is primarily taken from the annual *Medical Directory*. The histories help show overlaps in interest and connections with hospitalisation. Where available dates relating to promotions and graduations (as well as birth and death) are provided.

#### ***Dr Lewis Campbell Bruce (?-1946)***

Graduated from the University of Edinburgh. Assistant medical officer at Derby Borough Asylum and then senior medical officer at Royal Edinburgh Asylum under Thomas Clouston. Medical superintendent of Perth District Asylum (1899-1945). *Interests:* Active in scientific research and published several journal papers related to the scientific research of insanity. Author of 'The Complement Deviation in Cases of Maniac Depressive Insanity', *Transactions of the International Congress of Medicine*, (1913), 'Deviation of Complement in the Mental Disorder known as Mania', *Journal of Mental Science*, (1910); 'Bacteriological and Clinical Observations on the Blood of cases of Acute continuous Mania', *JMS*, (1903) 'Effects on Thyroid Feeding on some Forms of Insanity', *JMS*, (1895-6).

#### ***Dr Thomas Clouston (1840-1915)***

Graduated from the University of Edinburgh. Assistant physician to the Royal Edinburgh Asylum under Dr David Skae. Appointed medical superintendent of the Cumberland and Westmoreland Asylum, Carlisle. Medical superintendent of the Royal Edinburgh Asylum between 1873 and 1908. *Interests:* Acknowledged leader of the hospitalisation movement. Remained highly supportive of the occupation of patients as treatment. Produced numerous publications on the topic of insanity.<sup>1</sup>

#### ***Dr Charles Easterbrook (1867-1949)***

Graduated from the University of Edinburgh. House surgeon at the Royal Maternity Hospital, Edinburgh, Royal Infirmary and City Fever Hospital in Edinburgh. Assistant doctor at the Royal Edinburgh Asylum under Thomas Clouston. Appointed as medical superintendent of Ayr District Asylum in 1902 and Crichton Royal Institution, Dumfries (1908-1937). *Interests:* Open-air bed rest, classification of patients and scientific research. Author of *Chronicles of Crichton*, (1945), 'The Sanatorium Treatment of Active Insanity by Rest in the Open Air' and 'The New Hospital at Ayr Asylum' *JMS*, (1907).

#### ***Dr William Ford Robertson (1867-1923)***

Graduated from the University of Edinburgh. House physician at the Edinburgh Royal Infirmary and Royal Hospital for Sick Children, Edinburgh. Appointed as pathologist to the Royal Edinburgh Asylum under Thomas Clouston in 1893. Pathologist to the Scottish Conjoint Asylums Laboratory Scheme (1897-1923). Main publications include *Therapeutic Immunization in Asylum and General Practice*, (1921) *The Pathology of Mental Diseases*, (1900) and with Dr James Middlemass, (assistant doctor to the REA) joint papers on the pathology of the nervous system in the *Edinburgh Medical Journal* (1894-1896).



***Dr John Macpherson (1857-1942)***

Graduated from the University of Edinburgh. Worked at the Inverness Infirmary, then as an assistant medical officer at Stirling District Asylum from 1883. Following this, appointed as a senior medical physician to Edinburgh Royal Asylum under Thomas Clouston. Medical Superintendent of Stirling District Asylum from 1889. Replaced John Sibbald as a Commissioner in Lunacy for Scotland in 1899. *Interests:* Supported hospitalisation as well as moved to ban the marriage of people with learning disabilities and epilepsy. Publications include *Mental Affections: An Introduction to the Study of Insanity*, (1899); 'The Hospital Treatment of the Insane in Asylums', *JMS* (1896); 'Notes on a case of Myxoedema Treated by Thyroid Grafting', *JMS*, (1892); 'On a case of Acute Mania with Symmetrical Gangrene of the Toes (Raynauld's Disease)', *JMS*, (1889); and 'On the Dissolution of the Functions of the Nervous system in Insanity', *American Journal of Insanity*, (1889).

***Dr Ivy Mackenzie (no dates)***

Graduated from Glasgow University. Worked as a voluntary assistant physician to the Sick Children's Hospital, Dresden and as an assistant at the Pathological Institute, Dresden. Appointed as the First Director of the SouthWestern Asylums Research Institute in 1910. Visiting Physician to Victoria Infirmary, Glasgow and Consultant Physician to the Glasgow Board of Control. Publications include 'Connecting Muscle System of the Vertebrate Heart', *Transaction of the International Congress of Medicine*, 'Serum Therapy in Cerebro-Spinal Fever', *Journal of Pathology*, (1907), 'Pulmonary Changes in Asphyxia' and 'Recent Methods in Diagnosis and Treatment of Syphilis', *Journal of Anatomy and Physiology*, (1905).

***Dr Hamilton C. Marr (1870-1936)***

Graduated from the University of Glasgow. First appointment was as an assistant doctor at the Crichton Royal Institution, Dumfries under Dr James Rutherford. Subsequently appointed deputy Medical Superintendent of Woodilee District Asylum, Glasgow and became medical superintendent of Woodilee in the 1900s. Mackintosh Lecturer in Psychological Medicine in St Mungo's Medical College, Glasgow and Extra-Mural Lecturer in Mental Health at the University of Glasgow. Specialist in Mental Disease to the Troops in Malta (1915-1916) and Consultant in Neurology Scottish Commander (1916-1919). Appointed as a Commissioner in Lunacy for Scotland. *Interests:* Scientific research, shell shock and mental deficiency. Extensive publications include *Psychoses of the War including Neurasthenia and Shell Shock* (1919); 'Feeble-minded and backward children' *Kelynack's Defective Children*, (1913); (With Ivy Mackenzie and C. Browning) 'Use of Arsenic Preparations in Protozoal Affections' *JMS*, (1910); 'Examination of Cerebro-Spinal Fluid in General Paralysis for Purpose of Diagnosis', *Review of Neurology and Psychiatry*, (1908); 'Case of General Paralysis of the Insane occurring in Early Life', *Lancet*, (1899) and 'Case of Myxoedema with Insanity treated by Thyroid Feeding and Thyroid Extract' *Glasgow Medical Journal*, (1893).

***Dr Landel Rose Oswald (no dates)***

Graduated from University of Edinburgh. Appointed as first medical superintendent at Gartloch Mental Asylum and Hospital in 1896 and as medical superintendent at Gartnavel Royal Asylum, Glasgow between 1902 and 1921. Hon. Consultant Physician Gartnavel Royal Asylum and Lecturer on Insanity at Glasgow University. *Interests:* Advocate of open-air rest and introduced the practice at both asylums. Also established the Scottish SouthWestern Asylums Research Institute at Gartnavel in

1910. Limited publications include 'Haematoporphyrinuria following administration of Sulphonal', *Glasgow Medical Journal*, (1895).

***Dr William Parker (? - 1925)***

Graduated from the University of Glasgow. Assistant medical officer and Pathologist to Lancaster County Asylum. Appointed medical assistant and clinical officer to Gartnavel Royal Asylum under David Yellowlees. Assistant doctor and deputy medical superintendent to Landel Oswald at Gartloch District Asylum and Hospital from 1896. Became the second medical superintendent of Gartloch in 1901 and remained there until his death in 1925. No publications to note. *Interests:* Supportive of open-air rest and hospital rest for patients.

***Dr George Robertson (1864-1932)***

University of Edinburgh graduate. Appointed as a resident physician in the Royal Infirmary, Edinburgh and then assistant doctor at the Royal Edinburgh Asylum under Thomas Clouston. Appointed medical superintendent of Perth District Asylum in 1892 and Stirling District Asylum in 1899. Succeeded Thomas Clouston as superintendent of the Royal Edinburgh Asylum in 1908. Appointed as a lecturer in mental disease at Edinburgh University in 1908 and Professor of Psychiatry in 1920. *Interests:* Strong advocate of hospitalisation and the employment of female nurses in male wards of asylum. Robertson did not publish widely, but his articles include 'Hospital Ideals in the care of the Insane', *JMS*, (1902) and 'The employment of female nurses in the male wards of mental hospitals in Scotland', *Edinburgh Medical Journal*, (1922).

***Dr James Rutherford (1840-1910)***

Graduated from University of St Andrews and University of Edinburgh. Resident house physician at Edinburgh Royal Infirmary in 1864. Started a private practice in Bo'ness, near Linlithgow, Scotland in 1865 before becoming assistant medical officer of Birmingham Borough Asylum in 1867. Appointed medical superintendent of Argyll and Bute District Asylum (1870-1875); Barony Parochial Asylum [Woodilee], Glasgow (1875-1883) and Crichton Royal Institution, Dumfries (1883-1908). *Interests:* Abolition of airing courts, supporter of the open door policy and outdoor occupation for patients. Made little contribution to research literature except his co translation of Griesinger's *Manual of Mental Disease* with Dr Charles Lockhart Robertson in 1867.

***Sir John Sibbald (1883-1905)***

Graduated from the University of Edinburgh. Worked at the Edinburgh Royal Infirmary and the Royal Maternity Hospital, Edinburgh before becoming house surgeon to Perth Hospital and Brompton Consumption Hospital. Assistant physician at the Royal Edinburgh Asylum under David Skae. Appointed as medical superintendent to the Argyll and Bute District Asylum, Lochgilphead in 1862. Subsequently promoted to the post of Commissioner in Lunacy (1871-1899). *Interests:* the removal of 'airing courts and incorporation of "hospital" features in asylums. Supported and led the new move towards the 'village' style asylum from the 1890s. Publications include *Plans of Modern Asylums*, (1896); 'Clinical Instruction in Insanity', *JMS*, (1870) and 'The Cottage System and Gheel', *JMS*, (1861).



***Sir John Batty Tuke (1835-1913)***

Graduated from Edinburgh University in 1856. Served as an assistant in the Royal Edinburgh Asylum under David Skae. Appointed medical superintendent of Fife and Kinross District until 1873. Medical superintendent of the private asylum of Saughtonhall. Became president of the College of Physicians in 1898. *Interests:* Abolition of airing courts and supportive of the open door policy. Active in scientific research and published *A Plea for the Scientific Study of Insanity* in 1891. Earlier publications include 'The Open Door System', *JMS*, (1881) and 'The Cottage System of Management of Lunatics as Practiced in Scotland, with suggestions for its Elaboration and Improvement', *JMS*, (1870).

***Dr David Yellowlees (?)***

Graduated from the University of Edinburgh in 1857. Resident Physician, Royal Edinburgh Infirmary and Assistant Physician under David Skae at the Royal Edinburgh Asylum. Medical Superintendent of Glamorgan County asylum and then the Gartnavel Royal Asylum in Glasgow. *Interests* Although supportive of hospitalisation, Yellowlees continued to favour traditional approaches and retained both locked doors and airing courts at the asylum.<sup>2</sup>

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<sup>1</sup> See A. Beveridge, 'Thomas Clouston' in G. Berrios and H. Freeman, *150 years of British Psychiatry 1841-1991*, (Gaskell, 1991).

