*From 'What it Was' towards 'What it Ought to Be'**

The Montrose Bicentenary

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The founding of the Asylum

The Montrose Royal Asylum was founded by a remarkable person, Susan Carnegie, who lived at Charleton on the outskirts of Montrose. She had been greatly concerned about the appalling conditions under which many of the mentally ill were kept in the local Tolbooth. She appreciated the suffering experienced by these pauper lunatics, and perhaps also, being married to a Jacobite who had spent 20 years in exile in Sweden after fleeing from Culloden, had brought its own understanding.

Susan Carnegie was a person of great strength and determination. She was responsible for founding the first Savings Bank in Scotland and Scotland's first lifeboat was launched as a result of her energies. She had considerable skill as a poet and would have known and been interested in the work of Robert Ferguson, the young author of Scots poems and songs, whose death in 1774 after a period of 'furious mania' moved Dr Andrew Duncan to launch the appeal which eventually led to the foundation of the Edinburgh Royal Asylum.

Susan Carnegie's own appeal for the building of an asylum at Montrose met with a prompt, very liberal response from the local citizens and landed gentry. With the lively support of Alexander Christie, the Provost of Montrose, the appeal resulted in a sum of £632 1*s* 9*d*.[1] The tender of £420 for the proposed building was accepted and the asylum was officially completed on 23 June 1781. Mr James Booth was appointed Asylum Keeper and remained in that post for approximately 40 years. On 6 May 1782, the first patient was admitted to this, the first mental hospital in Scotland.

The 1818 Register of Lunatics

Up to 1834 the medical care of the patients was the responsibility of local doctors, usually two in number. It was not until 1818 that medical documentation became formalized. In that year the Managers resolved that a record be kept of all residents in the hospital. This 'Register of Lunatics 1818' is still extant and provides us with many fascinating details into types of treatment and in respect of social history.

In the opening pages of this Register one reads:

> The Managers of the Royal Asylum [the Asylum had received its Royal Charter in 1810] design that a history of the cases of Lunatic Patients confined in the said Asylum should be recorded in a book for the purpose. The Medical Attendants have to observe that it is impossible to comply with their request as they could wish, as hitherto no account of the rise and progress of insanity has been produced by their friends and relations, on their admission to the Asylum. To remedy this evil, they beg leave to suggest that it will be necessary before the admission of Lunatics that a history of their cases by a Medical person, or the Minister of the Parish, should accompany the certificate of Lunacy.

In glancing through the pages of the Register we find stories of sadness, crime, passion and thoughtlessness—familiar to the present generation of psychiatrists.

Since patients of the upper classes were usually treated at home or in a private madhouse, the patients in the asylum were either paupers or from the working classes. Shoemaker, servant, merchant, farm labourer, cabinetmaker, spinner, wife of a flax dresser—all walk across the pages. There were also those who had served in the Army or Navy. A midshipman injured his head in a fall while serving on an Indiaman. Lieutenant Thomas Brymer suffered from partial insanity following the 'disembodiment' of his regiment, the Forfar Militia. He was noted for a 'considerable degree of personal vanity, particularly on the beauty and bushing of his whiskers which are allowed to grow to a preposterous size.'

The majority of the patients came from the Angus (then Forfarshire) towns of Montrose and Arbroath; some came from as far afield as Edinburgh, Elgin and even Stromness in the Orkneys.

Diagnosis was vague. Terms like partial insanity, periodic insanity and common insanity were affixed to patients without any accompanying description of clinical features. Some terms, however, are more clear cut, such as puerperal mania and 'great despondency and religious melancholy'.

Music therapy of sorts

The Register of Lunatics, starting as it does in the lifetime of Susan Carnegie (who died in 1821), represents a direct link with the earliest days of the Asylum. At the time it was started, the oldest resident was Martha Wallace from the village of Stracathro, admitted in 1784. Her entry states that she is 'now quiet and composed' and subsequent entries merely say that she 'continues in the same state'. Then one day in May 1838 a fellow patient within the asylum created moments of magic and frenzy with his fiddle and bow, and Mrs Wallace, old and feeble as she now was, 'evinced her susceptibility to the charms of music by rising from her seat . . . and, with a cheerful countenance, hobbling and

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dancing, to the utmost of her strength, to the sprightly tune called Neil Gow.'

