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THERAPIES FOR MENTAL AILMENTS IN EIGHTEENTH-CENTURY SCOTLAND

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Most studies of early-modern therapeutic regimens are based on prescriptive literature or medical case-notes kept by medical practitioners.[1] In order to understand more fully what was done for sufferers from mental conditions it is essential to go beyond these potentially limiting sources. Some 600 statements of witnesses have been examined, drawn from Sheriff Court, Court of Session, and High Court of Justiciary cases where the mental capacity of an individual was questioned. Those with knowledge of a person's behaviour testified in court, giving examples of speech and behaviour to prove or disprove that they were 'fatuous' or 'furious' - the then principal legal categories. Their testimonies frequently described aspects of the sufferer's life over months or years, including any attempts to cure their condition. Approximately a fifth of witnesses were medical practitioners - physicians, surgeons, and apothecaries - but the remainder were laypeople from a wide variety of backgrounds. To these, information derived from asylum admission petitions, again mostly written by layrelatives of a deranged person, was added. Sufferers were generally diagnosed as suffering from 'madness', or from some more precise condition such as 'melancholia' or 'hypochondria' (then a significant psychosomatic ailment).

What these documents show is that what physicians administered by way of treatment was often the outcome of a process of negotiation with patients and their relatives. They also demonstrate the importance of self-therapy and of the 'medical market place'. Professional, quasi-professional, or laykeepers and carers generally tried, or presided over, some form of medical treatment. Their efforts, brief or prolonged, to alleviate or cure symptoms covered the whole range of traditional and modern medical theory and practice.[2] To the mainstream approaches - primarily the application of counter-irritants and evacuants - were added water cures, shocks, and a variety of less common but still well-known remedies. In the case of mental ailments, the significance of psychological as well as medical therapy, including the enduring importance of religion as an aid to recovery, must also be recognised.

What follows is not a systematic investigation of all types of care or cure but a qualitative analysis of the regimens and treatments used on those who appear in our civil and criminal court population and among asylum papers. The sources used have the merit of allowing us to look at the changing relationship between medical and other types of therapy, at the process of decision-making in day-to-day interactions between healers and sufferers, and at the place of self-therapy.

HUMOURS AND NERVES: CONTINUITY AND CHANGE

A formidable array of remedies was available to sufferers. These included evacuations, blood-letting, cathartics, purgatives, emetics, blistering agents, camphor, opium, warm and cold bathing, mercury, anti-spasmodics, belladonna, and digitalis.[3] Most of these derived from the tradition of heroic therapeutics and and were an attempt to restore the balance of 'humours' in the body. Galenic theory, which derived from the classical

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age, held that vital forces must be kept in equilibrium. If fluids in the body, of which blood was just one, got out of balance then the body might become too hot or cold, too wet or dry.[4] For example, blisters were intended to relieve the brain of 'morbid suppurations' while cold baths and bleedings helped 'cool' the body.

A routine treatment for all sorts of ailments will be considered first. Bleeding is occasionally mentioned as having a sedative effect on the 'furious'. James Mackie, porter to a Glasgow spirit dealer, saw William Young in church, 'restless and uneasy and shifting about in his seat and appeared to be absent in his mind'. Later he saw him in bed, 'calm having been newly bled'.[5] A more extreme case involved David, Lord Halkerton. Subject to 'furious', and on one occasion murderous, fits, Halkerton became the subject of a tussle between his mother and a cousin in 1709. Anxious to show her son was recovering, Lady Halkerton 'has put him in the hands of a pitiful cow-herd of a mountebank who has by extravagant bleedings brought his body to that degree of weakness that he is hardly able to walk, which could not but abate his former fury and heat, but as to his judgement it is much the same as ever'.[6] This last statement came from the cousin and was remarkable even by the standards of the tendentious and hyperbolic 'informations' and 'answers' which the Lords of Session had to hear. Yet, it fits the pattern of treatment which are known from other sources to have been conventionally meted out to the 'furious'.

Therapeutic regimens of the later eighteenth century were based to some extent on the new orthodoxy about the origin of diseases which was beginning to take over from Renaissance humoralism. Fashionable physicians of the period espoused the notion that it was all in the nerves. Robert Whytt's promotion of nervous physiology from the 1740s was a landmark in medical thought. The essence of the physiological side of the theory is nowhere more clearly expounded than in a 1780s advertisement for Dr Alexander Monro's *Observations of the structure and functions of the nervous system*.