<sup>2</sup> See J. Andrews, 'A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry: part 1 & 2', *History of Psychiatry* 8 (1997).

## Appendix two

Occupations of patients admitted to the Argyll and Bute District Asylum, Perth  
District Asylum and Woodilee District Asylum, (1889 – 1908)

### *Argyll and Bute District Asylum, Lochgilphead*

Occupations (Males)	No.	%
Professional	8	1,1%
Army and Navy	13	1,8%
Religion	1	0,1%
Agriculture and fishing	232	31,9%
Mining	32	4,4%
Manufacturing	18	2,5%
Building	18	2,5%
Trade and Craft	79	10,9%
Labouring	132	18,1%
Distribution and processing	9	1,2%
Retail or dealer	25	3,4%
Agent or Traveller	7	1,0%
Engineering	9	1,2%
Shipping	27	3,7%
Transport and Communication	23	3,2%
Clerk or bookkeeper	7	1,0%
Personal service	6	0,8%
Other service	9	1,2%
Culture and entertainment	4	0,5%
Student or scholar	10	1,4%
Gentleman	1	0,1%
No occupation	58	8,0%
<b>TOTAL</b>	<b>728</b>	<b>100%</b>

Occupations (Females)	No.	%
Professional	6	0,8%
Religion	1	0,1%
Agriculture and fishing	41	5,6%
Manufacturing	5	0,7%
Trade and Craft	6	0,8%
Labouring	5	0,7%
Distribution and processing	14	1,9%
Retail or dealer	14	1,9%
Agent or Traveller	5	0,7%
Transport and Communication	4	0,5%
Clerk or bookkeeper	1	0,1%
Personal service	324	44,1%
Other service	13	1,8%
Student or scholar	5	0,7%
Gentlewoman	2	0,3%
Housewife	218	29,7%
No occupation	71	9,7%
<b>TOTAL</b>	<b>735</b>	<b>100,0%</b>



*Perth District Asylum, Perth*

<b>Occupations (Males)</b>	<b>No.</b>	<b>%</b>
Professional	2	0,3
Army and Navy	11	1,5
Religion	2	0,3
Agriculture and fishing	126	16,8
Mining	14	1,9
Manufacturing	62	8,3
Building	24	3,2
Trade and Craft	78	10,4
Labouring	197	26,3
Distribution and processing	54	7,2
Retail or dealer	12	1,6
Agent or Traveller	12	1,6
Engineering	12	1,6
Shipping	6	0,8
Transport and Communication	35	4,7
Clerk or bookkeeper	24	3,2
Personal service	13	1,7
Other service	9	1,2
Culture and entertainment	3	0,4
Student or scholar	5	0,7
No occupation	47	6,3
<b>TOTAL</b>	<b>748</b>	<b>100,0</b>

<b>Occupations (Females)</b>	<b>No.</b>	<b>%</b>
Professional	3	0,5%
Agriculture and fishing	8	1,3%
Manufacturing	84	13,6%
Trade and Craft	20	3,2%
Labouring	54	8,8%
Distribution and processing	12	1,9%
Retail or dealer	8	1,3%
Agent or Traveller	10	1,6%
Transport and Communication	1	0,2%
Personal service	231	37,4%
Other service	12	1,9%
Housewife	108	17,5%
No occupation	66	10,7%
<b>TOTAL</b>	<b>617</b>	<b>100,0%</b>

*Woodilee District Asylum, Glasgow*

Occupations (Male)	No.	%
Professional	6	0,2%
Army and Navy	49	2,0%
Religion	1	0,04%
Agriculture and fishing	39	1,6%
Mining	50	2,0%
Manufacturing	287	11,6%
Building	51	2,1%
Trade and Craft	483	19,4%
Labouring	551	22,2%
Distribution and processing	80	3,2%
Retail or dealer	87	3,5%
Agent or Traveller	105	4,2%
Engineering	85	3,4%
Shipping	42	1,7%
Transport and Communication	93	3,7%
Clerk or bookkeeper	152	6,1%
Personal service	9	0,4%
Other service	82	3,3%
Culture and entertainment	21	0,8%
Student or scholar	5	0,2%
No occupation	206	8,3%
<b>TOTAL</b>	<b>2484</b>	<b>100,0%</b>

Occupations (Female)	No.	%
Professional	9	0,4%
Agriculture and fishing	4	0,2%
Mining	1	0,0%
Manufacturing	209	8,6%
Trade and Craft	45	1,9%
Labouring	2	0,1%
Distribution and processing	83	3,4%
Retail or dealer	45	1,9%
Agent or Traveller	15	0,6%
Clerk or bookkeeper	2	0,1%
Personal service	875	36,1%
Other service	44	1,8%
Culture and entertainment	4	0,2%
Student or scholar	2	0,1%
Housewife	942	38,9%
No occupation	142	5,9%
<b>TOTAL</b>	<b>2424</b>	<b>100,0%</b>

## Appendix three

Patient case notes, Crichton Royal Institution, Dumfries (CRI); Gartloch District Asylum and Hospital; and Woodilee District Asylum, Glasgow

The bold case denotes the original printed pro-forma of the case notes.

### CASE A: W.Y.

CRI Casebook of Male Admissions (1.6.1852-2.4.1853),  
CRI.1989.73SCA

No 254

Name: W.Y.

Admitted 2 October 1852

Aged 48, married, weaver but was originally 26 years in the army.

2. The cause of the patient's malady is said to be unknown but it is suspected to have been intemperance.
3. No pulmonary symptoms were known to exist.
4. He has not been suspect to epilepsy but is affirmed to have been for 6 months in a hospital in Canada.
5. The patient labours under mania – which is supposed to be increasing.
6. Appetite, digestion and evacuation regular and rapid.
7. This is the first attack.
8. The predominating delusion is that he has become heir to an immense sum of money and is engaged in speculations, in carpets, buildings, he is helpless.
9. He has not attempted to commit suicide.
10. "As yet" it is stated the patient is harmless.
11. No hereditary tendency to mental disease is known to exist among his relatives.
12. No treatment has been attempted but it became necessary to keep him in the house during the night by force.
13. The duration of the malady is about 5 weeks but the patient has never been secluded.

12 May 1853

As it was hoped at first that this patient's voluble mode of thinking and expression may be more allied to delusion than the characteristic incoherence of the monomania of ambition, he was prescribed opium. His mania became more calm and sleep was procured but for a long period he was fully convinced that he could walk twenty miles in a minute; that he was proficient in all trades and especially a fabricator of silk handicraft: that he has extensive enterprises in manufactures that his wealth was enormous sometimes measured by thousands sometimes by millions. In enunciating all this however his articulation was distinct though rapid and he walked around in a military manner without halt or impediment. In about a month subsequent to admission he is found to have contracted an attachment to the establishment and is to petition for a situation in its staff although no-one avails him in the main office. These ambitious views have disappeared. The patient has joined the labourers and is interested and energetic in his occupation and [is] now reduced to his original proportions.

His perfect equanimity, his good health and evidence that he now displays the aspect and deportment that characterised not only himself but his brothers in the army, he was,

Discharged.



CASE B: E.B.  
CRI Casebook of Female Admissions, (1881 – 1885),  
DUM.CRI.1989.69

**Name:** E.B.  
**Admitted:** 22 December 1884  
**Sex:** Female  
**Age:** 47  
**Marriage:** Married  
**Occupation:**  
**Education:** Good  
**Religion:** Protestant  
**Private or pauper:** Private (Voluntary)      **Where from?** Kilmalcolm

### HISTORY

#### Causation

**Disposition:**  
**Habits:**  
**Previous Attacks:** Several      **Where treated:** Crichton, Saughtonhall  
**Duration:**  
**Hered. History-Insanity:**  
**Other Disease:**  
**Predisposing:**  
**Exciting:** Intemperance

#### Symptoms

**First**  
**Mental**  
**Bodily**

**Present**  
**Mental**  
**Physical**

#### **Insane Habits and Propensities**

**Suicidal:** Threatens to be  
**Dangerous:**  
**Duration of existing attack:**

#### **Other facts or remarks**

This patient was admitted as a voluntary patient here on the 22 December 1884 and for a day or two was quiet and fairly rational but her delusions subsequently became so marked that it was necessary to certify her of unsound mind.

**Facts of medical certificate**

In coherent conversation. Thinks she has been visited by people who have not been here and hears voices and noises which do not exist. Her delusions are about her husband and daughter having visited her and having being badly treated.

**STATE ON ADMISSION**  
(on 27 Dec as certified patient)

**Exaltation:**

**Excitement:** She is restless attempting to leave her gallery to see her daughter and husband whom she believes to be outside.

**Depression:**

**Enfeeblement:** Memory and coherence weak.

**Memory:** Impaired. Cannot remember names

**Coherence:** Impaired

**Delusions:** Believes that people are plotting her death, that the food is poisoned and that her husband is here and being killed.

**Can answer questions?** Yes

**Other Abnormalities:** Seems preoccupied when spoken to. Has hallucinations of hearing. Hears people confessing having poisoned her.

**Appearance:** short and very stout

**Skin:** Greasy. A few patches of pigment on the shoulders

**Hair:** Greyish black

**Eyes:** Brownish grey

**Pupils:** Equal

**Muscularity:** Moderate

**Fatness:** Considerable

**Nervous system** -*motor*: functions normal  
-*sensory*: the sensibility is dulled.

**Reflex action:** blunted

**Special Senses:** Hearing damaged. Has hallucinations of hearing

**Retina:**

**Lungs:** Is suffering from slight bronchial catarrh and dry cough. Resp. 18 per minute.

**Heart:** Cardiac apex impalpable. First sound shortened and raised in pitch.

**Tongue:** Dry, thick white fur

**Bowels:** Regular

**Other Organs, abnormalities, Bruises &c.**

**Appetite:** Poor. Appetite disordered – craving for stimulants

**Urine:** S.G. 1018. Reddish yellow, acid – contains no unusual caustics

**Menstruation:** Has ceased for some years

**Pulse:** 66 per minute

**Temp.** 96.8

**Height:** 5 ft 4 ¾

**Weight:** 17 st. 10lb

**Disease:** mania

**Skæ's Classification:**

## General Bodily Health and Condition: Impaired

### PREDOMINANT FEATURES

A Acute Delirium and in- coherence	B Simple Excitement	C Simple Depres- sion	D Stupor	E Hypoch- ondria	F Strong Suicidal Impulse
G Remitt-ency or inter- mitency	H Choreic move- ments	I Halluc- inations	J Enfeeble- ment		
		yes			

### PROGRESSION OF CASE

- 21.12.84 Arrived at 11.30pm under the care of attendants Robinson and Irving. She was quiet and conversed sensibly. She slept for three hours and was then awake at intervals till morning. Did not eat well and asked for stimulants. Three ii of Whiskey were ordered for her. Complained at the evening visit of hearing people ill using a dog outside her room (which was not the case). She said that she would never fall asleep unless an attendant was allowed to stay with her. Attendant Johnstone slept in the adjoining room.
- 22.12.84 Restless and sleepless during the night. Stated that she heard people planning how to accomplish her death. She was visited by her husband during the afternoon whom she received well. Appetite poor.
- 23.12.84 Slept six hours but was afterwards restless. Said that she heard her death warrant read in her bedroom. Was restless during the day and demanded more stimulants. The bowels are constipated and her tongue thickly furred. *Mii of* croton oil given.
- 24.12.84 Passed a restless night and was noisy at times. Thought that she heard the voices of her husband and daughter talking to her. The bowels moved freely. Appetite better.
- 25.12.84 Slept badly. In the morning broke a window and in doing so made an incised wound  $\frac{3}{4}$  inch long on the back of her right hand. There was a good deal of bleeding at first but this stopped. Quieter during the day.
- 26.12.84 Had a special attendant at night, restless and excited during the day; believing that her husband and daughter are outside and that they have been injured, says she heard them calling to her to help them. Slept badly and tried to leave her gallery several times.