The Register notes that two other female patients had succumbed to the charms of music. Catherine Crighton of Arbroath, 'about ninety years of age' and a resident for twenty-seven years, 'smiled, her countenance brightened up, and she danced, as a Lunatic Musician played Scotch reels.' The other patient, Miss Forbes Anderson of Edinburgh, had been 'affected with Fatuity for twenty years past'; she too 'danced with considerable glee to the music of a fiddle'.

It seems likely that Dr David Paterson was the person who recorded these observations. Dr Paterson had been Medical Attendant at the asylum from 5 June 1810. A man of great compassion and strong convictions, he shared Susan Carnegie's abhorrence of the lack of continuity in medical care, for every six months two medical attendants were changed.

In a Report presented to the Managers jointly by himself and his colleague, Mr James Wills, Surgeon, in June 1828, the 'want of proper, that is to say, of permanent, medical attendance' is criticized. 'It is now very generally acknowledged that the services of a well-qualified Medical man cannot be dispensed with in a Lunatic Asylum—not only for the purpose of investigating the cases of the pitiable inmates, and prescribing medicine, diet, and moral treatment, but of duly arranging all things relative to them, for, in a Lunatic Asylum, there is very little indeed that does not resolve itself into Medical treatment. But, with an appointment of only six months, with a scanty allowance, and with other avocations, has a Medical person time or encouragement, or is it possible for him, to make the arrangements alluded to; and to do justice to seventy or eighty Patients. No, he has not, he cannot.'[2] In spite of this, no doctor was given a permanent contract until the appointment of Dr W. A. F. Browne in 1834.

But other observations that Dr Paterson and Mr Wills made in this 1828 Report bore fruit almost at once. They said: 'We have tried the power of music on the Patients and ... found it productive of the most happy effects ... inspiring almost all, more especially the females, to a greater or less degree, with happiness ... others, from seventy to ninety years of age, to rise from their seats and to move their feeble frames in time to the enchanting melody, and others sitting to listen and to gaze with wondrous delight.' They proposed making trial of a musician for two hours, twice or thrice a week.[3] The Managers complied with this request with both sympathy and promptness. The Sheriff Deputy of Forfarshire, on his official inspection in the Autumn of 1832 remarked: 'On Friday, a fiddler attends, and the Patients are allowed to dance—the males together and the females together. This is said to delight them very much.'[4]

Use of restraint

The 1818 Register reveals that some form of restraint was often used. Mention is even made of a male patient who was 'always furious—sometimes obliged to be chained in his cell.' The use of the strait-jacket (here usually spelt 'straight') and of unspecified 'constraints' is recorded from time to time. The strait-jacket or 'English camisole' is first mentioned in print in Alexander Cruden's description, in 1739, of his experiences as a patient,[5] while the first illustration appeared in Chiarugi's publication of 1794.[6] Haslam, writing in 1817, condemned the jacket as preventing the patient from feeding himself or wiping his nose, and expressed his preference for metal manacles to the wrists.[7]

One of the sadder cases at Montrose requiring constraint was Mr John Smith, aged 56, who had 'served for many years in the Royal Navy as a Gunner.' Mr Smith had been affected some years prior to his admission in 1827 with 'apoplexy which has deprived him of the free use of left arm and leg although he can walk with the assistance of a stick for a short distance ... the mental malady had been gradually increasing for some months past—a fortnight ago he was furious and required the straight jackets (sic)—now he is calm and peaceable.' But Mr John Hogg from Edinburgh, who was 'subjected to Epilepsy, and sometimes furious—never required the straight waistcoat.'

Mrs Munro Brechin, aged 29, who soon after 'gradually fell into a state of complete fatuity', and was still, several years later, 'furious, requiring to be constantly muffed—from her having destroyed her clothes with her teeth—a leather tippet (i.e. cape) has been put over the upper part of her dress.'

Laxatives and emetics

Frequent references are made to purging, vomiting and bleeding. Among these time-honoured remedies the use of laxatives held pride of place. Frequently one reads in respect of a patient's management: 'No medicines, occasional laxatives.'

