# The insane in 19th-century Britain: a statistical analysis of a Scottish insane asylum

Johnson, Mary Orr

Historical Social Research, Vol. 17 — 1992 — No. 3, 3-20

# THE INSANE IN 19TH-CENTURY BRITAIN: A Statistical Analysis of a Scottish Insane Asylum

*Mary Orr Johnson**

**Abstract:** This paper deals with an insane asylum population in the second half of the 19th century in Glasgow, Scotland. First, it attempts to place the asylum within the mental health context of the time by determining the extent of the use of moral management, a popular method for treating the insane in the 19th century. The results indicate that, in keeping with widely-held views, moral management was used alongside other, more traditional, methods, but that its use seemed to be in decline toward the end of the century. Second, it uses statistical data gathered from the admissions register of the Royal Asylum in Glasgow to describe the inmates' social and economic background, medical history, and experience inside the asylum. Third, it also uses these data to try to determine gender differences in the asylum experience of women and men. The findings do not indicate statistically significant differences between women and men in the asylum, suggesting that the asylum experience had less to do with gender than with social and economic status and background.

The study of insanity has enjoyed much popularity in the last twenty years due in large part to work done by Michel Foucault (1) and to an accompanying growth of interest in social history. In the past ten years or so the study of insanity has also involved many feminist historians, in British history, perhaps most notably Elaine Showalter (2). Important in both these and indeed in any British social history of the insane has been the recognition of society's attitudes toward the insane themselves. Questions that often arise include, for example, in what social and mental health context did the insane find themselves? This, in turn, helps us to discover to what extent such deviant behavior was accepted within a society. Also,

* Address all communications to Mary Orr Johnson, University of Strathclyde, z. Zt. Zentralarchiv für Empirische Sozialforschung - Abt. ZHSF, Universität zu Köln, Bachemerstr. 40, D-5000 Köln 41.

how was such behavior defined? In many feminist studies the questions also become, was the social and mental health context in which insane women found themselves the same as that of insane men? To what extent was such deviant behavior accepted from women, and was the definition of madness different for women as opposed to men?

There has, of course, been a great deal of excellent work done in the field of the history of British insanity. One need only look to such scholars as T.M. Brown, W.F. Bynum, M. Clark, A. Digby, K. Jones, R. Porter, A. Scull, M. Shepherd, E. Showalter, and V. Skultans to realize how much work has already appeared on the subject (see notes). However, in a field rich in conceptual theory, contributions still remain to be made. W.F. Bynum, Roy Porter, and Michael Shepherd, in the introduction to a collection of essays on the history of insanity called The *Anatomy of Madness* (vol. 1), point to the »slim foundations« on which the »sweeping generalizations« made in the history of insanity rest. After reviewing historiographical trends in the field, the editors write: »The work of criticism has thus been launched. What hasn't, to anything like the same degree, is the labour of actually *finding out* ... it is important that this research agenda should not be thought of as just a routine filling-in job ... rather there must be energetic dialogue between research ... and conceptual renewals They also stress the importance of how the recognition and interpretation of mental illness, indeed its whole meaning, are culture-bound, and change profoundly from epoch to epoch ... « (3) With a few notable exceptions (such as Digby), there has been relatively little statistical analysis in the field of British insanity. It is in the spirit of merging empirical data with theory that this study provides a statistical analysis of a Scottish asylum population in the latter part of the 19th century. From this description, it will be possible to answer the following questions: What kind of people were in the asylum? What were the causes of their illness? How long did they stay, and in what condition were they discharged? Studies in the history of British insanity show, as will be seen, a development in the field of mental illness beginning in the 18th century called moral management, which represented a radical break with past treatments of the insane. This study will also describe briefly one asylum's methods of treatment and how they compare with treatments - such as that of moral management - of the time. In this way we will see how the reality of treatment in a 19th-century asylum actually compares with presently accepted theories of 19th-century treatment; in turn, this should tell us something about the social/medical context in which the insane found themselves and also something about 19th-century British society's attitudes toward the insane.

