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# **Doctoring in a whisky-injured nation -the medical response to the “alcohol question” in Scotland, 1855-1925**

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## Abstract

Scottish people have a reputation for being high consumers of alcohol. Certainly this is the case today and was also the case throughout the nineteenth century-the most obvious comparison to be made, a comparison often made both then and now, is with supposedly more moderate English drinking habits. Less well known is the reversal of this perspective during the inter-war years (1918–1939), when Scotland was held in many quarters to be more sober than England. This turnaround was brought about by changes in popular culture alongside specific alcohol control legislation that had a greater impact in Scotland.

This thesis is not an exploration per se of why alcohol consumption rose in nineteenth-century Scotland, fell in the first half of the twentieth century and rose again to damaging levels at the end of the twentieth century. This high level of consumption persists in 2017 and the Scottish government is still acting to reduce alcohol-related harm by a variety of measures. Rather this thesis seeks to explore the response of the Scottish medical profession to the changing conditions in relation to alcohol over a seventy-year period from 1855 to 1925. (Chapter 3 and Chapter 4 set the scene).

The starting point of 1855 for the period examined in this thesis is taken from the 1855–57 Inquiry by the Scottish Lunacy Commission, which led to the Lunacy Act (Scotland) of 1857. This report demonstrates that Scottish psychiatry was already having to deal with the mental consequences of alcohol and describes oinomania, an early term for alcohol dependence. The report introduces the idea that alcohol can itself cause insanity – an estimated 20% or more of the cases in asylums were caused by intemperance around that time and this figure was deemed to rise as the century wore on. This seems like a curious and excessive causal attribution from today’s perspective.

In this thesis I trace how the idea of a persistent form of alcoholic insanity evolved in the Scottish context (Chapters 4 and 6), and I outline changing terminology and ideas around the mental consequences of alcohol (Chapters 5, 6, 7 and 8). These ideas were expounded by physicians and alienists<sup>1</sup> in the public arena of parliamentary inquiries in the second half of the nineteenth century (Chapter 4) as well as in the specialised literature of the time (Chapters 5, 6, 7 and 8), including the medical reports within the Annual Reports of asylums.

Original to this thesis in relation to primary sources is an in-depth analysis of the alcohol cases received by the Delirium Ward at the Royal Infirmary of Edinburgh between 1856 and 1867, in the May to July period of each of these years (Chapter 5). These 178 recorded cases (57% of all

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<sup>1</sup> Alienist being a term for a psychiatrist at this time.

admissions with threatening or actual delirium) illustrate that alcohol problems in the form of incipient or established delirium tremens were a common reason for admission to hospital at this early date and that such cases were of particular interest to physicians. It is striking that beyond the acute episode of what was erroneously thought to be an intoxication-induced illness there is no apparent attempt to help the person with their underlying intemperance (Chapter 5).

The idea that later emerged of an underlying condition of inebriety, differentiated from insanity, was to have practical consequences in that it led to the setting up and running of Inebriate Reformatories in Scotland, as elsewhere in the British Isles, in the first quarter of the Twentieth century (Chapters 7 and 8). I trace this story in detail through to the closure of the Inebriate Reformatories in 1925, whilst examining this in a Scottish context.

Other scholars have looked at the era of the Inebriate Reformatories in Scotland from the perspectives of sociology, of history and of feminist theory. I review the previous literature in Chapter 2, and provide a historiography spanning the last hundred years. I also bring a fresh medical perspective to the topic in Chapter 7, which uses records not available to some of the previous scholars, and produce a very detailed analysis of the female cases sent to the Glasgow Reformatory (Girgenti House). This is presented in Chapter 8.

The time period cut-off of 1925 for the end of the thesis is made for pragmatic reasons, as the trends in the conception of alcoholism and alcohol use disorders, and in treatment provision, since 1925 would merit separate full consideration. I do, however, sketch out these trends for this later period in a Postscript (Chapter 9) in order to give a context for drawing out some historic lessons from 1855–1925 in my Conclusion and Discussion (Chapter 10) about the “alcohol question” in the Scotland of today. The period I cover therefore includes an historic high in alcohol consumption in the late nineteenth century and an historic low in the 1920s. I aim to show how practice and theory interconnected during these years in the work of medical men such as Thomas Laycock, David Yellowlees, Sir Thomas Clouston, William Tennent Gairdner, James Craufurd Dunlop, John Cunningham and Sir David Henderson. I also describe some of the connections between these key medical figures within the Scottish system in Chapter 4.