> What has obtained the denomination of the Nervous System is known to be that medium which is interposed between the living principle and the different organs of which the bodies of animals are composed. The nerves are the instruments of sensation, and it is by their influence that all animal action is performed; they are the source of feeling, and they prompt all our propensities, instincts, and movements. Hence a knowledge of their structure, distribution, and functions must be extremely important, both to the philosopher and the physician, in the study of nature.[7]

Dr William Cullen proposed that diseases were often caused by having a surfeit or deficit of nervous tone: a 'neurosis'. If this theory was to become dominant, traditional interpretations of illness and methods of cure retained their hold even at the end of the eighteenth century. The managers of Glasgow Asylum stressed moral therapy in their public communications but the institutional practitioners' case-notes suggest that traditional methods such as restraint, bleeding, and purgation were still extensively used in the early years.[8]

Conventional medical wisdom had it that restricting the freedom of action of a manic person was likely to be therapeutic as well as practical i.e. for safety reasons. A former shipmate told how Robert Spence was lashed to a post or chained below decks during 'furious' phases on board during Captain Anson's lengthy expedition, concluding: 'the wholesome discipline he met with...contributed in some degree to depress the effects of this distemper'.[9] William Cullen's treatment regimens for both maniacs and melancholics involved restraint, a measure whose medical value was still accepted in the 1810s and beyond.[10] Going against the developing therapies of moral management,

Cullen's view that mental disorder was a function of 'lesions in our judging faculty' invited the coercion of the patient.[11] In cases of mania: 'Restraint...is useful, and ought to be complete; but it should be executed in the easiest manner possible for the patient, and the strait waistcoat answers every purpose'.[12] Using other people for restraint 'is often hurtful' because it causes struggles. 'The restraint mentioned requires confinement within doors, and it should be in a place which presents as few objects of sight and hearing as possible; and particularly, it should be removed from the objects that the patient was formerly acquainted with, as these would more readily call up ideas and their various associations.'[13] Furthermore, confinement of patients should not be 'in their usual habitation' and the patient should be kept away from 'the company of any of their former acquaintance; the appearance of whom commonly excites emotions that increase the disease'.[14] Maniacs should be kept in a state of awe or fear, especially of those usually with them. Awe and dread may have to be cultivated by force, including 'stripes and blows'.[15] It was also a good idea to restrain melancholics 'from pursuing the objects of their false imagination' but not to the extent needed with 'the impetuous and angry mania. It will be generally sufficient to acquire some awe over them...to check the rambling of their imagination, and incoherency of judgement'.[16] Later, in England, George Man Burrows was among the more prominent advocates of somatic not moral diagnosis and treatment.

Of course, this was not an orthodoxy. Dr William Buchan had argued trenchantly against restraint for melancholics. A proper regimen of diet, amusement and exercise 'would be a more rational method of cure than confining the patient in Bedlam, or sending him to a private madhouse. These institutions, as they are generally managed, are far more likely to make a wise man mad than to restore a madman to his senses.'[17] In the early nineteenth century, Cullen's views on restraint were certainly not accepted by those charged with investigating madhouses. The general observations on the shire of Edinburgh made by the nominees of the Sheriff in 1816 drew attention to the insecure nature of many private madhouses and the low ratio of staff to patients: 'the keepers received too many patients, considering the nature of the accommodation they possess, and the number of under-keepers they employ'.[18] Sheriff's reporters also recognised that long-term restraint was partly a response to the fear that patients would escape rather than because they were chronically 'furious'. At Mrs Bourhill's, Cottage Lane, Musselburgh, four patients from the eleven of this establishment were chained, including a man 'who seemed perfectly quiet and good-natured' simply because he had tried to escape.[19] At Thomas Cathy's 'a young woman fatuitous and pale, probably much confined to a very small room, not provided with any means of ventilation. When the door of this apartment was opened she instantly and in haste escaped from it like a dog from a kennel. She appeared afterwards quiet and manageable.'[20] Seclusion here was a punishment or a way of reducing the time keepers needed to spend on a patient. Sheriffs (or Sheriffs-Depute) tried, where appropriate, to reduce the use of restraint in licensed private madhouses and between the twice-yearly visits in 1815-16 reported that its incidence had declined.