However, there is another question this study attempts to answer *which* is also related to attitudes - that of 19th-century attitudes toward insane

women. Most literature on Victorian women and mental illness maintains that they were more likely than Victorian men to be seen as mad, that because of the rigid Victorian female social role there was less room for strong emotions which could be viewed as mad ravings. While this paper does not study attitudes which could have led to such unfair asylum admissions (4), it does study women already in the asylum in the hopes of discovering any discrepancies - or lack of them - between the sexes that might shed some light on the experience of women in Victorian asylums. Did insane women and men differ in areas such as marital status, age, education, length of stay, cause, and death rate? If so, how? What do answers to these questions say about the asylum experience, and were insane women's experiences really worse than their male counterparts'? What do the results imply about 19th-century attitudes toward women?

The database consists of 431 patients in the Royal Asylum at Gartnavel, Scotland, then just outside of Glasgow, in the years 1870 and 1880. Data were collected from the asylum admissions register, which listed 20 variables for each patient, 12 of which are especially pertinent to this study - those dealing with age, asylum class (whether the patient was considered a pauper, with fees paid by the state, or a private patient), marital status, occupation, bodily condition, diagnosed mental disorder, cause of insanity, duration of the attack leading to admission, level of education, whether the patient was considered suicidal or dangerous, duration of stay, and exit reason (relieved, recovered, dead). The case studies dealing with treatments were taken from doctors' rounds notes. It is unknown who actually entered the admission data into the admissions register - information about a patient was sometimes provided by a relative, sometimes the Sheriff, at other times by a caretaker or parish official. It is difficult for this reason to ascertain any kind of judgments that may have been made on the part of the asylum staff upon admission.

Regarding the asylum itself, construction of the original Glasgow Royal Asylum was finished in 1814, and moved to its present location in Gartnavel in 1843. It was one of seven Scottish royal asylums that were run from private philanthropic funds, although legally they were considered public institutions. (5) Although its clientele were from parishes near and far, not everyone was given equal consideration for admission: people from the Glasgow city parish were admitted first. From all accounts, the Glasgow Royal Asylum didn't differ markedly in its corporate, financial and medical structure from the other six royal asylums in Scotland in that all of them were run on local, privately contributed funds (with the exception of Edinburgh) and were staffed in much the same way. (6) In short, the results of this analysis will most likely be fairly representative of the majority of the insane population in Scotland, especially since the majority of the institutionalized insane were in the royal asylums. (7)

In most societies, insanity has been explained throughout history as being caused by whims of the gods (or devils), physical ailments, and the continuous battle between reason and unreason; it could be argued that all these views coexisted at the same time, with varying emphases put on any one of them, to a certain extent throughout history. (8) The insane, considered vagrants by the state when roaming the streets (9), were institutionalized in some cases (in such »grab bags« as state hospitals that also contained criminals and the physically handicapped) left to roam in others, or taken care of by friends and/or family. Those concerned with the insane continued to have difficulty defining madness: when did illness lead to insanity? How »unreasonable« did a person have to be to be labeled mad? What caused seemingly mad, irrational behavior-disease, loss of reason, the Devil? Before the end of the eighteenth century, insanity became viewed increasingly as a condition of immorality, and a reform movement began that attempted to improve conditions for the insane through institutionalized care and non-medical treatment. (10) Probably the most famous example of »moral management of the insane took place at the York Retreat (established 1792), founded by William 1\ike. It became famous the world over for its moral treatment, a treatment that relied on kindness and patience on the part of the staff in order to encourage patients in self-restraint and the »will« to recover. Spacious buildings with beautiful lawns and gardens were set up to provide as »homey« an atmosphere as possible, thought to be conducive to recovery, and patients were assigned tasks such as gardening and weaving. Samuel Tuke, son of the founder, stated in an article in 1813 that »neither chains nor corporal punishments are tolerated, on any pretext, in this establishment. The patients, therefore, cannot be threatened with these severities ... If it be true, that oppression makes a *wise* man mad, is it to be supposed that stripes, and insults, and injuries,... are calculated to make a *madman* wise?« (11)

What motivated the reformers is still debated today. For example, Michel Foucault, in *Madness and Civilization,* sees a dangerous mix of morality and medicine« in the eighteenth century that motivated society to incarcerate its undesirables (such as criminals, the ill, and the insane) and in fact to remove them as far as possible from the rest of the population, in the hopes of avoiding contagion itself. He views the reform movement that began in the second half of the eighteenth century as a result of this fear of contracting a kind of moral/physical disease; that the hospitals and penal institutions were cleaned up due not to any altruistic humanitarian impulses but because of purely selfish ones. (12) In his influential *Museums of Madness,* Andrew Scull also sees a scarcity of humanitarian impulses leading to reform, arguing instead that it was a combination of industrialization, an increasing sense of responsibility for the insane by the state, the new asylum, and »the developing link between medicine and insanity«

that changed the place of the insane from that of a vague and indefinable background to that of a more controlled foreground. (13) For whatever reasons, there was a profound change going on, and »moral treatment of the insane, which attempted to cure madness »through the moderate management and re-education of the patient ... [that] aimed to build up their self-esteem and self-re strain t« was, by the end of the 18th century, »not a novel phenomenon« but an accepted method of treatment. (14)