- 27.12.84 Today Mrs B. is discharged as a voluntary patient and admitted as a certified patient. She slept badly, was restless and believed that her husband and daughter were speaking to her, and she answered their questions in a loud tone of voice. Had suspicions about the food and refused most of it. Her stimulants which appeared to excite her were stopped.
- 30.12.84 Is still hearing voices speaking to her through telephones. She at times is suspicious of her food and refuses to eat it as she believes it is poisoned. The bowels are sluggish often required purgatives to remove them.
- 16.01.85 Is under the delusion that she is on board ship, is difficult with her food. Today her stimulants (2 bottles of beer and a glass of whiskey) have been recommenced. The effect has been beneficial. She is brighter and talks more sensibly.
- 20.2.85 Is much improved. The delusions and excitement have passed away. She is rational in conversation but excitable and very anxious to be allowed to leave as she says she is quite well. Asks frequently and persistently for more stimulants or for bromine of potassium or chloral to soothe her nervous condition. Was given a bottle containing [?] in water which she stole from the attendant room and swallowed 3*vi* of it believing it to be bromide. Her general health is improving.
- 15.3.85 Temp. 98.6 Pulse: 78  
During the last three days this patient's craving for alcohol and narcotics has been very marked. She complains of aches and pains in order to have sedative drugs prescribed and is troublesome and persistent in her demands for alcohol. She asks for scent from different ladies and swallows the contents of their scent bottles. In two visits to a lady who was confined to bed and who had recently purchased a large bottle of Eau-de-Cologne, Mrs B. drank it all. She purloined some lead and opium pills which another patient was taking for diarrhea, knowing them to contain morphia.
- 29.4.85 Discharged on probation
- Dec 1885 Since her readmission this patient has behaved in a most persuasively manner. She is cheerful and good-tempered and is comparatively contented. She has a glass of whiskey and two bottles of beer daily. She has outside parole and pocket money but has never abused the privilege. She attends the amusements and enjoys a hand at whist.
- Mrs B.'s parole has been stopped (a month ago) owing to her coming home on two or three occasions with appearance of drink. She grumbled and was very low-spirited for a week after the withdrawal of her privileges but is now quite cheerful again.
- 16.4.86 On the 12<sup>th</sup> April she received a letter from her husband who has just returned from Germany telling her he was coming for her that evening



and arranging with Mrs B. that she should meet him at the Railway Station on the arrival of his train, that they should go together and spend the night at a hotel and drive to the institution next day for Mrs B.'s luggage and then leave for Edinburgh where rooms have been arranged. As arranged, Mrs B. went to the station in plenty of time. The train arrived and with it Mr B., he looked up and down for his wife but she was not to be seen. He went on in a cab to the hotel and ordered rooms, then was coming out to drive to the Crichton when Mrs B. arrives in a cab at the hotel, from the station. She had been in the Refreshment room when the train arrived and was under the influence of drink already. Her husband gave her a glass of whiskey at bedtime. At about seven o'clock in the morning she was down at the bar and got more. She came up to the Crichton at about noon with Mr B. and was quite drunk. He left at 2 o'clock and went home without her. Since then Mrs B. has been considerably excited and unsettled begging for drink, stealing her neighbour's eau-de-cologne.

- 14.5.86 Liberated on probation
- 17.7.86 Returned from probation. Appears just as she was when she left. Her husband states that she has been drinking hard, and latterly has been quite unmanageable.
- 1.8.86 She is discontented and grumbling at her detention here. Talks as if she thought herself a very badly used woman, and no doubt she does. She is restricted to three bottles of beer daily.
- 28.8.86 Remains the same. Limited to three bottles of beer daily and does not ask for more.
- 14.9.86 Weight: 17 st. 12.
- 22.10.86 Discharged
- 13.11.86 Readmitted. Has been drinking heavily, her average daily according to her husband for a week before her admission having 3 bottles, 1 of stout and a pint of whiskey. For a week after discharge she had kept sober and was alright. Then her husband noticed that she frequently left the room and on returning went to the cupboard for a piece of cheese. This aroused his suspicion and by the end of the second week she had begun openly to drink. When admitted she was in a state of excitement, her hair dishevelled and very alcoholic. Constantly wanted beer or spirits. Her allowance has been limited to 2 bottles of beer per dinner. Large dose of Epsom salts given. Weight 16 st. 10 ½ lb
- 16.11.86 She is becoming more like herself again – says she cannot do without the beer.
- 22.12.86 Mrs B. is quite herself again and her merry ways and ready cheerfulness make her a great favourite as well. She still thinks she is on a very short common as regards alcohol. She is very much agitated on learning that

she was now a certified patient and that her husband and daughter have gone to the continent. She now however is becoming more reconciled to the facts, though is still much aggrieved at the way in which her relatives have berated her. Discharged.

CASE C: A.G.S.  
CRI Casebook of Male Admissions (1888 - 1893)  
DUM.CRI.1989.140.

**Name:** A.G.S.

**Admitted:** 15 February 1888

**Sex:** Male

**Age:** 19

**Marriage:** Single

**Occupation:**

Apprentice iron merchant

**Education:** Good

**Religion:** Protestant

**Private or pauper:** Private

## HISTORY

### Causation

**Disposition:**

**Habits:**

**Pervious Attacks:** None

**Duration:**

**Hered History-Insanity:** A maternal aunt has been insane

**Other Disease:**

**Predisposing:**

**Exciting:** Adolescent (cause unknown)

### Symptoms

**First**

**Mental**

**Bodily**

**Present**

**Mental:**

**Physical:**

**Insane Habits and propensities**

**Suicidal:** Yes

**Dangerous:** Yes

**Duration of existing attack:** 6 months

### Other facts or remarks

#### Facts of medical certificate

Dr Dryden – He is dull and depressed and is full of delusions. He says that Lord Rosebury, the Duke of Argyll and the Earl of Dunraven, disguised as working men all came to his father's house one night in December begging. He says he is a son of Mary Gullen of Scots. 2. He has been sending letters and telegrams to Lord Rosebury and several other state officials, making appointments with them and otherwise annoying them.

Dr Calderwood – Thornhill: - 1. He is depressed and says his father is persecuting him. He says he is the Son of God and calls his father a devil because he is taking luggage with his to heaven and tries to put him out.

### STATE ON ADMISSION

**Exaltation:** Marked. He has most exaggerated ideas of his own importance and powers, as indicated by some of his delusions.

**Excitement:** some restlessness.

**Depression:** He manifests a good deal of boyish grief at being compelled to remain here.

**Enfeeblement:** None

**Memory:** Seems impaired but this is probably due to his self-absorption.

**Coherence:** coherent

**Delusions:** That he is the Son of God. That he was confined he to prevent him from stirring up a revolution. He has delusions of suspicion and persecution.

**Can answer questions?** Yes

**Other Abnormalities:**

**Appearance:** prominent features, flushed face and defiant expression.

**Skin:** Dry and cool

**Hair:** brown

**Eyes:** Blue

**Pupils:** Equal and react to light

**Muscularity:** Fair

**Fatness:** poor

**Nervous system**      *-motor:* normal  
   *-sensory:* normal

**Reflex action:** normal

**Special Senses:** normal

**Retina:**

**Lungs:** Chest flat. Nothing abnormal

**Heart:** heart sounds distinct and pure in the mitial area: first sound very faint in the aortic area

**Tongue:** coated all over with yellowish white fur.

**Bowels:** Regular

**Other Organs, abnormalities, Bruises &c.**

No marks or bruises

**Appetite:** Good

**Urine:** Urine acid sp. gr. 1030. Contained a large quantity of water

**Menstruation:**

**Pulse:** 80, irregular in rhythm. Low tension

**Temp.** Normal

**Height:** 5 ft 9 in

**Weight:** 8 st. 10lb

**Disease:** Adolescent mania

**Skæe's Classification:**

**General Bodily Health and Condition:** good



### PREDOMINANT FEATURES

A Acute Delirium and in- coherence	B Simple Excitement	C Simple Depres- sion	D Stupor	E Hypoch- ondria	F Strong Suicidal Impulse
G Remitt-ency or inter- mitency	H Choreic move- ments	I Halluc- inations	J Enfeeble- ment		

### PROGRESSION OF CASE

Weight: 122 Ibs

Pulse (am) 80

Mr S. protests against being kept in this "damned democratic hole" and expresses his intention of burning it to the ground. He has most exhaled ideas of his own importance and powers. He says that he has frequently been told that he is the Son of God and he believes it. He is "a socialist but at the same time an aristocrat". He was sent here to prevent him from stirring up a revolution. At the same time he sheds tears of boyish grief and anger at being kept in check. He announced his intention after breakfast of taking no more food here and refused his dinner, but the demands of nature proved too strong at teatime. His expression is stubborn and defiant.