The post-1920 period also illustrates a sea change from a time where psychiatrists were arguing for the separation of the “inebriate” from the “lunatic” in terms of service provision to one where the “alcoholic” is seen as deserving of new forms of psychiatric help. This shift in practice, around the end of the period of my study, is seen in the context of a changing emphasis from a more biological view of the problem to a more psychodynamic, or dynamic, view as seen in the work of Henderson and others. The fact that this shift in theory and practice coincides with a decline in the alcohol



problem is discussed in the light of Skog's idea that our concerns around alcohol vary in relation to where we are in relation to "waves of consumption" (Chapter 10).

My overall aim in this thesis, then, is to set out how from 1855 to 1925 medicine in Scotland responded to the idea that habituated use of alcohol might represent a disease in its own right. The idea of such a "disease of the will" remains both legally and philosophically controversial to this day. This is perhaps why our diagnostic systems continue to change in this area without final resolution. An associated aim of the thesis is to look at three aspects of the "drinking disease", in Scotland, namely delirium tremens, alcoholic insanity and inebriety, where practice can be examined from case records and related to theory as represented in a range of publications.

I also prove, and highlight the fact, that institutionalised medicine cannot escape engagement with the problem of alcohol. From the beginning, Scottish doctors in both infirmaries and asylums were presented with the consequences of heavy drinking in a sizeable proportion of patients. As with recent epidemiological analyses, alcohol consumption levels in the general population during the nineteenth and early twentieth century are shown to correlate highly with the incidence and prevalence of such disease consequences from the Scottish national and local statistics available. Then, as now, doctors were inevitably drawn into the issue of how best to respond to the underlying habit of drinking both at an individual and societal level. I draw lessons from my study of the past for our continuing struggle in this regard.

## **Dedication**

For my wife Brenda, for supporting me and allowing me the time to pursue this project over these last six years.

For my father and mother, David and Margaret Smith, for supporting me through medical school at the beginning of my journey,

Also, for Graeme, my brother.

## Acknowledgements

First, and foremost, I would like to thank my three supervisors at the University of Glasgow: Professor Malcolm Nicolson and Dr. Rosemary Elliot, both of the Centre for History of Medicine, in conjunction with Dr. Kenneth Mullen, of the School of Medicine, Dentistry and Nursing. They all showed steadfast patience and encouragement to me in my research which, given the vagaries of full-time clinical practice and various personal circumstances, proceeded in fits and starts over the six-year period that is allowed for a part-time M.D. degree.

Also, as part of the supervisory system, the annual reviews conducted by Professor Jonathan Evans and Dr. Sarah Wilson were both supportive and encouraging and helped to keep me motivated as to the relevance of my research. The generic training from the University of Glasgow on such topics as literature searching and writing skills was also invaluable. The reading group at the Centre for History of Medicine led by Dr. Angus Ferguson along with both the Glasgow and Edinburgh History of Medicine Seminar Series gave useful grounding in the world of medical history over the last six and a half years.

The University of Glasgow additionally provides an exceptional online library service, which I was able to access through remote desktop at home. The same remote desktop provided all the tools I required for the basic quantitative analysis presented in this thesis in relation to the data from the Delirium Ward, the Girgenti women and the alcohol insanity statistics.

Unforeseen at the beginning, but most welcome along the way, was the overlapping scholarship by Dr. Thora Hands on the Girgenti women and the Scottish Inebriate System in general. My ideas on this topic were enriched by discussions with Thora over the years and through our collaboration on a poster, which was presented at the Society for Study of Addiction in 2012. The poster, and an associated short article published in the Medical Council on Alcohol newsletter *Alcoholis*, compared and contrasted our perspectives on the working of the Glasgow Certified Inebriate Reformatory. This collaboration undoubtedly helped broaden my thinking for Section IV of my thesis.