Moral management reflected the increasingly popular view of insanity as something that could be managed, controlled, and cured. Whether that happened because of industrialization, bureaucratization, society's paranoia, the concurrent rise of a specialized »mad« medical profession and the advancements made in medicine itself (which may have encouraged those dealing with the insane to look for a cure of madness), or a more complex mixture of societal, scientific, philosophical and economic factors, is still, as seen above, under discussion. (15) But the idea of insanity as something controllable and curable - whether caused by physical or emotional means - remained until the second part of nineteenth century. The biggest reason why it was thought to be more and more controllable was that it was seen increasingly as a moral defect or lack of restraint, qualities that a mad patient could ostensibly be »re-trained« in. Vieda Skultans, in *Madness and Morals,* explains that »moral« meant the same thing in the nineteenth century as »psychological means to us today, »[while] at the same time retain[ing] certain ethical implications.« (16) Kathleen Jones, in *A History of the Mental Health Services,* also equates the word »moral« with a view of insanity that involves the emotions, both with the causes of madness and its treatment. (17) In the early part of the nineteenth century moral causes of insanity gained favor in the growing profession as opposed to physical causes, moral causes implying a certain lack of self-governance or will. (18)

As the nineteenth century wore on, and numbers in the asylums continued to swell, the atmosphere of reform and optimism began to wane. The Lunatics Act of 1845 (which provided for a Lunacy Commission in Great Britain set up to inspect asylums) and the Asylums Act (also of 1845, mandating the construction of county asylums for paupers) did not create the Utopia the reformers had hoped for: costs of building and maintaining asylums had proved to be huge financial burdens, and no one had expected them to be filled (and, by the end of the century, over-filled) as fast as they were. (19) At the same time, neurological experiments were being performed in Germany by such early psychiatrists as Griesinger, Meynert and Wernicke, who were establishing a much more rigorously scientific connection between the body and insanity than had ever been done before. (20) Along with other social change (21), the latter part of the century saw an increasing belief in the physical causes of madness, and a turning away

from the moral/emotional ones that had so influenced the early part of the century.

As far as causes of insanity were concerned, both heredity and the notion of a person having a predisposition to madness exemplify the physical and the moral/emotional arguments of the time. Heredity became more popular as an explanatory factor at the end of the century, when the influence of the body held sway; predisposition, on the other hand, was more likely to be found as an explanation at the beginning of the century. Predisposition was a cause strongly tinged with morality - that is, a person disposed to vice and unrestrained living was »predisposed« to madness; once there, these patients could, in effect, cure themselves by a strong will to rebuild their character and change whatever damaging behavior had gotten them there in the first place. (22) Only the madman himself was responsible for his condition and his cure.

The data from Gartnavel certainly reflect these trends. In 1870 there is a marked prevalence of such predispositional causes such as general paralysis and predisposition itself (see table 2), while »Heredity« places a measly fifth as a cause of insanity. In 1880, however (table 3), the percentage of cases due to predisposition and general paralysis drops significantly, and the percentage of cases attributed to heredity increases significantly, second only to unknown causes. Interesting also is the prevalence in 1870 of »Unknown« as a cause; in 1880, the percentage of cases attributed to unknown causes drops dramatically, and there is all of a sudden a much greater number of causes (some a mix of »Predisposition« and »Heredity« with other causes; this could represent a transitional stage from a »moral« to a »physical« framework).

To what extent was moral management practiced at Gartnavel in the years 1870 and 1880? There are some clues in the doctors' rounds notes taken from the first handful of patients in 1870. These notes were kept by the overseeing physician when he made his rounds, which, according to the notes themselves, were infrequent.