- 17.2.88 Mr S. is sleeping and eating well and is not quite as self asserting this morning. Discipline is telling upon him already.
- 20.2.88 Mr S. is quiet and sullen and does not speak except in answer to questions. His delusions are unchanged. He believes that a number of distinguished statesmen came in disguise to his father's house, presumably to make his acquaintance, for he regards himself as a great power in the political and social world. He dislikes all kinds of recreations but is made to take plenty of walking exercise. His health is good.
- 5.3.88 No change in Mr S. He writes letters in which he signs himself "God".
- 14.3.88 Mr S. has been put into the High West and approved of the change as he considered the infirmary a "damned hole". He speaks in a bitter way of his father whom he accuses of persecuting him. His delusions of grandeur continue and his manner is very curt and disagreeable.
- 28.3.88 Weight: 124 Ibs

- 5.5.88 Mr S. attempted to escape today but was seen getting over the wall at the cricket field and easily returned. He is dogged and sullen and does nothing but abuse the place and vow vengeance on the officials. He has been sent out to work with the barrow squad for the last week but makes a most unwilling workman, throwing down his barrow and swearing promiscuously.
- 6.5.88 Mr S. smashed 12 panes of glass in one of the windows of the gallery today. He showed no excitement, saying merely that he wishes to get out. He cut his finger slightly. He was kept in the padded room for the rest of the day and put on short rations. He tore his underclothing to ribbons and the straitjacket applied. This seemed to cow him completely.
- 7.5.88 He is very meek this morning, and has been sent out to work. He has been ordered a cold plunge every morning.
- 8.5.88 Mr S. spent last night in the padded room but was quite quiet. He was sent back to the High West today. He promised not to misbehave again.
- 16.5.88 When out working this morning Mr S. attacked the attendant, throwing stones at him and threatening to strike him with a shovel. He was sent to the second house where he will have harder work with the pauper squad. He is abusive and sullen.
- 17.5.88 Mr S. came back tonight but is as dogged as ever and seemed none the better for his day with the paupers.
- 26.5.88 Had a fit of ill temper tonight during which he smashed a window and destroyed his hat.
- 27.5.88 Knocked his fists through a large pane of glass in the gallery door this morning and cut both his hands. Two cuts required to be stitched. He will give no reason for his conduct. He was recently visited by his brother but would scarcely speak to him.
- 30.5.88 Smashed his chamberpot this morning and was sent over to the 2nd House. Yesterday he broke seven panes of glass in the boot room with a brush. He shows no excitement and smashes whatever comes his way without the slightest warning. He is silent and sullen and answers questions with a muttered curse or the remark "I want to get out".
- 20.6.88 While in the 2<sup>nd</sup> House Mr S. wore the pauper clothes and worked all days at the barrows. The discipline has done him good, he is quiet though still sullen and has a less exaggerated idea of his importance. He writes a good many letters to his friends but they contain little else than "I am in agony. Come and get me out". It is feared that he will pass into dementia.
- 21.7.88 Weight: 124lbs

No improvement. He is sullen and threatening but never violent or destructive. He complains of indefinite ailments but his objective appears to be to escape work, which he detests. He is becoming more weak minded. He laughs a great deal to himself without apparent cause. He denies that he masturbates but says people come into his room at night for improper purposes. He still writes incoherent letters.

15.9.88      Weight: 121 lbs  
19.2.89      No change  
22.4.89      Weight: 129 lbs. No change.  
18.12.89     Died drowning

*Taken from Minute Book*

3/1/90 monthly

The Medical Superintendent reported the circumstances attending the death by drowning of Mr S. who leaped from a wagon while crossing the new bridge and threw himself into the river.

CASE D: J.K.  
Woodilee Casebook of Male Admissions  
(1896 - 1898), HB30/4/4

Name: J.K.

Admitted April 1898

Aged: 21 10/12 Single

Occupation: Clerk

Dear Robert Blair

29/4/98

Dear Sirs

I was with Mr Motion\* at the Barony office today when he inquired through the telephone regarding my son's condition and he requested me to write to you giving particulars of the cause of my J.'s mind giving way. My second son Alexander 20 years of age died very suddenly at the 20th inst. And the shock J. got commenced his troubles. I saw at the funeral on Saturday that he were greatly upset. On Sabbath forenoon he would go to the church and after the service he got quite excited and was shaking hands with some of his acquaintances and he was quite convinced that his brother Alexander was now safe with Jesus and that he himself had similar and consistent expectations. We tried our best to keep John at home in the afternoon but he was determined and went again to church. On Monday he went to work and at night put in one of his drills as a volunteer. On Tuesday he again went to work but I have been informed that he was a little excited and speaking to his fellow clerks about religion. He went to a religious meeting at night and came back very much excited. On Weds he did not go out but kept his bed. He sang all day hymns and sacred music and was in a very excited condition. And his medical attendant urged his removal to the asylum without further delay. J.'s mind as far as I can see has given way under the shock of the very sudden death of his brother. He is a lad who would never touch liquor. I think it is right I should mention that I had an uncle who died in an asylum. I cannot however give particulars. Trusting J.'s reason will be restored to him.

From Yours truly William K..

\* Inspector of Poor

This is the first attack and is of a few days duration. The cause is mental shock.

He is both suicidal and dangerous to others. An uncle of his father is insane.

- 1) H is talkative, restless and violently religious. He cannot be conduced to keep quiet and argues with everyone on religion inquiring in an incoherent way as to their salvation and declaring their sins pardoned.
- 2) Is excited and very noisy. Muttering in an incoherent manner on religious subjects. Says his body is dead and buried and that he is in heaven.



Mentally he is very excited and is very treacherous and strikes out and kicks without prevarication. He is constantly talking says that he is in heaven and asks everyone what their earthly name was. Does not take his food himself so has to be fed with a spoon. He sleeps badly at night notwithstanding a draught of paraldehyde.

- 10 May 1898            He is still excited and restless to permit a physical examination. Does not talk quite so much. He is getting somewhat feeble and exhausted.
- 12 May                He is now in a state of exhaustion. Lies quietly in bed but at times gets excited, throwing the clothes off. He is not taking his food well and will not take any medicine. Nothing abnormal can be detected in his lungs. Heart's action very feeble.
- 15 May                At 9 o'clock this morning patient became much worse. Pulse almost imperceptible, breathing slow and laboured. At 11 o'clock he was given a hypodermic injection of Lij Strych. Pulse improved somewhat but the effect passed off in about an hour. Another hypodermic was given to him at 6 PM and as he was unable to swallow even liquid he was given a beef "emule". He showed little or no improvement after this and died from exhaustion at 9.32 PM.

CASE E: E.M.  
Gartloch Casebook of Female Admissions  
(1901), HB1/13/6

Name E.M.  
Admitted April 18 1901

Class I  
Form mania                      Cause Adolescent  
Hereditary Predisposition to drink

Aged 19 Single                      Weaver Protestant

First Attack      Cause uncertain  
Not epileptic but suicidal and dangerous

Mother is Margaret W. or M. of 33 Gray Street, Parkhead

*Medical Certificates.*-1) "she is foolish in her manner and appearance, answers questions in a confused way, laughs and sings to herself and refused to work or do anything whatsoever". "Her mother" states that she has been in this state for weeks and is occasionally violent in her conduct. 2) She is restless, excited and foolish in manner and appearance, she gives incoherent and foolish answers to questions and she is apparently quite delusive in her ideas.

Mrs R. (minister's wife) Parkhead Parish Church  
Father very drunken "a horrible man." Wife very steady hard worker. Known of no H.P. [hereditary predisposition] or crime. Patient was a nice steady girl and was not long ill before admission – only a few weeks.

Sits giggling causelessly and continuously. She will not or cannot pay attention to questions but two out of many she did answer. She states that she is 19 and a weaver.

April 20                      This girl has laughed for two days but is now settling a little and answers questions and helps a little in the ward work. She is still foolish and inclined to giggle but appears free from delusions. She is fat and nosy.

April 29                      Up till yesterday, this girl was doing very well and worked steadily and well in the kitchen and was pleasant and orderly in her relations with those around her. She ate and slept well and had ceased to giggle. Yesterday she became dull and would not work, sat in her chair motionless and had to be roused to eat even. Today this was more marked. She appears to be passing into a stuporose condition. She will pose for a time in any attitude she is placed in and needs to be fed.

Evening: after being fed at tea time this girl let herself slip down on the floor and her face began to twitch and she began to mumble her saliva and hawk up and spit. She lay and arched her back and rolled about and made a loud noise. She appeared to be trying to simulate a fit.

Sensations and reflexes quick and good if taken by surprise. She rolled off her chair and off the sofa but came down feet first and very gently.

- May 6<sup>th</sup> Remains in a continuous stupor. Is hand fed all her food. Has not given any trouble yet with bladder or bowels. Reflexes impaired but not absent. Saliva dribbling from her mouth semi cataleptic, the hand and arm when extended remaining in that position for some time. She cannot be roused to do anything.
- May 9<sup>th</sup> Two days ago the stupor passed off and suddenly and she became active and talkative and distinctly above the line of health. She now takes her food well herself, is happy and smiling and amorous but with much silliness running through all her actions. She sings and talks a great deal and at times answers questions quite rationally. Has written a sensible letter to her friends.
- August 27<sup>th</sup> This girl has all summer been in a state of mania. She is mischievous and often destructive, restless, vain and erotic and cannot be got to employ herself in useful work. At night she has often been noisy and has undressed and exposed herself. Blistering her neck and sulfonal made no improvement. At present she is getting 30 gram K or RBv [?] 3 times a day. She is on the whole better. She is less noisy and mischievous and she sleeps and eats well and her dress is tidier and less tawdry.
- Sept 18 Is kept entirely in bed and is making but little of it though for a few days has seemed better a trifle. She is getting 5 gram doses of thyroid extract.
- Jan 15<sup>th</sup>  
1902 This girl shows a very marked improvement. She is plump and rose, bright and fairly intelligent, acts on her own initiative in taking up work and is reported to work steadily and well. Menstruation occurred about a fortnight ago without having a bad influence on her mental condition. Altogether the condition seems very promising of a full recovery.
- Feb 1<sup>st</sup> Is keeping very well and is today discharged.

CASE F: M. G. or O.  
Gartloch Casebook of Female Admissions  
(1901), HB1/13/6

Name: M. G. or O.

Admitted 4 Sept 1901

Mania

Aged 38

Married

Domestic

Protestant

1<sup>st</sup> attack

Duration a few days

Cause: pregnancy

She is epileptic, suicidal and dangerous

Information from patient's husband

Information on Sept 7<sup>th</sup> 1901

Married about 21 years ago. Husband has no knowledge of her history previous to marriage. She has had in all 6 children and 2 miscarriages (at about 6 months cause unknown). Five children are alive and well. The seventh child died at 10 years (pulmonary). The second last child in 6 years old. There was a miscarriage 4 years ago.

Patient was quite well – tidy – up till the miscarriage 4 years ago. Sometime after that she took to drink. She would sit all day undressed and neglected her house and children. Gradually getting worse and for the last three months has been occasionally violent. Has attempted to cut her husband's throat, has ill-used her children in addition to breaking the household furniture. For the last two years has been leading a loose life and her husband says he is not the father of the child born here. Her husband denies venereal disease. He knows nothing of his wife's people except that her mother was a very heavy drinker.

Medical certificate – she is restless, excited and foolish in behaviour and she is quite incoherent in her talk and delusive in her ideas.