During the last eight years I have been welcomed as a clinician into the world of the Alcohol and Drug History Society (ADHS) and received encouragement for my work at the outset when I presented at the Biennial Conference held in Glasgow in 2009, prior to commencing the MD research. Further useful discussion was gained towards the end of my MD when I presented as part of a panel of three talks on Scottish and British alcohol history at the ADHS 2015 conference in Bowling Green, Ohio. Additional ideas for my work were gained when the two worlds of addiction historical research and addiction science and practice came together in November 2016 in York.

The Society for the Study of Addiction hosted a joint conference with ADHS. I had the privilege of closing the conference, giving a talk on why the field of addiction science needed to be aware of its own history. Particularly so in relation to the contested status of the phenomenon of addiction it seeks to study.

I also need to thank all my clinical and administrative colleagues at the Kershaw Unit at Gartnavel Royal Hospital for their support during these six years. In particular, Dr. Frances Skelton, who has shown understanding for my occasional absences from the unit, during my agreed study time, when I needed to pursue the many hours of archival research required for this work.

In relation to archivists there are a number of sets of staff I require to thank. The journey began with visits to the National Records for Scotland (NRS) in Edinburgh, continued with both early and late visits to the Archive room at the Mitchell library which hosts both the archive of the City of Glasgow and that of NHS Greater Glasgow and Clyde. In the middle of the journey there were numerous visits to the Lothian Health Service Archive (LHSA) based at the Centre for Research Collections (CRC) at the University of Edinburgh library. Particularly at LHSA I wish to thank their former archivist, Dr. Mike Barfoot, who having attended one of my talks at the Centre for the History of Medicine pointed me in the direction of the casebooks of Ward X, the Delirium ward. As far as I can ascertain I am the first scholar to utilise this source in regard of the interesting story that surrounds the history of the diagnosis and treatment of delirium tremens; a story, which will hopefully become more widely known.

Proofreading help came from a number of sources; my supervisors throughout with extra help at the end from Dr. Rosemary Elliot and also Fiona Bannatyne. However, it is difficult to comment on an ever-changing manuscript and I can only thank them for their help and encouragement. The flaws in the work, the known and the unknown, are in the end entirely my own responsibility.

The journey began with the award of a Wellcome Clinical Research Fellowship for a four month sabbatical taken in 2009. This allowed me to look at the State Inebriate Reformatory records and the records of the civil service in relation to the workings of the Inebriates Acts in Scotland. I owe a debt therefore to the Wellcome Trust.

Finally, I would to thank my friend of thirty years, fellow psychiatrist Dr. Allan Beveridge, for helping me to sustain an interest in the history of psychiatry. From our many conversations over those years, we both share the hope that the next generation of psychiatrists will have some amongst them who will see the relevance of historical study for their ongoing clinical practice.

## **Author's Declaration**

I declare that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Iain David Smith