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

Rodger R., admitted two days later, was a 30-year-old laborer, single, suffering from mania. The notes regarding him are as follows: »Prior to admission the symptoms were - staring eyes, flushed face, ceaseless talking of nonsense, was incoherent and restless. Also had broken windows, and at times struck at any person near him. Had been apprehended by the Police. On admission he labours under acute mania, is noisy, incoherent and violent. Bodily health indifferent; tongue furred, eyes suffused. Treatment: rhubarb and Hdg. with creta. Readmitted 18 Jan. Labouring under an attack of acute mania. Treatment same. Discharged cured again.«

Rhubarb had been used for centuries in cases of insanity. »Hdg.« could stand for mercury, which was widely used for many disorders and later for treating syphilis. (23) »Cret.« most likely stands for chalk, in this case a prepared form of chalk, used as a source of calcium carbonate and used as an antacid and as a treatment for diarrhea. (24) Whatever the concoction was, it was most likely a very traditional treatment designed to purge the body of whatever ailed it (a common method from time immemorial), and did not necessarily represent any kind of »moral treatments (25)

Isabella M., a 53-year-old domestic servant, was admitted for dementia, cause unknown. »Prior to admission she laboured under peculiar delusions about property. The Inspector of Poor stated that she was subject to periodic attacks of excitement. On admission she was free from excitement ... Jan. 15: She is very quiet and orderly ... Feb. 14: She is very industrious and quiet ... appears to be quite happy.« Treatment: None mentioned, except her working in the galleries and foundry, which is much more along the lines of moral treatment. However, she died six years later.

Andrew K. was a 27-year-old clerk suffering from mania from unknown causes. His case: »Prior to admission he was in abject terror of being lost, sent to Hell; protested that he would do anything to be saved; pointed a neighbour as being Satan. Was afraid his wife was going to do him harm, that she was tempting him - was very troublesome and had to be watched. On admission he is in great distress and in constant fear of being killed - believed he is lost and delivered up to the 'devil'; is very restless and incessantly asking what is to be done with him. Bodily health very indifferent; tongue furred.« Treatment: Blistering of the neck. »Seldom is prevailed upon to take medicine,« and what this may be is not given. Blistering was also a traditional treatment and certainly did not constitute moral treatment. He was discharged a year later as »Relieved,«

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

doses of rhubarb and Hdg. with cret.; sleeps generally well but occasionally is noisy; confused and inclined to ramble in conversation, his mind is weak with a much impaired memory, mistakes the identity of others. Relieved (removed to his settlement in En gland).« Again, a traditional medicinal treatment is given. There also seems to be no correlation between violent behavior and seemingly harsh treatment (even though such treatment was not seen as harsh) (26): Andrew K., whose neck was blistered, was not violent but suffered from great fear; while Robert P., who was »very violent« and »assaulted his sister in a savage manner« was given medicine. Very often in these cases no treatment at all is mentioned.

It is difficult, dealing with so few cases with so little information in them, to determine to what extent the Royal Glasgow Asylum practiced moral management. However, these cases do suggest that by 1870 moral management had lost much of its charm, and practitioners had gone back to using more traditional methods. In this sense, the Glasgow Royal Asylum seems to fit into the trend established by so many scholars - that is, that while at the beginning of the century insanity was viewed as something concerning the insane person's moral sense, and was curable through the »civilizing« means of a sober, industrious life, towards the end of the century the continued existence of madness seemed to prove the futility of such methods, and in the void between moral management and the onset of neurological treatment practitioners in mental health fell back on traditional forms of treatment. Attitudes toward the insane were in a transitional period: the era of moral management, with its view of the insane as people lacking only the moral will and fortitude to cure themselves, was coming to an end, and the era of neurological causation, where the insane were seen as victims of an unavoidable hereditary destiny, was only just beginning.

What can the data tell us about the insane population and what they were actually experiencing? Do they suggest certain attitudes of the period toward the insane, and if so, what are they? Looking at the general population in table 1, several things are already apparent. For example, the number of men and women in Gartnavel was roughly equal. Three-quarters of the population were between the ages of 20 and 50, and over three-quarters of the patients had never been in an asylum before. Just over 60% were listed as pauper patients, and roughly the same amount were from the working classes. The highest concentrations of patients were listed as insane for unknown reasons, although there was a multitude of causes possible (see tables 2 and 3). Half were single, 40% were married. Most suffered from mania, which was characterized by delusions and not depression, as in melancholia, for example. Most patients could read and write or had »good educations.« The highest concentration of patients was considered neither dangerous nor suicidal (although just under a third were

labeled as dangerous). Over 60% were considered »Persons of unsound mind,« in all probability the mildest description of mental disorder of those possible. About 60% were discharged (for whatever reason) within a year of being admitted. And the death rate was high - overall, 22.5%