Sheriffs-Depute and their medical advisers sought to restrict confinement or restraint whose cause was laziness or vindictiveness on the part of keepers. That does not mean they wholly discountenanced therapeutic confinement of short duration, though their leanings were clearly towards moral therapy. Nor was it unacceptable to bind or lock up a man who presented a threat to himself or the 'lieges'. Everyone seems to have accepted the need for such restraint in the interests of patients and public, and in many cases it is difficult to see what other steps could have been taken. John McCormack

was the eldest son of the late William McCormack of Upper Merryflats in the parish of Meikle Govan near Glasgow. He was prone to bouts of outrageous behaviour and a neighbouring farmer told how one day he had seen John running down the road hotly pursued by his father and brothers. Just prior to his cognition the family surgeon found him:

> in a 'furious' state and quite insane and that he had cut his throat with some sharp instrument. That the deponent sewed up the wound and when he visited him the following day he found that the sewing and bandages about it were torn away and the deponent was told that the said John McCormack had done it himself...that from his outrage it was judged expedient to tie and put him under confinement.[21]

The better-off could afford servants to attend an unpredictable relative 24 hours a day and to employ one or two strong men to accompany them on their walks in town. Reformers criticised restraint on the grounds of ignorance or laziness whereas they may more accurately be attributed to poverty and a lack of resources - as Sheriffs-Depute understood. If some sufferers needed confinement and restraint, others were thought to require space and freedom. A change of scene was part of conventional wisdom about improving mental health. Sea voyages, visits to the country, changes of asylum, moves into or out of madhouses - all were tried on patients of means. Some patients had the appearance of dedicated travellers. In his late teens Thomas Holmes suffered a 'severe nervous fever' as a result of which 'he became dejected and entertained a very unfavourable opinion of his own abilities - thought he could do nothing correctly'. He took to bed for weeks at a time and seldom spoke. Recommended to take a voyage to Lisbon, he returned apparently much better but soon relapsed. Four or five years later, in autumn 1805, he went with a brother to Jamaica but had to return in the summer of 1811.[22] Apart from removing stressful stimuli, voyages may have had other functions. Many sea travellers would have suffered from seasickness, a condition which would prevent them from dwelling too much on other anxious or gloomy thoughts. A similar idea lay behind the use at Glasgow asylum from 1819 of a 'rotating or whirling chair'.[23] Patients were suspended above the ground in a chair turned on a pivot until they became nauseated and thus pacified. The chair seems to have had both a therapeutic and punitive function.

This was an age of scientific advance and medical optimism. For all that, practitioners recognised the limits of their art. Scottish physicians of the eighteenth century seem generally to have tried their best for a patient and then given up. Dr James Gordon of Pitlurg treated Jean Bannerman from May 1746 because she had 'for some time before been afflicted with a melancholic disorder which affected much her health, spirit and senses'. He found 'the disease...pretty far gone', but her health was improved by his applying external and internal medicine. After attending her for nearly a year 'he found the disease a continued and fixed melancholic madness with little or no lucid intervals', and pronounced 'he could be of no manner of service', though he did later advise on 'her diet and method of management'.[24] Patrick Nisbet, surgeon in Perth, gave Elizabeth Nairne 'several medicines' for her derangement but all proved ineffectual. In the three weeks before she went to Edinburgh Infirmary he stopped visiting her 'as he thought it to no purpose, and as her disorder seemed to him incurable'.[25] Even in the early nineteenth century, medical treatments were far from ubiquitous. Medicine was seldom used at the Spittal Asylum (Aberdeen) because the inmates were idiots and imbeciles assumed to suffer congenital defects. Even among the 50 patients in Montrose Asylum in 1818 (mostly of some years standing), four-fifths were not given medicine

at all and the other 20% were exclusively prescribed laxatives.[26] At the prestigious York Retreat in England, physicians had recognised how much was to be done by moral, and how little by any known medical means.[27] We shall deal with the 'moral management' shortly.