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## **SECTION I**

**The alcohol question in Scotland,  
1855-1925 (and beyond) -  
setting the scene**

## Chapter 1

### The medical response to the “alcohol question” in Scotland, 1855-1925 - an introductory overview.

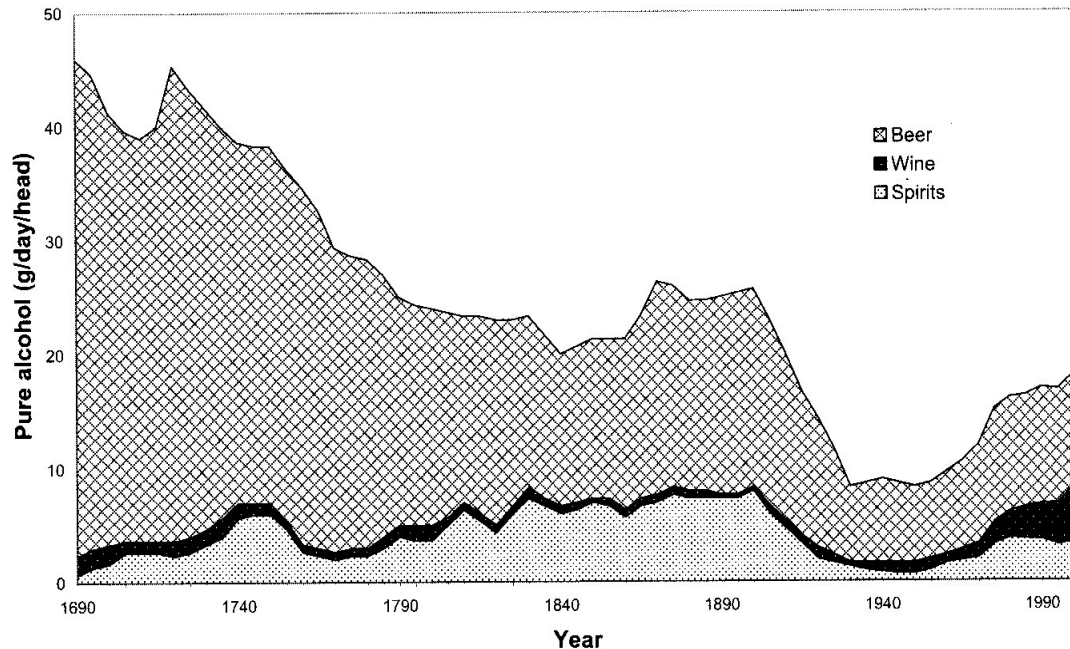


Figure 1. Graph of alcohol consumption in Britain, 1690-2000.

## 1.1 Introduction

### 1.1.1 General theoretical considerations

This thesis will explore medical responses to the troubled relationship Scottish people have had with their favourite drug – alcohol – over the past two centuries. Scots have a worldwide reputation as heavy drinkers, mainly based on perceptions that persist from the nineteenth century – statistics in the latter part of the century showed more drink-related crime than elsewhere in Great Britain. In the earlier part of the nineteenth century heavy drinking seemed the norm throughout Scottish society whereas by the end there was a stark contrast to be made between “refined” and “rough” cultures. The drinking culture within Scotland’s central belt was also affected by Irish immigration after 1830.

This thesis will focus on a seventy-year period from the middle of the nineteenth to the end of the first quarter of the twentieth century, from 1855–1925. During this period there is an extreme peak and trough in relation to the population’s alcohol consumption in Scotland - Figure 1 shows that in the 1880s and 1890s, the average individual in Britain was drinking 25 grammes (or more) of pure

alcohol per day whereas by the 1920s and 1930s this had more than halved to an average of under 10 g/head/day<sup>2</sup>. This fluctuation in alcohol consumption also coincides with a formative period in relation to the engagement of the Scottish medical profession with the “alcohol question”<sup>3</sup>. This period therefore provides an opportunity to research changes in diagnostic practice, aetiological explanation and treatment in relation to the underlying addictive habit in those “enslaved”<sup>4</sup> by alcohol. Inextricably linked to such an exploration is the need to study the treatment and management of the physical, psychological and social consequences that arise from the habit. It was mainly these consequences of heavy drinking that would bring an individual to the attention of the physician and the alienist.

Explanatory theories as to the nature of problem drinking have varied considerably over the modern period in both Scotland and Great Britain. There are two broad groups of paradigms competing for centre stage in the social and political arena in the nineteenth century and again in more recent times. The first group of paradigms consists of those that emphasise the availability of the drug as the main problem, since alcohol, or particular types of alcohol, are seen as capable of affecting and undermining all individuals. The temperance movement or the more recent public health/population approach are examples of this. The second group of paradigms emphasise individual vulnerability to the effects of alcohol as the main issue, whether this is innate or acquired or a mixture of both. The latter grouping is the medical model in its earliest and later formulations, and this idea can still be seen in some modern incarnations, particularly those models influenced by research from the USA that emphasise biological and genetic factors. (Sometimes this idea is referred to as the “NIDA paradigm” or the “hijacked brain” model.)<sup>5</sup>

### **1.1.2 Enlightenment Scotland and the idea of heavy drinking as a disease**

The history of Scottish medical concern with alcohol addiction inevitably needs to touch on the conditions in Scottish medical education that led to two pupils of William Cullen – Benjamin Rush and Thomas Trotter – to write seminal texts on the medical aspects of alcohol use. These are seen as the forerunners of the concepts of alcoholism and the disease theory of alcohol addiction. Most notably in 1804 Thomas Trotter, an Edinburgh-trained physician, published his revised and expanded 1788 M.D. thesis.