In the course of some basic analysis (crosstabulations and frequencies) other characteristics concerning women and men as compared and contrasted with each other come out which are not apparent at first glance. Although the number of men and women in the asylum was basically the same, certain age groups (those under 20 and between 50 and 59) contained many more women than men. Women under 20 seemed to be viewed as both »crazier« and more dangerous than their male counterparts; and women between the ages of 50 and 59 stayed in the asylum much longer than their male counterparts, ostensibly because their societal role at that age was less important than a man's, and there was less of a role to return to. However, these populations represent a statistically small portion of the overall population, and as such do not represent gaping differences between women and men.

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

Although the highest percentage of patients of both sexes had »Unknown« listed as the cause of insanity, those causes taking second and third place differed for men and women. Women were much more likely to have »Predisposition from previous attacks« listed as a cause, probably due to the fact that they tended to be admitted after longer »bouts« of insanity, thereby making »Predisposition« a logical choice. Men, on the other hand, had higher rates of general paralysis (at the time not recognized for what it was, the advanced stage of syphilis) intemperance (a full half of the intemperate men were considered dangerous), and epilepsy. The fact remains, however, that the majority of both sexes were still considered insane for reasons unknown.

Finally, men had a higher death rate than the women, due to more cases of general paralysis, which, because it was not recognized as the advanced stage of syphilis, was treated ineffectively, leading inevitably to death.

Still, the overall impression of the sexes in this particular asylum is that they were very similar in most ways. While there were differences between men and women in two age groups, these groups themselves were relatively small within the population when compared with the largest groups, where trends were the same between the sexes. There was a difference also

in terms of asylum class (pauper or private), but again, the majority in both sexes was the same. Women tended to hold more unskilled jobs and the men more skilled, but this was true of the general population as a whole. (27) The majority of men and women were categorized very similarly by the doctors, and differences, again, only appeared between smaller groups. And most people of both sexes were diagnosed as having mania stemming from unknown causes.

In other words, there were differences between women and men in this population, but they were not as statistically significant as the similarities. This is not to say that women were not victims in some ways of Victorian life (and in the area of mental health); but in this asylum, they appeared to be no worse off than their male counterparts, and it probably can be assumed quite safely that it was a fairly miserable experience for all. The fact that most patients of both sexes were admitted with mania, with causes unknown, suggests that a similar definition of madness applied to both women and men, and that attitudes toward the insane of both sexes did not differ greatly, and that indeed, women's and men's experiences within such institutions were not very different at all. It is already accepted that economic standing was a bigger factor in asylum populations than anything else, and it seems again to be the case here.

Of course, such a conclusion from a population this size can be only tentative. Hopefully it has provided, however, some clues as to what actually went on in a 19th-century British asylum. What is needed is a broader view over a broader period of time, with a larger population, taken from other British asylums. Only then will we be able to form more accurate theories of differing gender experience in the asylum and, indeed, gain a more nuanced understanding of the role gender played in 19th-century British society.

## NOTES

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

(2) Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (New York: Pantheon, 1985).

(3) W.F. Bynum, Roy Porter, and Michael Shepherd, eds., *The Anatomy of Madness: Essays in the History of Psychiatry, vol.* 1 (London: Tavistock, 1985), 4.

(4) See Showalter, *The Female Malady*, for a thorough study of this.

(5) Francis J. Rice, »Madness and industrial society: A study of the origins and early growth of the organisation of insanity in 19th-century

Scotland c. 1830-1870,« PhD diss., University of Strathclyde, 1981, 246.

(6) Ibid.

(7) Ibid., 224-25, 245^6.

(8) For work on earlier societies and their attitudes toward the insane, see Basil Clarke, *Mental Disorder in Earlier Britain* (Cardiff: University of Wales Press, 1975); E.R. Dodds, *The Greeks and the Irrational* (Berkeley and Los Angeles: University of California Press, 1951); George Rosen, *Madness in Society: Chapters in the Historical Sociology of Mental Illness* (Chicago: University of Chicago Press, 1968); M.A. Screech, »Good madness in Christendoms,« in Bynum, Porter, and Shepherd, Anatomy, vol. 1, 25-39; and Bennett Simon, *Mind and Madness in Ancient Greece: The Classical Roots of Modern Psychiatry* (Ithaca and London: Cornell University Press, 1978).