CHOICE OF REGIMEN

The physician or surgeon was generally working with, but not for, the mental patient. Caring for the insane was in a way similar to treating children where parents or guardians would call in the doctor, negotiate treatment, and pay the bill. The merely ill generally sought medical help by themselves, whereas the mentally ill usually became the subject of medical attention initiated by others. Doctors sometimes stumbled on people who thought that perfectly healthy parts of their body needed to be cut off or who believed without apparent justification that they were being poisoned. Samuel Clark, surgeon in Glasgow, visited William Young on 14 May 1815 and found him 'very incoherent'. Clark would only have been in his early or mid-twenties at this time and perhaps a little cautious and unsure. Since he had 'not been called upon to make a report of his situation he did not so particularly attend to him'.[28] Clark proceeded to a routine bleeding and it was only when the patient asked to be allowed to bleed to death that he began to pay attention to his sanity. In this case and most others, practitioners came at the behest of a relative or at the patient's request to attend to a physical ailment. If the 'client' was not the family, he was an official. Peter Rolland told how he had visited Janet Brown with another surgeon 'in consequence of an order from the Sheriff'.[29]

Physicians and surgeons had limited sovereignty in the medical regimens prescribed, for the patient's 'friends' (close and extended family) ultimately retained control. Medical practitioners were employed like clerks and teachers, clients being prepared to challenge a man's diagnoses and decisions - or even to go elsewhere if dissatisfied. As Rosner notes, successful practitioners needed an 'easy, obliging and attentive manner'.[30] Georgian doctors naturally understood the relationship. In discussing hypochondriac patients, Cullen observed that they frequently changed their doctor 'for a physician who does not admit the reality of the disease, cannot be supposed to take much pains to cure it, or to avert the danger of which he entertains no apprehension'.[31] Dr John Rutherford, an ageing Edinburgh physician, told the inquest on Michael Potter how 'he some little time ago received a card from some of Mr Potter's relations desiring that he would prescribe bathing in the sea which the deponent did rather to satisfy the persons who had desired this than from any expectation that it would have success.'[32] Treatments were not simply dictated by doctors but were influenced by fashion and the central role which patients or their relatives had in choosing a medical regimen.

Bathing was certainly a fashionable cure for all sorts of ailments. Doctors William Buchan and William Cullen discoursed on the merits of cold and warm bathing for maniacs and other sufferers of nervous diseases. 'Bagnios' or bathhouses were in existence before the Restoration. The first known bathhouse was opened in the 1650s at Leith, and bathing was an established part of the medical regimen by the 1700s when the principal city bathhouse with hot water was run by the surgeons.[33] A 'table of the prices of provisions' in Hugo Arnot's *History* includes an entry for 1705: 'use of the cold bath per half-year' £2 sterling. A hot bath on one's own would cost the huge sum of ten shillings but only five shillings if shared; a cold bath was four shillings. A footnote reads: 'The bath belonged to the company of surgeons. We may, therefore, rest assured that the hot or cold baths were then prescribed for all diseases'.[34] The Royal College of Physicians ran a cold tub at St Michael's Well in the Cowgate.

Season tickets were available but business was never particularly good, even for the hot baths, and the surgeons' bagnio was stripped of its marble, tiles and fittings during the 1730s.[35] In 1735 John Douglas, architect, proposed building another one at the foot of Carruber's Close - a street which also contained a dancing school and other diversions.[36]

The fashionable people who frequented Carruber's Close would surely have been able to gloss as a superstition the belief in the healing power of water and wells. Yet examples of immersion in water or drinking it, both accompanied by suitable rituals, were collected by Mitchell from newspapers and oral testimony referring to the north and west of Scotland up to the early nineteenth century. In particular, a shrine on the island of Innis in Loch Maree was said to possess a power 'unspeakable in cases of lunacy'.[37] Mitchell presented such beliefs as 'superstitions' believed to help lunatics, though throughout his article many of the examples cited relate to the attempted cure of epileptics.[38] Campbell too cited examples of the power of water to cure madness. These included the ruined chapel at Clachan next to the River Tay at Strathfillan (near Tyndrum) where a ritual involving immersion was performed.[39]

This was used by one father of a 'furious' son. John McLauchlane younger of Auchintroig started behaving wildly in March of 1733. In May 'he was carried to the Strathfillan Well for cure where madmen were carried' or, as another deponent put it, 'as a man discomposed in his thoughts'. While there, James McFeat and others 'put and tied him in the kirk or chapel all night where mad men use to be put and when they washed him in Strathfillan Well and dooked him therein he behaved very civilly and complied with all they did'.[40] Strathfillan was a holy well held to be particularly efficacious at that time of year. In the evening, sufferers were instructed to bring up three stones from the bottom of the pool, then walk three times round each of the three cairns on the bank, placing a stone on each. They were then tied on to a stone 'bed' in the adjacent chapel overnight.[41] Significantly, it was not until June that Dr Brisbane from Glasgow was called in to look at John.[42]