Sept 4<sup>th</sup> On admission was most markedly resistive. She won't sit, stand, lie down, dress undress etc. She is filthy and lousy. She is not noisy but is in a very excited condition and yet very stupid. She won't speak at all. Her strength is very considerable and she is very obstinate. She appears to be far advanced in her pregnancy but a detailed examination is utterly impossible. She was admitted at three am and slept none afterwards spending the night on her feet. This forenoon she has spoken a little and answered questions, occasionally coherent (she says that she used to have fit as a girl, five years ago got worse and has had none for last year). She today tried to get out of the windows as well as the doors and has only had three glasses of milk so far.

Sept 5<sup>th</sup> Last night at about midnight this woman gave birth to a child (son). Her violent behaviour may have brought it about rather prematurely but if not full time the child is very near it. She is mentally much better today and speaks quite sensibly for short periods at a time. There is a manifest prolapse of the lower end of the bowel and the patient strains and struggles so that all efforts to return it have failed.



- Sept 6<sup>th</sup> Is very excited and troublesome. She was today given chloroform and the bowel returned. It was kept up till 3pm when her bowels moved and again it came down. She says it has troubled her before. Her very restless resistive condition makes it very unsatisfactory to treat her. Her child has been removed from the ward as the mother's jealousy and roughness is a source of danger. Mentally she is twisted. She believes that poison is given her in her food and is very suspicious of those around her. She talks a good deal of nonsense and at intervals is quite incoherent and her actions are often very foolish. Physical examination impossible.
- Sept 18<sup>th</sup> Is much better and bowel condition is also better. She no longer suspects and resists as much as she did and she keeps her bed better and interferes less. Appears to be making a good recovery from her confinement.
- Sept 21<sup>st</sup> Is now very well mentally and is up and going about but determined to get away. The bowel condition has now improved and gives no trouble now.

Physical Examination

Sept 23<sup>rd</sup> 1901. Well developed and well nourished. No congenital defects. Expression dull and vacant. No peculiarity in shape of head. No deformities. Considerable scalding of left forearm and wrist (burn). Scar on left side of forehead about 2" and ½ . small scar on left foot and on right thigh. Linear abrasions on abdomen. Skin dark – great pigmentation of skin of abdomen and lower part of back, while nothing around breasts, chest and arms. Considerable baldness on top of head. Only a fringe of fairly thick hair remaining around the bald patch. This hair is turning grey. No evidence of tubercle. Rolling glands in each groin.

Circulatory system

Pulse 73. Somewhat irregular in rhythm. . Small and easily compressed. Apex beat punctual in 5<sup>th</sup> interspace within the upper line and about 2 ½ - 3" from middle line  
Some varicose of veins in legs

Respiratory system

Respiration 20 abdominal, natural. Expansions seem to be less in the left clavicular region than the right

Digestive system

Tongue moist and clean. Appetite and digestion said to be good. Complains of habitual constipation. Palpitations of abdomen usual – nothing abnormal.

Urine

Nervous system

Gait natural. Strength good. No ocular paralysis. Movements of eyes natural. Her pupils are unequal the left being slightly larger than the right. Both pupils react actively to light or accommodation. Speech slow but other wise natural. Sensation as

tested by touch appear normal but painful impressions are not always appreciated. Plateau reflexes are obtained but not active. The abdominal reflexes are not obtained. Colour vision is normal. Smell is natural. The field of vision is not tested. Taste is natural. Hearing is fairly good.

- April 25<sup>th</sup> 1902      She is keeping better mentally except at and after "fit" times when she is suspicious delusional and mendacious. The fits occur with no great frequency but are very severe. She is always on the look out for escaping. She is in good bodily health and works generally and steadily well in the laundry. About 6 weeks ago she escaped but was caught and brought back.
- Oct 17<sup>th</sup>              Continues to work in laundry. She is a constant beggar for days off. She works well and apparently thinks she earns a holiday. Fits occur much as before and her general health remains fair.
- April 14<sup>th</sup> 1903      On 9am third of this month she took a fit in the laundry and fell forward with her hands in the wash tub and her left arm under the hot running tap:- her arm and hand and the left side of her face and scalp – especially the arm were severely burned. Two days afterwards she had a right haemophilia with unconsciousness which lasted for about one hour but for several days she has stayed silent. A few days afterwards there was noticed the slight loss of power on the left side of the face also but this soon passed off. At the same time as the original haemophilia, aphasia was noted and remained complete for 6 weeks after which time she was able to say "yes" but not to repeat anything said to her or to write. The haemophilia has nearly passed away now but there is still some paresis of the right arm. She is at times very emotional. It was observed that almost all her gain in power was lost for a few hours or even a day after a succession of fit – this is also less marked now although still present to a slight degree. She is now able to walk about at times and help with ward work but is not much use. Her arm is well. The vocabulary at present comprises of "yes", "fine" and "it's a fine day" and it is only within the past 6 weeks that she has seemed to clearly understand what is said to her. She is not yet able to repeat anything she is asked to say. Her bodily health otherwise is fairly good.
- Nov 6<sup>th</sup>                Aphasia is still almost complete though there is some gain of her power so she can do a little simple work i.e. polishing but anything like a return to her previous normal is out of the question. She is much more demented too but less irritable. Fits are still very severe. Physical health is good.
- April 6<sup>th</sup> 1904      Continues simple work like polishing: aphasia nearly complete still. Bodily health and condition good.
- Oct 15<sup>th</sup>              No change. Subject to erythema of scalp.

- Mar 24<sup>th</sup> 1905 Gives little trouble. Can only say yes or no (aphasia) but understands all said. Bodily health and condition fair. Still takes severe fits and is at intervals noisy and excited.
- Sept 6<sup>th</sup> As in March
- June 25<sup>th</sup> 1906 Scabs on head and hair scarce. Nutrition good. Tongue clean, teeth in poor condition. Pupils equal and react to light. Heart sounds of good quality.  
No sign of disease
- April 12 1907 Generally as mentioned in March. Had seven fits at night during this month, is irritable but a fair worker in C ward. Has lost weight, is now 8 stone 4lbs.
- Feb 27<sup>th</sup> 1908 In C. Has recently been more irritable. Weight Jan 8 stone. Had 5 fits in January
- Oct 1<sup>st</sup> Appears to have had a slight hemorrhage. A few days after lost power of her left leg.
- Nov 5<sup>th</sup> About 14 days ago had a slight pyrexia and then difficulty in swallowing noticed. Died at 7.45am.

CASE G: S.A.C.I.  
Woodilee Casebook of Female Admission,  
(1905), HB30/5/11

Name S.A.C.I

Age 33      Married Yes      Single -      Widowed -

Religion Protestant

Whether First Attack

Duration

Length of Time insane

Previous Care

Kirklands Asylum, Bothwell 6 March 1905 to 23 March 1905 (Transfer)

Address of Nearest Relative Husband, James I., 105 Camden Street, Govan  
Admitted 23 March 1905

Facts of Medical Certificate

She labours under delusional insanity. She gives expression to delusions chiefly of suspicion and of persecution at the hands of her husband and her neighbours.

Date of Sheriff Order 7 March 1905

Previous History ascertained from synopsis of present illness,  
previous health, Social History and Family History

### STATE OF ADMISSION, SYNOPSIS OF

Diagnosis

Prognosis

Summary of Treatment

Summary of Progress of Case

*History as obtained from her husband – James I.*

The father of this patient is dead having died in Kilmarnock Infirmary at the age of 45 years. Cause unknown. About 20 years before his death he suffered from some affection of the knee joint. Her mother is also dead, having died at the age of 42 years, cause unknown, may have been paralysis of some kind. She has one brother living and two sisters dead. They died in childbirth – aged one and two years respectively – cause unknown.

On father's side no friend known to have been in an asylum. Patient's father was drunken and erratic. Did not provide for his family, was lazy, ill tempered and jealous. He was a good musician and taught bands, was also handy. Patient's brother is erratic also, quick in temper and extremely deceitful. No friends on mother's side [has] ever



in an asylum. Patient's mother was a sensible woman and free from disease. Her friends show no tendency to any particular disease.

Patient was always erratic, her temper was short and violent. She was generally overbearing and unreasonable and her husband had to give way to her for peace's sake. In November 1903, delusions became more manifest. There were telephones in her room by which her neighbours heard everything said there. She was always reserved and suspicious but her suspicions now increased. People were watching all her movements and operating on her by electricity. She said that her husband should have his head cut off and his brains examined as he was mad. She would go to a friend's house and refuse to leave it. She would wander about the streets, speaking to no one and leave her children alone in the house. She has suffered a good deal from indigestion. Twelve years ago she had fever (probably enteric) and was ill 3 or 4 weeks. The present attack may be said to date from around 1903. No previous acute attack. She has always suffered from irregular menstruation. She was in Norway a few months with a family with whom she was a domestic servant. Her circumstances were always comfortable. She was never addicted to alcohol and never took drugs other than purgatives which she is said to have abused. She is married and has 4 of a family – 1 boy and 3 girls, all living and healthy. The eldest girl is moody but can be easily roused.

### Physical Condition

Weight 7 stone 11 lbs

Height 5 feet

Patient is pale and anemic. She was confined 5 months ago, but she has been ailing for some months previous and a month ago after the confinement she had a severe flooding while out walking. She also had an acute mammary abscess which was raised in two or three places, subsequently she became extremely weak and exhausted. She answers questions in a fairly rational manner and can give a full account of herself. She seems to be suspicious of her husband and blames him for bringing her here. She is fairly quiet and is not emaciated. Her limbs are well shaped and her muscles are in good tonic shape. Her chest is slightly flattened but expands quite freely. Percussion note is not impaired and no adventitious sounds can be detected. There is no impairment of the vocal chord or vocal resonance.

Heart sounds are weak but fairly regular – no murmurs can be heard. Pulse is regular soft and full – rate 90 per minute.

Lung [?] is slightly displaced downwards – normal in size. Appetite is good and bowels are regular.

Tongue is moist and slightly coated in the centre. Fine fibrillate tremors are present.

Her abdomen is covered in the lower part with stretches and the skin over it is loose and lax. Muscles here are toneless. No abnormality can be detected.

### Nervous System

Her pupils are normal and contract to light and accommodation. Knee jerks are normal in both limbs.

Abdominal and epigastria reflexes are absent. Ankle bone [?] Is absent in both limbs. Gait and station normal.

**Urine**

S.G. 1012. Light amber Colour. Slight powdered ivy deposit (oxalate of calcium) No sugar or blood.