Mary Low, single, aged 42, '... appeared in a state of profound Melancholia and believed herself in the power of evil spirits ... required to be in constant and severe restraint ... She refused all food for several days ... Bowels very obstinate. Had her head shaved, evaporating fluid applied. Had repeated strong doses of Calomel, Croton oil, etc.—with Cathartic evacuation.' She 'improved in mind and body' and was 'indulged with greater liberty.' Sadly, about seven weeks after her admission she developed 'catarrhal symptoms, to which severe Diarrhoea was soon added.' She relapsed mentally, refused food and was dead within the week. Possibly this middle-aged woman had had a depressive psychosis which terminated fatally as a consequence of poisoning with Calomel, i.e., mercurous chloride.

John Lyall of Montrose suffered from 'complete Mania brought on by hard Drinking and hereditary Predisposition.' His medical attendant directed: 'Let him have the Tartar Emetic occasionally and Purgative Medicines.' The fashion for inducing vomiting was to slowly recede. Burrows, in 1828, boldly stated: 'My confidence in emetics

alone in cases of insanity has been entirely dissipated.'[8]

Cases of recent insanity would often be subjected to shaving of the head: '... simple denuding of the scalp produces a calming and even soporific effect, in violent mania.'[9]

Blood letting

Bleeding, whether by application of leeches, venesection or cupping, followed the idea that there was 'increased vascular action or congestion of the vessels of the brain.'[9]

At Montrose head leeches were used, without success, on a patient described as of 'very irregular habits (and) a good deal given to the use of intoxicating liquors.'

Cupping involved the local abstraction of six to eight ounces of blood from the shaved head, the nape of the neck or between the shoulders. Removing blood by leeches or cupping was generally considered safer than venesection.[9] At Montrose there were accidents at times using the latter treatment, though not always with a disastrous end result.

A man of 40, David Gadd, on 13 October 1818 'had appeared distracted for some days ... he left his place in great haste with the notion that a Plan had been laid to assassinate him. He is of a very full and Plethoric Habit ... He has been blooded freely and to have strong purgatives.' The next note says: 'In the night after he was bled the Wound in the Arm had opened and he had lost a considerable quantity of blood from which he seemed to derive advantage. The Disease has gradually subsided and he goes out well.' The doctor later inscribed the words, 'Mark this well!!' at the foot of the page.

The first Superintendent at Montrose

Susan Carnegie, like the visiting doctors, had expressed her dissatisfaction with the provision for medical care and had pleaded with the Hospital Managers to arrange for the appointment of a Resident Physician. A resident Medical Superintendent was eventually appointed in 1834. She would, undoubtedly, have approved of the Committee's choice which fell to a young physician from Stirling, W. A. F. Browne (1805–1885). Browne's enthusiasm, knowledge and imagination had a most salutary effect on Managers, officials and attendants. While still a student at Edinburgh, he had been attracted to the study of the human mind under the influence of the Combe brothers.[10] He had visited continental asylums, and in fact spent the year 1832 studying mental diseases under Esquirol at Charenton and Pariset at the Salpêtrière. He was, of course, acquainted with the achievements of Pinel—he refers to the freeing from their chains of the lunatics at Bicêtre in his own book, *What Asylums Were, Are and Ought to Be*.[11]

This book was based on a set of lectures delivered by Browne before the Managers of the asylum and was published in 1837. In it Browne expressed his condemnation of the practices of the bad old days and presented his vision of an ideal asylum, a hive of activity, where freedom, comradeship and mutual assistance pervaded—a true therapeutic community. The book had a considerable influence, both directly and indirectly. It led, in the following year, to Browne becoming the first superintendent of the newly-opened Crichton Royal at Dumfries, where he was able to realize many of his plans.[12] When the Scottish Lunacy Laws were reformed in 1857, he was appointed one of the first Commissioners under the new Act.[9] Through his writings, his example as a Superintendent and his activities as Commissioner, Browne became probably the most celebrated Scottish psychiatrist of the mid-19th century. His influence on psychiatry has perhaps been insufficiently recognized, though the most striking passages in his book have been quoted and praised in fairly recent years.[13,14]

Browne's first clinical records

Browne brought to the study of the mentally ill a thorough, systematic approach. Immediately after coming to Montrose, he introduced a new casebook, which is still extant. He set to the task of writing up the histories of all 63 inmates for which purpose he devised a method of Queries and Answers. Browne insisted on classifying patients into diagnostic categories. In his book he produced his own classification of mental disorder. There were four categories: Idiocy, or non-development of faculties; Fatuity, or obliteration of faculties; Monomania, or derangement of one or more faculties; and Mania, i.e., derangement of all faculties. There were further sub-divisions of each of these four groups; those relating to Monomania comprise the following: Satiriasis, Destructiveness, Pride, Vanity, Timidity, Religiosity and Superstition, Despondency and Suspiciousness. The flourishing and extravagant nature of the delusions experienced by the psychotic patients of those times makes interesting reading today.