RELIGION AND PSYCHOLOGICAL HEALING

Practices like this were increasingly written off as superstitious during the eighteenth century. If magical remedies were becoming less acceptable, mainstream religious ones were available throughout our period. Moral therapy 'was not so much a specific technique as a range of non-medical treatments designed to involve the patient actively in his recovery.[43] It was a tendency within treatment rather than a specific regimen, taking account of the patient's sensibilities and reactions. The emphasis was on rational and emotional rather than organic causes, and a range of non-medical techniques which involved the patient in his or her own recovery. Excessive constraint and domination of the patient was replaced by more 'humane', interactive therapies, which stressed the emotional aspects of care.[44] Self-control rather than external restraint was at the heart of moral management, which was 'directed to the mind and character of the sufferer, engaging his attention, gaining his respect, breaking evil habits and associations'.[45] Of course, the borderline between coercion and co-operation may have been blurred in practice.[46]

From medical practitioners is derived a picture of interrogation and of gentle but insistent (sometimes impatient) confrontation with the lunatic. This was not merely a crude exercise of power, but was designed to help the patient to regain his or her standing as an independent moral agent rather than an involuntary actor. Andrew Wardrop, a surgeon in Edinburgh, spoke of his visits to John Hay of Paris while he was

incarcerated at Saughtonhall private madhouse. He remarked on how John Hay 'sometimes shows an unreasonable suspicion of him'. Wardrop agreed that 'it is natural for a person who is confined on supposition of derangement to be suspicious of those who visit him' but said he had tried strenuously to persuade John Hay 'that he did not visit him with any intention to injure him or to have him detained there unjustly. That it was in Mr Hay's interest to prove by his conversations that he was not deranged and the deponent is of the opinion that if Mr Hay had not been deranged he would have been convinced by the deponent's reasons and would have laid aside his suspicions'.[47] Among other things, Wardrop wanted Hay to acknowledge that his father was dead, a simple fact of which everyone else was aware. Of course, the aim remained ultimately to re-establish social conformity in the patient just as traditional therapies had done - and were still employed to do even in the early nineteenth century.[48]

'Modern' methods of care such as moral management included the use of religion as an aid to self-control. In some ways, this was merely an extension of the traditional role which faith had played in healing. Part of Margaret Crawford's delusional world of the 1720s and 1730s featured spirits and demons. As mediated through those around, her understanding of her condition was antipathetic to the godly state of mind prescribed in devotional literature.[49] Thus, her cousin Alexander Livingston advised her to compose herself by reading the Bible, a path conventionally laid out for those who wished to find their way from spiritual turmoil. God's word was the voice of sanity. For Margaret Crawford that avenue was closed off because she believed that her Bible was 'charmed' or had a spell on it.

Others regarded the word of God as a bridge back to sanity for those who had crossed into madness. When Alexander Goldie's business partner was worried he might kill himself, he used a religious homily to warn him of the heinousness of self-murder'.[50] Close introspection which lead to faith and repentance, coupled with immersion in the Scriptures, had long been a Calvinist cure for all sorts of ills. Hugh Maxwell of Halkerston was visited at the Edinburgh Bedlam by Mr Moncrieff, minister at Redgorton. He brought with him a Bible 'to try if he could read and get some of the psalms by heart and Mr Moncrieff promised he should get out if he did'. George Steill, keeper of the Bedlam, saw Hugh Maxwell appearing to read the Bible at various times 'but the deponent never heard him read'. Later he found the leaves of the Bible cut out and hidden under the bed.[51]

Being in church was itself supposed to calm people, just as reading the word of God was held to be a way of restoring sanity. Where medical practitioners confronted the insane with observable reality and conventional wisdom, clergy sometimes tried to use a spiritual level of analysis and cure. When the healing power of God's word was effectively blocked by lack of reason a person's situation was truly parlous. When the minister of Airth visited George Thomson in October 1817 he thought him deranged and 'deemed him in such a state as no clergyman should attempt to offer him religious admonition'.[52] With their continued emphasis on prayer and fasting, Scottish clergy provided a source of psychological healing throughout the period.[53]