**PROGRESS OF CASE**

- 26.03.05 This patient had a fainting fit today. It occurred as she got out of bed to go to the lavatory and resulted in her falling on her forehead, afterwards she complained of pain on the frontal bone.
- 8.4.05 Since admission, this patient has been very quiet, resting well in bed, at times she becomes very talkative about her relationship with her husband, but it is impossible to say if there is much fiction about the ill treatment to which she says she has been subjected. There is just a suggestion of apathy and lack of interest in things in her general behaviour.
- 18.5.05 This woman gave me this morning a very long rambling statement regarding her husband's treatment of her. She states that her husband kicked her and also kicked her three little girls. She did not tell her story in a coherent manner. Her bodily health is fair. She did not sleep well last night.
- 30.5.05 She is a very hard patient to manage, wants to have her own way in everything. The last bathing day she objected to have her hair washed and because the nurses insisted she struck out all round. She refuses to do any work, reads a book all day and is always trying to get into corners, behind screens.
- 25.10.05 Has been giving trouble again. On Monday morning when she came back from tea she was using abusive language to the patients. Nurse Anderson asked her to be quiet and she flew at her, tore off her cap, pulled down her hair and gave her a blow on the mouth. A few days before this she attacked Nurse Morrow and scratched her face. When asked for reason for doing these things she always says that it is the nurses who attack her and that she never struck them. On Monday evening another patient Mrs. M. was present at the time of the attack and corroborates Nurse Anderson's statement. Had it not been for this patient's help Nurse Anderson would have fared badly.
- 27.12.07 Mentally she is becoming worse. Is more incoherent and rambling in her talk and delusions of persecution are more marked. She is always grumbling about something. She will do no work.
- 23.1.11 She is very voluble in conversation and is a chronic grumbler making strong complaints on the slightest pretext. Her emotions are easily stirred and she is lacking in will power. Her physical condition is fair and she is working in the laundry.

- 30.9.12 Refuses now to work. Delusions of persecution are fixed. Bodily health fair.
- 22.10.13 She has been working well for several months in the kitchen. She has not expressed ideas of persecution for many months. Bodily health is fairly fair.
04. 9.14 No change
- 20.10.14 Transferred

*(No further details given of the case)*

CASE H: H.A.  
 CRI Casebook of Male Admissions  
 (1908 – 1913), DUM.CRI.1989.153

**Name:** H.A.

**Admitted:** 4 April 1911

**Sex:** male

**Age:** 39

**Marriage:** single

**Occupation:** Doctor

**Education;** very good

**Religion:** Presby.

**Private or pauper:** private: 150

**Where from:** Belfast

No restriction on letters

### HISTORY

**Disposition:** Highly strung, nervous, irritable, sensitive, easily upset.

**Habits:** None as far as known. Very clever, quick, brilliant student

**Previous Attack:** None

**Kind:**

**Where treated**

**Hereditary Insanity:** father nervous and highly strung

**Other disease** mother died of phthisis

**Predisposing**

**Exciting**

***First Symptoms Mental & Bodily:***

Patient who was a good student graduated about 12 years ago and after doing locum work and taking a voyage to South America went out to India as a doctor to a "tea plantation". When doing a circumcision he is stated to have contracted syphilis and was removed to a hospital in Calcutta where he remained for 4 months and underwent treatment. Was discharged and returned to work but became suddenly violent and was sent to an asylum in Calcutta. Remained there for three months and after great difficulty was brought home in a troop ship – landing about 2 weeks ago and going direct to Belfast.

**Recent Symptoms**

Since then he has been the subject of delusions and hallucinations upon which he at times acts and thereby becoming very difficult to manage. Recently he has been improving.

**Insane habits and propensities**

**Suicidal:** no

**Dangerous:** no

**Duration of existing attack:** 9 months



**Other facts or remarks: not epileptic**

Letter of 8/11/10: Captain Kegan who is in charge of the asylum in Calcutta thinks the case is one of GPI. Contracts syphilis after doing a circumcision shortly after going to India. Went through long course of mercury. Much exposed to all sorts of weather and about 1 year ago had much worry.

Presidency Calcutta Hospital  
Feb 27<sup>th</sup> 1911

Dear Mrs Dunn

Your brother will probably reach home at about the same time as this letter. I am afraid that you will all find him considerably changed in disposition as he is by no means completely well yet. For the last few weeks he was very quiet except for an occasional outburst when something annoyed him but he still was under the impression that providence was torturing him and in consequence his language was sometimes blasphemous. Of course the proper line of action to be adopted in his case will depend largely on what happens during the voyage. If he should give any trouble when he arrives home you should advise that he be sent at once to an asylum even if he should raise objections himself. His general health was good while here, he put on weight considerably after the first four weeks and on the whole he was quite contented. You must not hope for a complete recovery all at once and even at the best I am afraid that there will be some permanent impairment. I should like to hear how he progresses after his return home.

Yours sincerely  
WE Kegan

**Facts of medical certificates**

Restless, excitable. Affirms that he hears voices from God commanding him to cease taking medical treatment. Says that he took ill in April 1910 and that the present year is 1915.

**STATE ON ADMISSION****Mental**

**Exaltation:** the true nature of this patient's usual state is somewhat unclear and obscure but the diagnosis would appear to lie between general paralysis and syphilitic paranoia. He certainly has well marked delusions of grandeur, thinks that God has offered him the title of "King of kings".

**Excitement:** Delusional excitement about the 'Diety' and his doings, knows no bounds. He thinks that he is persecuted by God, that he is tortured by him, thinks that he hears him talking to him. His delusional state is fundamentally not that of a GP

[general paralytic] and there are not sufficient physical signs to justify that diagnosis at present.

**Enfeeblement:** He thinks that people have been reckoning wrongly and that this is the year 1915. Is at times very emotional, shouts and curses and bemoans his lot.

**Can answer questions**

**Memory**

**Coherence**

**Delusions** (see above)

**Bodily**

**Appearance:** impulsive highly strung appearance

**Skin :** clean

**Hair:** dark

**Eye:** (only one) brown

**Pupils:** "one only" (nothing abnormal)

**Muscularity:** fair

**Fatness:** spare

**Nervous system**

- *motor.*

nothing abnormal

- *sensory*

Nothing abnormal. Reflexes normal.

**Reflex Action:** all reflexes tremendously exaggerated

**Special senses;** artificial eye

**Retina**

**Lungs:** healthy

**Heart:** aorta rather weak. Sounds slapping

**Tongue:** dirty

**Bowels**

**Other organs, abnormalities, bruises:**

There is a distinct swelling on the right mastoid

Slight eczema rash on legs and groins

**Appetite:** fairly good at present

**Urine:** contains no abnormal constituent

**Menstruation**

**Pulse:** 70.

**Height** 5 ft 7 ½

**Weight:** 9 st. 4 lbs

**Disease:**

**Skæ's classification**

**General Bodily Health and Condition** Poor

### PREDOMINANT FEATURES

A Acute Delirium and in- coherence	B Simple Excitement	C Simple Depres- sion	D Stupor	E Hypoch- ondria	F Strong Suicidal Impulse
G Remitt-ency or inter- mitency	H Choreic move- ments	I Halluc- inations	J Enfeeble- ment		

### PROGRESSION OF CASE

- 5.4.11      Had a fairly good night.
- 10.4.11     No improvement as yet. He is outside in bed and his delusions are still most persistent. He abuses and curses his "maker" whom he thinks is poisoning him, culling short his life.
- 17.4.11     Remains much the same both mentally and physically.
- 25.4.11     If anything a little quieter. Is still of the same opinion about his maker but is not so obstinate and loud in his language against him.
- 30.4.11     Still keeping rather better.
- 9.5.11      Patient has today been allowed his clothes and is getting up. Still in the Low West.
- 15.7.11     Moved to Mid West, has improved but still hears voices.
- 25.8.11     In status quo but does not hear the voices so often.
- 21.9.11     Not so well, moved to the Low West, his eye offended him so he plucked it out and cast it from him
- 1.10.11     Is better again and back in Mid West. Seems like a G.P [general paralytic] now
- 6.10.11     Removed to Lower West very unsettled.
- 17.10.11    Patient today seized a piece of paper, lighted it at the fire and tried to set fire to himself.
- 10.11.11    In all his actions he is a typical GP.
- 14.12.11    Patient is going downhill. Stupid and easily excited.

- 29.12.11 Patient's condition is now in all respects mental and physical, that of a general paralytic and is steadily becoming weaker.
- 10.01.12 No change demented.
- 22.10.12 A case of G.P steadily going downhill. Is still in the Low West but his life is now a mere animal existence.
- 13.3.12 Transferred today to intermediate division
- 7.5.12 Died today



### Appendix four

Poorhouse admission form for Lismore and Appin (17 April 188\_)

## PARISH OF LISMORE AND APPIN.

Name of Pauper, *Flora M. Call*

I have this day examined the above-named Pauper, and hereby certify, on oath and conscience, the particulars underwritten to be true, to the best of my knowledge and belief.

(Signed) *Archibald Mackay*  
Medical Officer.

(Date) *17<sup>th</sup> April*

Is the Pauper in good health? *No*  
 Is the Pauper able to do any work? *She is able to do light work*  
 Nature of Pauper's sickness or infirmity? *Debility*  
 If Pauper has Dependents, state whether they or any of them suffer from sickness or infirmity, .....  
 Nature of sickness or infirmity of Dependents .....  
 Does the condition of Pauper or Dependents require immediate attention and medical advice? *No*  
 Is Pauper or any Dependent *lunatic, insane, idiot, or of unsound mind?* *No*  
 Are Pauper and Dependents able to be removed to the Poor House or Loxh without injury to their health? *Yes*

\* No Person or description can be legally sent to or received in a Poor-house unless it possesses licensed lunatic ward, and then only with the sanction of the General Board of Lunacy.

No.....

## PARISH OF LISMORE AND APPIN.

.....188.....

SIR,

Please to admit the Bearer into the LOXH COMBINATION POOR HOUSE, chargeable on the PARISH OF LISMORE AND APPIN.

NAME	AGE		Married or single.	Trade or Occupation. Religious Persuasion.	REMARKS.
	Years	Months			

DONALD MACINTYRE,

Inspector of Poor.

To House Governor, Loxh Combination Poor House

## Appendix five

Correspondence from James Rutherford (medical superintendent of the Argyll and Bute District Asylum) to Mr Cameron (Inspector of Poor for Lismore and Appin) regarding the transfer of a patient from Perth District Asylum (1873).

Argyll and Bute District Asylum  
Lochgilphead 17 January 1873

Mr Angus Cameron  
Inspector of Poor  
Lismore and Appin

Dear Sir,

I am in receipt of your letter of the 14<sup>th</sup> Instant. On receipt of a letter from the Medical Superintendent of the Perth asylum enclosing order for transfer of Mary M. and requesting, as he could not spare a nurse, that I might send one for her, I sent one for the patient. I was aware that you wished the services of a nurse to aid you in bringing the patient here. But the experienced attendant that I sent did not require any third party with her and the patient. In fact you, or anyone else, would have been in the way, as the nurse was quite able to bring the patient alone. No charge is made to your parish for the nurse's service. The outlay only is charged.