Delusions of a religious content were exceedingly common among patients suffering from depressive psychosis—monomania in Browne's classification. The following case is a slightly unusual variation of the religious theme. Mr James Williamson, aged 50, a shoemaker, was a long-term patient by the time Browne arrived at Montrose. Browne noted that this patient was often to be heard giving sermons which were composed of 'scriptural texts, directions for cookery and occasionally of obscenities.' He would 'retire to his cell ... where he performs the rites of baptism and marriage ... his shoes and boots acting as the parties in these ceremonies.'

Patients with expansive and grandiose delusions often claimed that they were on equal social terms with the local artistocracy. One such patient was David Dingwall who had been a grocer, and had been resident in the asylum for 30 years. Browne noted that he claimed 'acquaintance with all the great personages including Lords Aberdeen and Loughborough: the latter he sees constantly seated in the corner of the wall of the airing court.'

Miss Agnes Barclay, aged 22, a milliner, said to be pious and of irreproachable character, was noted by Browne to be

'walking on her tiptoes, the only mode suitable, she said, to her dignity, she being then Princess Victoria.' This patient was ordered emmenagogues (to stimulate the menstrual flow), but her recovery eventually followed the introduction of wine and restoratives.

Early diversional therapy

Directly as a result of his experience at the asylums at Charenton and Bicêtre, Browne became an earnest advocate of the 'benefits of engaging every patient in some suitable occupation.' 'Gardens, grounds, or farms must be attached to each establishment, and must be cultivated by or under the direction of lunatics.' He went on: 'By using the proper incentives 90 out of every 100 recent cases may be induced to do this. Even in old cases, where the mind and muscles have been allowed to slumber, wonderful transformations may be accomplished.'[15]

One of the occupations pursued was oakum teasing. One patient, William Graham, a weaver, was astute enough to reverse the process involved in oakum teasing; from strands collected surreptitiously from the asylum workshop he manufactured a rope in order to effect his escape! The details make fascinating reading: 'Mr Graham was admitted violent and in a state of intoxification. He said that the Bible had been altered and written in characters of blood. He was noted to be full of cunning and concealment, adept at deception and stratagem. He has escaped from Dundee, Aberdeen, and Montrose asylums in succession. Even upon this occasion he had contrived to form a ladder of ropes by stealing oakum and twisting it in his cell during moonlight; to the end of this rope he attached a part of his beam, threw the whole over the wall of the airing ground and made good his depart. He returned, however, the following morning being drawn back by the extreme cold which then prevailed.' It was December!

Browne as Commissioner

Undoubtedly the managers of the Montrose Royal Lunatic Asylum were devastated by the news of Browne's acceptance in 1838 of the Superintendency of the Crichton Royal Hospital at Dumfries. The Managers can only have hoped for a second Browne as his successor; they stipulated that he must be of 'gentle and amiable disposition and high moral worth. The Superintendent is absolutely despotic within the walls of the institution; it rests with him whether the unhappy maniac shall be treated with a cold bath or the straight waistcoat, or be indulged with the fiddle, newspaper, or the backgammon board.' W. A. F. Browne left for those who followed him a challenging and radical attitude that we would do well to emulate today.

After a gap of twenty years, W. A. F. Browne returned to the Montrose Asylum as one of the three statutory Commissioners in Lunacy, his first visits being in June and December 1858.

Browne's reports contained both wholesome praise and pungent criticisms. In June 1858 he noted with approval the number of patients engaged in a dozen different occupations, and the busy social programme: 'There is a weekly ball, a monthly concert, lectures, exhibitions of the magic lantern, excursions and drives into the country as means of distraction and diversion. There is a class for improvement in singing twice a week. Service is performed by a Chaplain every Sunday morning. It is especially worthy of remark that ladies from the neighbouring town assist in conducting the school once a week and add the beneficial influence of sane and sympathizing minds to the ordinary effects of occupation and intellectual training.' But at the same time he deplored the 'crowded state of some galleries, the proximity of the Asylum to a populous quarter of the Town . . . There is a need to expedite the completion and occupancy of the new establishment (being built in the village of Hillside three miles north of Montrose), estimated to contain accommodation for 300 paupers as well as for the affluent classes.'