In terms of institutional presence in early nineteenth century asylums, the religious profession was as well-represented as the medical. Throughout the eighteenth century medical and spiritual intervention went hand in hand. Early-modern men and women saw clergy far more commonly than they did doctors. A minister was easier and cheaper to consult, and was a more likely first resort of those who were troubled in mind. Charity workhouses and early specialist asylums were as likely to have resident

chaplains as resident doctors. Glasgow asylum had religious services from 1819, and even before that individual patients might be visited by clergy or allowed out to attend church in the city.[54] A chaplain was appointed in 1823. According to one's point of view, exposure to religion could exacerbate or alleviate religious melancholy. It could do the same for 'furious' patients.[55] Some argued that certain types of participation, or certain messages, could agitate rather than palliate or uplift.[56] Some claimed that inmates should not be allowed to worship publicly, but that instruction should be given to them in private.

Whatever the emphasis, among those providing care in public institutions, religion was broadly accepted as a part of moral therapy, the debates being about 'how, when, and to whom, religious instruction should be imparted'.[57] The most sophisticated analysis was that some people already so predisposed would have mental illnesses triggered by religious inputs and that such people were likely to demonstrate insanity in religious ways.[58] The acutely ill could not be allowed to attend but for those on the mend the benefits were clear. It was claimed in 1818 that a patient suffering from 'religious melancholy' was brought back from the brink of suicide by a suitably delivered biblical text.[59] With any direct benefit of attending services went the psychological boost to patients of being allowed to participate in a central social institution from which they had previously been excluded because of their 'furious' behaviour. If behaving badly in church had been a sign of derangement or stupidity, being allowed to worship was a reward and a possible bridge back to ordinary life.[60]

Very broadly defined, the goals of modern psychiatry are to relieve symptoms, support the patient, help him or her to 'find themselves', and help them adapt to the needs of society. Conversely, 'the concept of a "normal" person... implies a mental condition of creative self-fulfilment, a productive attitude towards life, gratifying relationships with people, etc.'[61] Eighteenth-century practitioners concerned with mental illness or incapacity concentrated on relieving symptoms and socializing the patient, focusing hardly at all on the promotion of self-identity or realisation. The scope of treatment was firmly determined by cultural expectations which placed the greatest emphasis on outward conformity and contribution to the family and wider society. Patients were not being helped to find themselves but to rediscover their place in the social fabric. This was an age in which people were only beginning to define themselves as individuals. Family, community, and society took priority over the individual and many of the rights modern observers assume he or she might have had. Just as definitions of insanity were partly tied up in a person's place within a network of social relationships, so criteria of the efficacy of therapy were predicated on culturally distinctive concepts of social utility. On 11 March 1777 John Philip's brother William, a merchant in Edinburgh, petitioned to have him moved from the tolbooth to a Bedlam cell. John, he claimed, was getting worse in the common jail and should be removed to a place 'where quiet, privacy, and proper care may give the unfortunate sufferer a chance of recovering his distracted senses, of becoming again an object of trial [fit to stand trial]...and of being again restored to his friends and to society'.[62] A newspaper advertisement of 1800 defined a desirable outcome for the mental patient as: 'being restored to health, and to the society of his friends'.[63]

Indeed, medical treatment was only part of the equation. William Somervell seems to have suffered from a communication failure which caused him to become increasingly isolated from those around him. His mother and those employed to help him aimed to restore his ability to interact but more obviously to assist him in conforming to certain elements of the social context. For example, Britain was at war during the

1790s and 1800s. Many of those who appeared as claimants or subjects before the Sheriff Court were styled 'captain' or 'lieutenant', meaning they were either serving or reserve officers - Janet Somervell's late husband for one. Donald McDonald, officer of the Highland Society, was employed for 14 months to teach William Somervell 'to walk properly he being a cripple and having no ability in his hands'. After two months he claimed some success in teaching him to march, to hold a knife and fork, to fire a pistol and musket, to shoulder a musket and to present arms.[64] Carers valued passivity in a patient for this indicated malleability, educability, and the possibility of restoring obedience to social norms. MacDonald spoke approvingly of how biddable Somervell was. Communicating with and securing the co-operation of the patient was not an issue outside moral therapy.