It is my desire as much as possible to aid Inspectors of Poor in such matters as the admission, discharge and transfer of patients, though I must admit it is no part of my duty. It was purely in this spirit that the nurse was sent to Perth without waiting for you – merely to save you unnecessary travelling. This act you designate “mindless interference with your duty”. I hope that you will not again request any aid from us in bringing patients here. Hitherto I have only had thanks from Inspectors for such assistance given and I certainly decline again to lay myself open to such charge as you have made in your letter.

Yours truly  
James Rutherford

*Source: Correspondence, Inspector of the Poor for Lismore and Appin, (1873), CO6/30/30/5.*

## Appendix six

Letters sent from James Rutherford to Mr Cameron regarding the  
Boarding out of patients (1870-71)

### Letter one

Argyll District Asylum  
Lochgilphead August 13 1870

Sir

F.M. although irritable at times and disposed to show a little temper when crossed, is in my opinion harmless. Therefore if her friends feel disposed to be at a little trouble with her I see no reason why she should be detained in the asylum. It is merely a question of whether they will bear with her and take a little trouble to pacify her when cross. If they agree to do this I recommend that she be boarded with her friends.

I am,  
Yours truly  
James Rutherford  
Medical Superintendent

To  
Mr Cameron  
Inspector of Poor  
Lismore and Appin

Letter two

Argyll District Asylum  
Lochgilphead August 15 1870

Mr Cameron  
Inspector of Poor  
Lismore and Appin

Sir, I find that there are two patients in the asylum called F.M.. One from Mull and one from your parish: the one from Mull has been longer here, is unmarried and is known by her proper name. The other is known by the nurses (as a distinctive) as F. C. and it was only this morning that I learned that her proper name is Mrs F.M. and that it was she to whom your letter referred. In answering it I thought of the other.

Flora C. or M. is a very different case from the one regarding which I wrote on Saturday. She is yet capable of further improvement and I would not say that she was incurable, she is listless and melancholic, 45 years of age, a critical period – moved to her home now her chance of recovery or even improvement would be greatly diminished. Therefore I recommend that she be confined in the asylum for sometime yet.

The case from Mull is harmless and absolutely incurable – all such cases are in my opinion better boarded out than confined in asylums.

Yours truly  
James Rutherford  
Med. Supt



Letter three

Argyll District Asylum  
Lochgilphead August 20 1870

Mr A Cameron  
Inspector of Poor  
Lismore and Appin

Sir,

I am in receipt of your letter of the 17<sup>th</sup> saying that Flora C.M.'s husband is anxious to have her home and that the Board are inclined to assist him to support her.

I presume that you have not received my second letter dated 15<sup>th</sup> when yours was written and suppose that it alters the position of the board to remove her at present.

Your obedient servant

James Rutherford  
Med. Supt.

Letter four

Argyll District Asylum  
Lochgilphead September 4 1871

Mr Cameron  
Inspector of Poor  
Lismore and Appin

Sir,

I have had F.M. under special observation since the last report I wrote on her condition and I really think she is as well as we can make her. I can scarcely call her a complete recovery but she is very much improved, probably as well as she had been for years before her admission into the asylum and before the attack which came on which necessitated her removal to it. Please send her husband for her.

Yours truly  
James Rutherford

*Source: Correspondence, Inspector of the Poor for Lismore and Appin, (1870-71), CO6/30/30/2-3.*

## Appendix seven

Case of C.M. admitted to the Argyll and Bute District Asylum in 1872.  
Correspondence taken from the Lismore and Appin Parochial Board and James  
Rutherford, Medical Superintendent of Argyll and Bute District  
Asylum in Lochgilphead.

### Letter one

Brecklet Stores  
Ballachulish

Feb 23<sup>rd</sup> 1872

Mr Angus Cameron

Dear Sir

It is now evident that C. M. must be taken away and sent to the asylum. he was for a few days up at Lochgilside along with his uncle but could not be prevailed upon to stop but a very short time. Since his arrival home he became violent and had no help been at hand he would have taken the life of his mother. They are now in terror of him and cannot sleep at night whilst he is in the house, his poor father came up to me this evening and told all this and desired to write immediately that he could not be removed too soon and that he was afraid what might happen if any delay would take place.

Please look into this case as quick as you can.

Yours always  
Angus McKenzie

Letter two

Glencoe

27 March 1872

Dear Sir\*

I have just seen C. M. He, I understand has been very much excited today. Seeing that his friends are so peculiar I shall not interfere in this case (i.e. to give a certificate for his removal to the asylum) until I have your orders to do so. They are the most disagreeable people I have had to do with for some time and I mean to let them manage as they may think best.

I am yours truly  
A Blair\*\*

\* Angus Cameron, parochial officer

\*\* presumably the parochial medical officer



Letter three

Lochgilphead District Asylum

23 September 1872

Inspector of Poor  
Lismore and Appin

Dear Sir

C. M. from your parish made his escape on Saturday and I dare say by this time has reached home. He was convalescent and allowed a good deal of liberty but the fact of his escaping leads me to think that he was not so well as I considered him.

However, I do not think it necessary to bring him back to the asylum at present. Please ask your medical officer to call and see him, examine him and send me a certificate as to his state. By that I will be pointed as how to discharge him as recovered or merely relieved.

Yours truly

James Rutherford  
Medical superintendent

Letter four

Argyll and Bute District Asylum  
Lochgilphead

31 September 1872

Angus Cameron  
Inspector of Poor

Dear Sir

I received your telegram about C. M. and beg to thank you for your attention. By this time he will have arrived at home. Please let your medical officer say whether it is necessary for him to be returned to the asylum or whether he is fit for discharge. I may mention that his running away is the worst symptom of insanity I have seen in him for a considerable time and that I was going to discharge him very soon.

Yours truly  
James Rutherford

Letter five

Mr Angus Cameron  
Inspector of Poor  
Lismore and Appin

28 Oct 1872

Dear Sir

I am in receipt of your favour of the 21<sup>st</sup> instant regarding C. M. and also of a letter from his father in which he states "C. is better than he was when he went under your care but very dull yet" and asks for medicine. No medicine will do him any good. The moral treatment in the asylum is the only thing for him (his bodily health being very good) and if he cannot be managed at home the only course is to send him back here. I am sorry he is not so well – before his escape he was very much improved.

Yours truly  
James Rutherford

Letter six

Argyll and Bute District Asylum  
Lochgilphead

3 December 1872

Mr Angus Cameron  
Inspector of Poor  
Lismore and Appin

Dear Sir

I am sorry that C.M. will require to be brought back. A fresh warrant is necessary the expense of which will require to be defrayed by the party at whose instance the warrant is sought. If your board demur at the expense you may remind them that the patient has been more than 10 weeks out of the asylum thus saving nearly £5 to them and besides has had a good chance of recovery, in fact has proved that he cannot reside outside of the asylum – a proof of great benefit to him for as I told you in my former letters I would sooner in any case have discharged him.

As you seem to think there is some hardship in this case, (though I cannot see it myself) I will if it will save you any trouble or expense send an attendant for the patient, charging your parish board and outlay only. If you have difficulty in obtaining a second medical certificate and the sheriff warrant these can be obtained here. I will do anything in the way of trouble to assist you with this case but I cannot defray any necessary outlay.

I am  
Yours truly

James Rutherford



## Appendix eight

Circular issued to medical superintendents regarding the reception of Voluntary boarders in their asylums, (1892)

Reception of voluntary boarders under the provision of Section 15 of the Act 29 and 30 Vict. Cap 51.

The statutory provision relating to voluntary boarders has worked well and has proved to be exceedingly useful; but the fact that its benefits are becoming more widely known and more extensively taken advantage of makes it desirable that the limitations fixed by the statute should be kept steadily in view and that inducements to give a lax interpretation of the statute should be carefully guarded against.

The Board fully recognise that there is no hard and fast line which separates those who may properly be certified as lunatics from those who could not be properly be so certified. In determining therefore whether a Voluntary Inmate or a proposed boarder ought or ought not be certified, much must necessarily be left to the discretion of the Medical Superintendent.

Persons who have entered asylums as voluntary boarders are not infrequently found to be in a condition requiring certification and compulsory detained and often regard themselves, not unnaturally, as having been entrapped by the procedure, and feel a sense of resentment at their voluntary action having been, as it seems to them, taken advantage of to secure their confinement.

In the case therefore of all Voluntary Boarders requiring to be certified, and especially in the case of those whose mental condition has not undergone a marked change since reception, the Board strongly recommend that the friends should be advised to remove the patient, on certification in which he has been a voluntary boarder, to another Asylum.

## Appendix nine

### Admission, discharge, death and recovery rates at Scottish Asylums between 1858 and 1914

Table: a: Private patients:  
Admissions, Discharge, death and recovery 1858-1879

Year	Total	Total	Rec.	Total.	Not. Rec	Total	Died	Total
	Admitted	Rec.	% <i>disch.</i>	Not Rec.	% <i>disch.</i>	Died	% <i>disch.</i>	Discharge/ Died
1858	428	171	41%	168	40%	80	19%	419
1859	400	162	43%	134	35%	84	22%	380
1860	400	159	43%	136	37%	77	21%	372
1861	453	167	42%	165	41%	70	17%	402
1862	403	137	36%	167	44%	76	20%	380
1863	389	161	43%	132	35%	82	22%	375
1864	374	155	45%	125	36%	63	18%	343
1865	442	166	43%	160	41%	64	16%	390
1866	468	191	46%	129	31%	91	22%	411
1867	484	191	43%	167	38%	84	19%	442
1868	428	169	39%	158	37%	103	24%	430
1869	488	197	44%	175	39%	75	17%	447
1870	476	196	44%	162	36%	92	20%	450
1871	535	172	37%	206	44%	91	19%	469
1872	431	161	39%	165	40%	88	21%	414
1873	498	176	39%	178	40%	96	21%	450
1874	479	186	40%	191	41%	85	18%	462
1875	522	198	40%	192	39%	103	21%	493
1876	562	189	38%	179	36%	124	25%	492
1877	522	214	41%	219	42%	91	17%	524
1878	517	193	39%	207	42%	89	18%	489
1879	528	177	36%	228	46%	86	18%	491
<b>Total</b>	<b>10227</b>	<b>3888</b>	<b>-</b>	<b>3743</b>	<b>-</b>	<b>1894</b>	<b>-</b>	<b>9525</b>