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<sup>2</sup> The graph is an extension of that provided by Spring and Buss, 1977 in their *Nature* article on alcohol in the British diet.

<sup>3</sup> The phrase the “Alcohol Question” is used in the historical literature as shorthand for the broad question of how a society should respond to an epidemic of overuse.

<sup>4</sup> The word addiction has Latin roots: *addictionem* (nominative *addictio*) “an awarding, a delivering up.” The central question from the nineteenth century onwards in our concept of addiction remains to what extent our will is given over to the object of the condition, whether alcohol, other drugs or non-chemical behavior such as gambling.

<sup>5</sup> For a recent analysis of this concept see Hall et al, 2014.

In it he states:

“In medical language, I consider drunkenness, strictly speaking, to be a disease, produced by a remote cause, and giving birth to actions and movements in the living body that disorder the functions of health . . . The habit of drunkenness is a disease of the mind.”<sup>6</sup>

This doctrine sets the scene for the nascent discipline of psychiatry’s future entry into the debate around the alcohol question later in the nineteenth century. Exploring the Scottish psychiatric viewpoint on the alcohol question is one of the main threads of original research in this work.

The medical concern over heavy alcohol use in the nineteenth century eventually crystallised in the various and overlapping diagnoses of habitual drunkenness, dipsomania, oinomania, mania a potu, alcoholic insanity, delirium tremens, inebriety and chronic alcoholism.<sup>7</sup> At the core of most of these medical diagnoses is the notion that the will has been subverted and what initially may have been a vice has transformed into a now irresistible urge that can be categorised as a disease of the mind and brought under medical governance<sup>8</sup>.

This thesis will explore the differences and similarities in these diagnostic categories as they were applied in the Scottish context, and explore the evolution and changing meaning of these terms over the time periods under consideration. It will show how the emergence of the concept of inebriety, distinguished in both medical and legal terms from insanity, was to have practical consequences in the setting up and running of Inebriate Reformatories in the first quarter of the twentieth century.

### **1.1.3 The interplay between temperance and medicine**

Of course, some common ground existed between these two broad sets of ideas – the temperance and medical models – but there were definite tensions to be found between the paradigms, which were to play out later in the policies of the early twentieth century. The two approaches have also produced consequences that are still in evidence today. Today’s medical commentary is likely to echo the temperance of the nineteenth century, pointing to social harm to self and others through alcohol rather than confining itself to the direct effects of alcohol on mind and body.

Therefore, for example, in a reversal of the nineteenth-century norm, most medical authorities would be in accord with the temperance idea that alcohol needs to be limited at a population level

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<sup>6</sup> Trotter’s book is available still with a foreword by Roy Porter, 1988 and 2013

<sup>7</sup> There is renewed interest in the evolution of terminology in the addiction field.: see Berridge et al, 2014 for output from the ALICE RAP project.

<sup>8</sup> For an extended discussion of the idea of Diseases of the Will see Valverde. 1998.



to reduce health and social harm across the board. This is sometimes referred to as the Population Approach and it is coupled with the idea of the Prevention Paradox. This states that more alcohol-related disease can be prevented by somehow getting the majority of moderate drinkers, who do not have alcoholism or alcohol dependence, to shift their consumption downwards. This is found to be superior to the Targeted Approach, where resources are only used to assist the relative minority of the severest drinkers to shift their intake to a reduced level. In practice both approaches are needed in any comprehensive alcohol strategy.