While these emphases may seem archaic to modern readers, it is plain that the relatives of the insane themselves wanted little more than a return to behavioural conformity. The ageing cottar employed to look after Neil Campbell of Dunstaffnage recounted how 'in harvest last it was found necessary to tie him with cords for a night or part of a night' but went on approvingly to inform the inquest that since Martinmas Neil had been 'low spirited but peaceably and inoffensively'.[65] While he might still walk naked around his castle and talk to himself, Neil was not currently a problem for those around him. In so far as they acknowledged their condition, the mentally troubled sought to understand it and to find peace within themselves. If they expressed any positive feelings about those around them then it was generally a wish to be able to function with friends and neighbours.[66]

SELF-THERAPY

Doctors conventionally advised attention to diet, healthful exercise, and moderation in all things. In so doing, they catered to a shared belief that people had a responsibility for their own health which could be realised through their own actions. In addition, those who knew or were persuaded that they were physically or mentally ill might try medical self-therapy. Taking medicine was itself fashionable, even when unnecessary. The wife of John Halliday's ploughman dismissed the idea that her husband's employer had been poisoned by his wife with the retort: 'he was as well as ever he was although he had too many drugs in him'.[67] Charles Graeme dosed himself liberally with medicines when he caught a 'chill' while on military service in North America, but nobody close to him knew where they came from or what they were.[68] The historian rarely knows what was in the medicines unless they were common ones like laudanum or thought to be worthless, as with the antidotes Duncan Campbell took against imaginary poisons.[69] The use of opiates on lunatics is not well documented though Porter speculates that narcotic painkillers were prevalent in late eighteenth-century England. Buchan advised caution in the use of opiates 'as these only palliate the symptoms'.[70] Cullen also opined that while opium alleviated mania he was uncertain if prolonged use would bring about a cure.[71]

The most commonly mentioned 'medicine' was alcohol, both self-administered and as part of a treatment regimen. The role of alcohol in producing temporary mood and behaviour swings is mentioned in more than half of the cases of alleged furiosity among men. It was the most potentially harmful and the most used psychotropic substance in eighteenth-century Scotland and, in all likelihood, anywhere in early-modern Europe. In the public asylums and better private madhouses of the early nineteenth century strong drink was banned - as was gambling for money.[72] Alcohol was nevertheless part of many treatment programmes in Edinburgh Royal Infirmary

and was vigorously advocated by followers of John Brown's medical system in the 1780s.[73]

The administration of alcohol remained a part of the recorded treatment of men throughout the century, though used as a sedative rather than a stimulant. Speaking of Neil Campbell, an illiterate farmer recalled: 'during the periods that the deponent was employed in watching Dunstaffnage they were frequently in use to give him spirits and sometimes he himself would take more than they were inclined to give him though the deponent does not recollect that at any of these times Dunstaffnage took what left him intoxicated'.[74] After his removal from his seat at Dunfermline, James Edwards was accommodated with the clerk to Edinburgh Charity Workhouse who lived next to the Bedlam. A woman servant called Janet MacLeod told of Edwards' craving for spirits, but added that if they were given to him they are mixed with water, 'in so much that it can do him no harm'.[75] Edwards was described by all around him as dependent on alcohol.

MacLeod's comment, and that of Campbell's ploughman, refers to the physical impact of large quantities of raw spirit. Neil Campbell started on whisky in the morning. Some doctors and families recognised that mental derangement could originate from excessive drinking but that did not prevent the continued use of alcohol as a 'medicine'. An Airdrie surgeon of the 1760s gave Joseph Howie 'spirits' to ease the pain of his 'gravelish disorder...[which] he imputed...to proceed from a rising of the spleen or a hypocondryacal distemper'.[76] Alcohol was an analgesic; it palliated the worst fears and delusions, and the most disruptive verbal abuse and physical violence of these men. But it ultimately left them in the same state whether watered or neat, whether in the guise of a patent medicine or as common whisky, rum, or brandy. A letter filed with the admission papers for Mary Hinshaw from Hamilton warned the keepers of Glasgow Asylum that when she left that place she had a bottle of laudanum and one of brandy secreted about her.[77] In the case of a young Stirling confectioner called John Raeburn his friends reported that he had: 'no lucid intervals except he gets a very little strong ale; smokes a great deal, frequently 6 or 7 pipefuls of tobacco without stopping'.[78] Compared with alcohol, and for all its contemporary fashionability and modern connotations, opium was probably of lesser significance in the care of most 'furious' people in eighteenth and early nineteenth-century Scotland.