At his second visit in 1858, Browne noted with approval that 'an additional medical assistant was to be appointed, and, with his views on the importance of filling the patients' leisure hours he must have relished the 'evening entertainment consisting of music and dancing' which he witnessed and which, he wrote, 'demonstrates the amount of good humour and contentment and positive enjoyment which are compatible with some of the most severe and indurable forms of mental disease.'

By this time twenty-two patients had been 'removed to the new Building at Sunnyside' and were engaged in the formation of an airing ground there. But Dr J. C. Howden, appointed as Superintendent of Sunnyside in the same year, was distinctly unimpressed by this exercise. After twenty years of hard campaigning he persuaded his board to have the airing court walls removed. He wrote: 'Whatever be the results in a curative point of view, it is certainly pleasanter to an onlooker to see the patients all joining in amusements in a large open park, where they can have recourse to cricket, croquet, lawn tennis, archery, football, and other outdoor sports, than to see them pacing about aimlessly in an enclosed pen.'[16]

That, however, is another story in the annals of the Montrose Asylum . . .

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Foreign Report

Psychiatric Research in India

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The progress of psychiatry in India during the last 35 years is indeed impressive. At the time of Independence in 1947, there were just a handful of Indian psychiatrists looking after some 20 odd mental hospitals scattered throughout the country. Colonel M. Taylor (1946), who reviewed the status of mental health services for the Bhore Committee on Health Survey Development in India, ruefully noted the gross inadequacy of mental health services. A major recommendation of the Committee (1946) was to start local training facilities for doctors and other health professionals in the field of mental health. The first landmark was the opening of the All India Institute of Mental Health at Bangalore in 1954. The role of Dr Mayer-Gross, who was closely associated with the development of this Institute in its early years, will be long remembered by many Indian psychiatrists.

Following this event, progress was rapid. Soon a number of other centres in Delhi, Chandigarh, Bombay, Calcutta, Madras, Ranchi, Lucknow, etc., took up postgraduate training programmes in psychiatry. At present there are over 25 postgraduate training centres. Every year about 80-100 new psychiatrists qualify (the present total number of qualified psychiatrists in India is about 800). Psychiatry is no longer confined only to mental hospitals (which number over 40), but has spread to over 150 teaching and other general hospitals. In many states like Kerala, Tamilnadu and West Bengal there is now a psychiatrist at almost every District. There are also many psychiatrists, especially in the big cities, who have gone into full-time private practice. However, total mental health problems of India are nowhere near a solution. For a population of about 700 million, the ratio still remains about one psychiatrist for a million people. Other mental health professionals are even fewer, and facilities are mostly confined to big cities.

Against the background of such limited resources and heavy pressure of patient care work, many psychiatrists in developing countries necessarily regard psychiatric research as luxury. On the other hand, many others have felt that service, training and research are three essential components of any good health programme and research is of vital importance for a developing country.

At the time of Independence, psychiatric research was virtually non-existent. Occasionally some good papers by Indian psychiatrists had appeared in the world literature but these were very few and no organized psychiatric research was being conducted anywhere. The meetings of the Indian Division of the Royal Medico-Psychological Association, which were not very frequent, provided a forum for academic discussion. Since 1946, the annual meetings of the independent Indian Psychiatric Society have become the principal forum for psychiatric research presentations. The main impetus for research, however, came with the opening of the psychiatric postgraduate training centres. Many of these centres were situated in teaching medical institutions in general hospitals and these provided not only special laboratory help, but also much needed research atmosphere.

One major handicap to a research scientist in a developing country is lack of openings for publication. Research workers in developing countries often feel, perhaps unjustifiably, that their papers are refused not so much for the content of the research material as for the poor sophistication in presenting the results in a foreign European language. It is also true that problems relating to India may not be of much interest to the average reader of British or American psychiatric journals. Thus, emergence of local journals has been a significant step in the promotion of medical research. In India at present there are five or six journals devoted to psychiatry, clinical psychology and related mental health disciplines. Of these, the *Indian Journal of Psychiatry*, under the editorship of first Dr