Arguably the nineteenth century medical conception of alcoholism lives on today in an organisation that has gained worldwide reach and success – Alcoholics Anonymous (A.A.), which was eighty years old in 2015. A.A. distinguishes the “true” alcoholic from the mere heavy drinker in its writings, chiming with these earlier medical doctrines. It holds that the alcoholic is constitutionally different and will sometimes talk of an inborn diathesis or “allergy” to alcohol. This approach represents an individual or targeted or person-centred approach more in accord with a traditional disease or medical model of addiction. As well as A.A., some neuroscientists also emphasise this concept and in the North American context of today these ideas are mutually reinforcing a disease theory of alcoholism/alcohol addiction.

At the end of the nineteenth century in Britain, inebriates legislation was passed which was based on this particular medical conception of the problem – contrasting with the simultaneous zenith of the temperance movement that was soon to follow. The era of Prohibition in the United States and control and restriction of alcohol in Great Britain during and after World War One was to be the crowning achievement of a hundred-year campaign by temperance advocates that arose from, among several locations, small beginnings in the West of Scotland<sup>9</sup>. This success was a major influence in closing down the Inebriate Reformatories and restricting the nascent medical discipline of addiction medicine or psychiatry to a reduced private sector of care.

The quiescent interwar years hold interest for the medical historian, given the all-time low levels of recorded consumption in Great Britain – the beginning of this period is explored in this thesis. Additionally, alcohol was considered a major political issue during the whole period being examined in this thesis.<sup>10</sup> In the forty-or-so years that followed (1925–1965) this was much less the case, as the issue seemed largely resolved. It has only regained prominence in the United Kingdom over the last five decades in the post-World War Two period, i.e. 1965 to the present day, and once again there is a particular Scottish slant to this public concern within the United Kingdom context, just as there was in the late nineteenth century.

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<sup>9</sup> See King, 1979 for a discussion of the seminal contribution of Scottish thinkers to the Temperance Movement.

<sup>10</sup> See Nicholls, 2011 for discussion of this.

The problem with rising alcohol consumption in the UK over the years since World War Two is beyond the research period of this thesis. However, given this rise is a large part of the explanation of Scotland's current status as the “sick man of Western Europe” in relation to public health, it is hoped that lessons for today can be learned from the responses to the previous alcohol peak in the 1890s. The responses to the consequences of the culture of intoxication at that time have much in common with ideas again under consideration today<sup>11</sup>.

Today we have good evidence derived from alcohol sales figures that show Scottish people are consuming more alcohol per person each year than people in England and Wales. This has uncanny echoes of the nineteenth-century situation, where Scotland was seen as more drunken based on arrest statistics, and helps make the case for examining Scotland separately from England and Wales. Beyond what can be explained by the obvious sociodemographic factors relating to poverty and class, the characteristics of Scottish culture, that underpin this stark difference remain elusive but will be touched upon, as far as the various protagonists mention them. Additionally, it should be noted that this same culture was to be more successful in pursuing the temperance agenda than other home nations, such that Scotland was held up as an exemplar of sobriety in the early 1930s by the UK parliament.

With the most recent turnaround in consumption, today's devolved parliament in Scotland has had to invest heavily in trying to combat Scotland's current poor health consequent upon alcohol and is leading the way in this regard compared to other countries in the British Isles and within Europe. The Scottish alcohol strategy is still to be implemented fully in relation to the measures that may have the greatest effect. In particular, Minimum Unit Pricing is a source of ongoing legal challenge from the Scottish Whisky Association. Despite this, much progress has been made in respect of other measures as documented in the final MESAS report<sup>12</sup> (March 2016). With no modern-day temperance movement emerging to combat our present Scottish culture of excessive drinking it now falls to the medical profession, among others, to champion the population-based approach to lessening the ill effects of alcohol. Today's counterarguments for a solely targeted approach to the alcohol problem are found to come from some unexpected quarters, in particular the drinks industry. The targeted approach, when put forward by the Portman Group among others, is an attempt to deflect public policy away from the population-based approach, which would undoubtedly have more of an impact on industry profits.

We will explore all of this again in a postscript to the thesis, which looks briefly at medical involvement with the reemerged “alcohol question” in the Scottish context.

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<sup>11</sup> The recent Scottish Labour proposal for Alcohol Treatment and Testing Orders (ATTOs) as a court disposal has similarity to the Inebriate legislation of the 1890s.