Table b: Pauper patients  
Admissions, Discharge, death and recovery 1858-1879

Year	Total	Total	Rec.	Total.	Not. Rec	Total	Died	Total
	Admitted	Rec.	% <i>disch.</i>	Not Rec.	% <i>disch.</i>	Died	% <i>disch.</i>	Discharge/ Died
1858	1198	452	46%	246	25%	290	29%	988
1859	1203	442	46%	238	25%	276	29%	956
1860	1204	491	45%	270	25%	335	31%	1096
1861	1196	502	45%	284	26%	319	29%	1105
1862	1135	439	40%	289	27%	362	33%	1090
1863	1250	452	38%	447	37%	301	25%	1200
1864	1611	429	29%	712	48%	335	23%	1476
1865	1320	462	40%	391	34%	299	26%	1152
1866	1774	482	29%	810	50%	342	21%	1634
1867	1583	513	37%	457	33%	419	30%	1389
1868	1535	584	45%	358	28%	349	27%	1291
1869	2014	596	33%	742	41%	453	25%	1791
1870	1677	646	41%	493	31%	449	28%	1588
1871	1632	638	40%	502	32%	448	28%	1588
1872	1688	714	45%	455	29%	426	27%	1595
1873	2012	813	42%	631	33%	471	25%	1915
1874	1923	754	43%	574	33%	429	24%	1757
1875	2231	776	39%	767	38%	458	23%	2001
1876	2390	903	42%	792	37%	461	21%	2156
1877	2263	900	45%	627	31%	470	24%	1997
1878	2230	861	43%	650	33%	489	24%	2000
1879	2178	865	43%	626	31%	533	26%	2024
<b>Total</b>	<b>37247</b>	<b>13714</b>	-	<b>11361</b>	-	<b>8714</b>	-	<b>33789</b>

Table: c: Private patients  
Admissions, Discharge, Death and Recovery 1880 - 1914

Year	Total Admitted	Total Rec.	Rec. % <i>disch.</i>	Total. Not Rec.	Not. Rec. % <i>disch.</i>	Total Died	Died % <i>disch.</i>	Total Discharge/ Died
1880	479	167	40%	175	40%	92	21%	434
1881	471	206	34%	155	34%	100	22%	461
1882	439	150	36%	147	36%	107	26%	404
1883	501	185	40%	185	40%	92	20%	462
1884	512	213	35%	172	35%	102	21%	487
1885	475	161	38%	169	38%	117	26%	447
1886	487	177	39%	175	39%	99	22%	451
1887	541	209	36%	165	36%	88	19%	462
1888	555	183	37%	166	37%	101	22%	450
1889	505	201	39%	189	39%	99	20%	489
1890	552	199	31%	154	31%	140	28%	493
1891	607	226	33%	190	33%	152	27%	568
1892	572	204	34%	166	34%	121	25%	491
1893	565	224	30%	156	30%	144	27%	524
1894	546	197	36%	170	36%	106	22%	473
1895	548	203	33%	164	33%	125	25%	492
1896	535	209	34%	179	34%	131	25%	519
1897	604	231	30%	159	30%	147	27%	537
1898	607	269	28%	168	28%	159	27%	596
1899	606	250	31%	186	31%	165	27%	601
1900	580	239	29%	168	29%	170	29%	577
1901	576	227	28%	152	28%	170	31%	549
1902	585	274	27%	166	27%	181	29%	621
1903	654	274	33%	211	33%	158	25%	643
1904	638	243	34%	207	34%	164	27%	614
1905	582	244	29%	171	29%	183	31%	598
1906	586	221	28%	166	28%	205	35%	592
1907	639	232	28%	166	28%	189	32%	587
1908	650	234	32%	190	32%	171	29%	595
1909	534	215	31%	187	31%	209	34%	611
1910	538	215	28%	144	28%	163	31%	522
1911	568	210	32%	170	32%	146	28%	526
1912	592	198	29%	176	29%	228	38%	602
1913	621	222	31%	185	31%	196	33%	603
1914	590	222	26%	144	26%	188	34%	554
Total	19640	7534	-	5993	-	5108	-	18635



Table d: Pauper patients  
Admissions, Discharge, death and recovery 1880 - 1914

Year	Total	Total	Rec.	Total.	Not. Rec	Total	Died	Total
	Admitted	Rec.	% <i>disch.</i>	Not Rec.	% <i>disch.</i>	Died	% <i>disch.</i>	Discharge Died
1880	2343	941	44%	661	31%	518	24%	2120
1881	2572	982	43%	783	34%	539	23%	2304
1882	2389	962	40%	873	36%	566	24%	2401
1883	2478	1035	43%	791	33%	605	25%	2431
1884	2476	990	41%	823	34%	578	24%	2391
1885	2566	920	37%	1012	40%	581	23%	2513
1886	2383	961	40%	844	35%	576	24%	2381
1887	2351	876	39%	776	35%	596	27%	2248
1888	2436	944	42%	691	31%	608	27%	2243
1889	2517	944	40%	807	34%	593	25%	2344
1890	2534	975	41%	739	31%	638	27%	2352
1891	2703	959	38%	765	31%	776	31%	2500
1892	2767	1112	42%	810	30%	745	28%	2667
1893	2851	1185	44%	801	30%	723	27%	2709
1894	3088	1130	41%	897	33%	712	26%	2739
1895	3254	1164	37%	1139	37%	814	26%	3117
1896	3173	1131	41%	922	33%	721	26%	2774
1897	3516	1168	37%	1188	38%	808	26%	3164
1898	3403	1293	43%	876	29%	816	27%	2985
1899	3318	1289	42%	853	28%	934	30%	3076
1900	3420	1276	41%	908	29%	958	30%	3142
1901	3401	1268	42%	842	28%	917	30%	3027
1902	3613	1346	42%	855	27%	1020	32%	3221
1903	2973	1291	35%	1270	34%	1127	31%	3688
1904	3959	1274	35%	1338	37%	1047	29%	3659
1905	3310	1215	38%	828	26%	1137	36%	3180
1906	3528	1126	33%	1123	33%	1128	33%	3377
1907	3613	1203	36%	979	29%	1189	35%	3371
1908	3231	1181	39%	734	24%	1141	37%	3056
1909	3234	1030	34%	850	28%	1184	39%	3064
1910	3137	1031	35%	706	24%	1181	40%	2918
1911	3332	1161	38%	697	23%	1179	39%	3037
1912	3293	1090	35%	769	24%	1295	41%	3154
1913	3432	1199	37%	723	22%	1320	41%	3242
1914	3575	1183	36%	736	23%	1345	41%	3264
Total	106169	38835	-	30409	-	38835	-	99859

Table e: Argyll and Bute District Asylum  
Admission, Discharge, Death and Recovery 1881-1908

Year	Total	Total	Rec.	Total	Rel	Total	Not Imp	Total	Died	Total
	Admitted	Rec.	% <i>disch.</i>	Rel.	% <i>disch</i>	Not Imp.	% <i>disch</i>	Died	% <i>died</i>	Discharge Died
1881	83	30	43%	16	23%	9	13%	15	21%	70
1882	74	31	35%	26	29%	8	9%	24	27%	89
1883	75	26	27%	34	36%	8	8%	27	28%	95
1884	81	24	36%	16	24%	7	10%	20	30%	67
1885	119	32	45%	9	13%	7	10%	23	32%	71
1886	77	43	47%	24	26%	1	1%	24	26%	92
1887	71	38	44%	25	29%	3	3%	20	23%	86
1888	67	26	25%	44	43%	9	9%	23	23%	102
1889	84	36	41%	27	31%	3	3%	21	24%	87
1890	91	29	37%	20	25%	8	10%	22	28%	79
1891	71	19	28%	19	28%	3	4%	27	40%	68
1892	69	31	46%	11	16%	3	4%	22	33%	67
1893	88	36	46%	10	13%	5	6%	27	35%	78
1894	91	27	42%	16	25%	8	13%	13	20%	64
1895	75	34	45%	10	13%	1	1%	31	41%	76
1896	58	18	33%	8	15%	5	9%	24	44%	55
1897	74	33	46%	6	8%	3	4%	29	41%	71
1898	98	34	51%	7	10%	3	4%	23	34%	67
1899	79	32	37%	19	22%	4	5%	32	37%	87
1900	69	32	42%	10	13%	5	6%	30	39%	77
1901	70	34	51%	9	13%	4	6%	20	30%	67
1902	67	34	46%	4	5%	9	12%	27	36%	74
1903	73	23	37%	4	6%	6	10%	30	48%	63
1904	64	19	36%	13	25%	1	2%	20	38%	53
1905	52	18	30%	11	18%	7	12%	26	43%	60
1906	84	18	30%	5	8%	5	8%	33	54%	61
1907	67	20	30%	8	12%	4	6%	35	52%	67
1908	67	23	37%	6	10%	4	6%	30	48%	63
	2138	800	-	417	-	143	-	698	-	2056

Table f. Stirling District Asylum  
Admission, Discharge, Death and Recovery 1881-1908

Year	Total	Total	Rec.	Total	Rel	Total	Not Imp	Total	Died	Total
	Admitted	Rec.	% <i>disch.</i>	Rel.	% <i>disch</i>	Not Imp.	% <i>disch</i>	Died	% <i>died</i>	Discharge Died
1881	145	66	54%	18	15%	4	3.3%	34	28%	122
1882	127	74	64%	17	15%	3	2.6%	22	19%	116
1883	144	83	54%	17	11%	13	8.4%	41	27%	154
1884	235	121	65%	21	11%	7	3.8%	37	20%	186
1885	141	74	48%	35	23%	3	2.0%	41	27%	153
1886	158	75	54%	32	23%	5	3.6%	27	19%	139
1887	171	97	59%	22	13%	2	1.2%	43	26%	164
1888	181	79	55%	17	12%	6	4.2%	42	29%	144
1889	150	72	46%	28	18%	9	5.8%	46	30%	155
1890	174	86	45%	50	26%	9	4.7%	45	24%	190
1891	159	65	47%	33	24%	2	1.5%	37	27%	137
1892	173	57	33%	63	36%	7	4.0%	46	27%	173
1893	197	67	44%	35	23%	3	1.9%	49	32%	154
1894	172	67	43%	37	24%	8	5.2%	43	28%	155
1895	207	89	52%	29	17%	2	1.2%	50	29%	170
1896	204	81	38%	61	29%	1	0.5%	69	33%	212
1897	207	90	50%	36	20%	1	0.6%	54	30%	181
1898	233	93	45%	52	25%	4	1.9%	59	28%	208
1899	256	104	46%	59	26%	3	1.3%	59	26%	225
1900	243	108	43%	40	16%	5	2.0%	97	39%	250
1901	266	90	41%	41	19%	3	1.4%	85	39%	219
1902	250	108	43%	61	24%	3	1.2%	79	31%	251
1903	274	110	40%	64	23%	1	0.4%	98	36%	273
1904	255	89	35%	72	28%	2	0.8%	92	36%	255
1905	258	106	41%	69	27%	1	0.4%	81	32%	257
1906	241	106	42%	72	29%	0	0.0%	73	29%	251
1907	251	93	38%	93	38%	0	0.0%	62	25%	248
1908	233	95	38%	78	31%	1	0.4%	75	30%	249
	5705	2445	-	1252	-	108	-	1586	-	5391

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