Some of the actions to which the mentally ill resorted were interpreted as signs of mental derangement. However, sympathetic practitioners could see that there was a purpose to their actions. The third report on Glasgow Asylum told of a young man who tore his clothes and destroyed his mother's furniture when he was sent home. He refused to enter into a pact not to repeat this since 'I may be again, as I have been already, in such a state that nothing but breaking furniture can give me any ease.'[79] Even if the root cause was delusional, the means taken to alleviate symptoms might have a measure of rationality behind them. Going naked in public was a strong indicator of insanity but the 'furious' could rationalise their actions. As Jean Blair ran away from the house in Charles Street where she had murdered her mistress and set fire to the curtains: 'she threw off her shirt in the lane between Potterrow and Bristo Port and her reason for doing so was that she thought there was an evil spirit following her'.[80] Jean wanted to distract or ward off what she dreaded.

Standing back from contemporary interpretations or self-justifications, it is possible to read into certain actions attempts at self-therapy. Nakedness might ease the claustrophobic sensation of wearing clothes or provide a decoy for following spirits or provide an escape for sufferers who thought their garments somehow poisoned or

polluted. Immersion in water might serve to cleanse sufferers who believed they were tainted, as well as being a recognised religious or magical means of care (Strathfillan Well) and an approved medical technique based on physiological theory (cold or warm water bathing). Running may have been a manic act designed to burn off energy but it was also a natural step for patients who believed there was something or someone trying to harm them. Once in the open, those who wandered the wilds of Scotland for hours or days on end without seeking shelter would have eased any feelings of claustrophobia which had prompted their escape. Cutting oneself was certainly self-destructive but it may also have been an emulation of medical practice for some sufferers. Self-administration of alcohol too was ultimately damaging but must have palliated certain symptoms. Drinking may have helped a man to relieve his restlessness. It is possible to rationalise even the most apparently irrational acts, even if not all the above explanations were recorded by those who dealt with the eighteenth-century insane. For that reason we should treat them as speculative.

CONCLUSION

In a very simple sense, different approaches, such as external restraint and the attempts to re-establish a person as a moral agent (internal self-restraint), which were at the core of 'moral therapy', were variants on the physician and philosopher John Locke's basic notion that since knowledge comes from experience, people may be modified by their experiences. This paper has dealt only indirectly with the outcomes of therapy, except in cases where practitioners abandoned medical treatment. Most readers would regard many of the therapies used on the troubled in mind as at best useless and at worst barbaric. However, it is unwise to claim that the 'techniques and agents employed were therapeutically useless' compared with some modern standard.[81] Indeed, it is fundamentally anachronistic to speak of 'rudimentary' medical writing and 'undeveloped medical thinking' in the early nineteenth century.[82] The eclecticism shown in treatments was the result of a genuine competition between theories and practices whose intellectual roots were as strong as any today.

Many of the treatments outlined above were prescribed by medical practitioners. Yet, the relationship between doctor, patient, and therapy was not as simple as it is nowadays. Friends and relatives were also part of the equation and the nature of the transactions between the three parties is more complex than it might at first appear. The heavily skewed power relationship which exists between modern patients and their physicians was not replicated in eighteenth-century Scotland. Even in 1820, the sovereignty of doctors remained limited by their status as employees of their patients and by the existence of institutional checks on their freedom of action, notably through the courts. There was, of course, a qualitative difference between mental ailments and the voluntary, patient-centred relationship in cases of somatic illness.[83] Yet, even in a hospital, patients with money had a say in their treatment and they or their relatives could always go elsewhere. Some therapies were self-chosen and administered. Indeed, the broader issues of power in the definition and treatment of mental illness or handicap remain to be analysed.

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[19] PP 1816, VI, 368.

[20] PP 1816, VI, 369.

[21] SRO SC36/74/5, John McCormack (1795).

[22] GGHB HB13/7/184.

[23] Smith 55.

[24] SRO SC5/24/2, Jean Bannerman (1755).

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[41] Marshall W. *Historic scenes in Perthshire* Edinburgh:Oliphant, 1880; 438-9. The well was still used in the 1840s but, according to the *New Statistical Account*, it was only visited by strangers and produced no cures. It was presumably this to which Tobias Smollett was referring in his 1752 *Essay on the external use of water*: 'in some parts of this island it hath been a common practice in the *mania*...to reinforce the power of the cold bath by shutting up the patient alone, and properly secured, in a solitary church, where his fancy might be haunted all night long'. Quoted in Hunter and Macalpine, *Three hundred years of psychiatry*, 255.
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