(9) William F. Bynum, Jr., »Rationales for therapy in British psychiatry, 1780-1835,« in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era,* ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 36.

(10) Bynum, »Rationales for therapy in British psychiatry, 1780-1835,« 38; see Bryan Crowther, »Bleeding,« »Purging,« and »Vomits,« from *Practical Remarks on Insanity* (London: Underwood, 1811); John Haslam, »The therapeutic value of confinement,« and »Restraint,« from *Considerations on the Moral Management of Insane Persons* (London: R. Hunter, 1817); and George Man Burrows, »Gyration and swinging,« »Blistering,« and »Separation and seclusion,« from *Commentaries on Insanity* (London: Underwood, 1828); in Vieda Skultans, *Madness and Morals: Ideas on Insanity in the Nineteenth Century* (London: Routledge & Kegan Paul, 1975), 98-128. These were all common treatments for insanity, although, increasingly, »indiscriminate« use was to be avoided, as Burrows states in »Blistering« on page 188. These treatments had in the past not been viewed as cruel and inhuman, but as tried and traditional medical practices; a doctor practicing such methods was not necessarily a monster, but a medical man practicing his profession.

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

(12) Foucault, *Madness and Civilization,* 206-207.

(13) Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (New York: St. Martin's Press, 1979), 14.

(14) Anne Digby, »Moral treatment at the Retreat, 1796-1846,« in Bynum, Porter, and Shepherd, Anatomy, vol. 2, 53.

(15) Charlotte MacKenzie, »Social factors in the admission, discharge, and continuing stay of patients at Ticehurst Asylum, 1845-1917,« in Bynum, Porter, and Shepherd, Anatomy, vol. 2, 169.

(16) Skultans, *Madness and Morals,* 2.

(17) Kathleen Jones, *A History of the Mental Health Services* (London: Routledge & Kegan Paul, 1972), 100.

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

(19) Scull, *Museums of Madness,* 113-114.

(20) Klaus Doerner, *Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry* (Oxford: Basil Blackwell, 1981), 273-291; Bynum, »Rationales for Therapy in British Psychiatry, 1780-1835,« 35.

(21) See Skultans' criticism of Scull's economic model and her own proposition of the influence of the »emerging middle classes,« in *English Madness: Ideas on Insanity, 1580-1890* (London: Routledge & Kegan Paul, 1979), 10-11.

(22) Skultans, *Madness and Morals,* 1-28.

(23) Richard Hunter and Ida Macalpine, eds., *Three Hundred Years of Psychiatry, 1535-1860* (London: Oxford University Press, 1963), 1052; for the fruitlessness of using mercury in cases of hysteria see also Walter Johnson, *An Essay on the Diseases of Young Women* (London: Simpkin, 1849), ibid., 971.

(24) *Webster's Medical Desk Dictionary,* 1986 ed., s.v. »creta.«

(25) Hunter and Macalpine, *Three Hundred Years,* 1052; for »moral treatment as nonmedicinal, see Bynum, »Rationales for therapy in British psychiatry, 1780-1835,« 37.

(26) See note # 10.

(27) Olive and Sydney Checkland, *Industry and Ethos: Scotland, 1832-1914* (Edinburgh: Edinburgh University Press, 1984), 200-205. See J.H. Treble, »The standard of living of the working class,« in T.M. Devine and Rosalind Mitchison, eds., *People and Society in Scotland,* vol. 1 (Edinburgh: John Donald Publishers, 1988), for a discussion on the at any rate low standard of living in Scotland.

## TABLE 1

### POPULATION FREQUENCIES
### (Glasgow Royal Asylum, 1870, 1880)

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

## (FEQUENCIES CONT'D)

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

## (FEQUENCIES CONT'D)

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

## (FEQUENCIES CONT'D)

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

# TABLE 2
## Causes of insanity, 1870

## (in actual numbers and percentages)

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

Total of 318 valid cases; 3 missing cases.

# TABLE 3
## Causes of insanity, 1880

## (in actual numbers and percentages)

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

Total of 110 valid cases; 0 missing cases.