<sup>12</sup> MESAS stands for Monitoring and Evaluation of Scotland's Alcohol Strategy. An expert group was set up to track the effects of the policies implemented from the strategy.

## 1.2 Why study the history of alcohol in all its aspects?

This thesis has arisen because of my awareness of a thriving field of study in relation to alcohol and drug history. I would like here to briefly describe this area of research and set out reasons why studies such as my own are of relevance to the field of practice.

Firstly, the historical perspective on addictive substances is capable of challenging polarised views on drug and alcohol policy. It is often the case today that journalistic and political accounts in this area lack a sense of this longer history with current “drug scares” being accompanied by amnesia regards the past. It is a hopeful sign that historians have established research networks in this field and have made inputs into health and social policy<sup>13</sup>. Within the British context, the work of historians such as Virginia Berridge and James Nicholls has been influential in addressing this interface between our historical understanding of addictive substances and the formulation of a policy response to the current alcohol and drug “epidemics”<sup>14</sup>.

Secondly, alcohol and drug history is, of course, a branch of study that is only in small part medical history. Arguably alcohol and drug history belongs more to the fields of social, political, economic and cultural history. We are well aware that great wealth and political influence has resulted from trades in opium, alcohol and tobacco as well as cocaine and cannabis. Also, some historians have viewed mind-altering substances, given their ubiquitous nature, as “cultural-signifiers” in terms of their patterns of use in every-day life across time and place. Our history around alcohol goes deep into our evolutionary past, predating written records<sup>15</sup>. Both Hames (2012) and Phillips (2014) give us broad-sweep histories on the role of alcohol in civilisation from the earliest times up until today. Phillips has a section in his book called “The Enemies of Alcohol” in which he discusses the rise of temperance and prohibitionist ideologies.

Thirdly, studies focusing on the role of the medical profession in the history of mind-altering and addictive drugs (including alcohol) are of particular note for this thesis. Such studies are far from numerous and much work remains to be undertaken in this area. One theme from such research as exists is that doctors often discover and advocate the use of substances prior to a period of reversal where the medical profession seeks to restrict the use of the same drug. One author (Mike Jay) describes this as a Frankenstein narrative (Jay, 2000; Jay, 2011). Whilst unlike many other mind-altering drugs, doctors didn’t invent alcohol -for many centuries they recommended its use and saw

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<sup>13</sup> The Alcohol and Drug History society (ADHS) has gone from strength to strength in recent years.

<sup>14</sup> See Virginia Berridge, ‘Public or Policy Understanding of History?’ *Social History of Medicine*, 16 (3), 2003, pp. 511-523 for discussion of this nexus.

<sup>15</sup> See Hornsey, 2012 and Dudley, 2014. Both these authors introduce us to the idea of the “drunken monkey” and explain the evolutionary advantage of an adaptation that allows for alcohol consumption.

it as having medicinal properties. This helps to explain some of the ambivalence amongst Scottish doctors towards the temperance movement in the nineteenth century that I will describe below.

Finally, it should be noted that the writing of history in this area is potentially problematic given the polarised political and moral views that exist around the use of licit and illicit drugs, including alcohol and tobacco. It is interesting to note that in the nineteenth century the leaders of the temperance movement documented the history of their own organisation over many decades and in great detail, with a view to bolstering their campaign to lessen or abolish the scourge of alcohol. An early book on the history of alcohol in the British Isles published in the 1830s was the product of a clergyman and temperance advocate pursuing this interest in his spare time. This was history with a particular purpose. The biases today within polemical rather than balanced histories tend more towards the opposite viewpoint, i.e. advocacy of legalisation and liberalisation rather than restriction and prohibition, because of the failure of the “War on Drugs”<sup>16</sup>.

Thankfully, just as there has been a trend within medical history generally to move away from the biases of “Whigism” – i.e. an anachronistic view of history from the knowledge and beliefs that prevail at the point of authorship – there has also been a renaissance of studies in the alcohol and drug history by professional historians seeking to be as neutral as is achievable. These historians consider how their own biases and beliefs may be influencing their research and historical writing. In the United Kingdom Virginia Berridge, as already mentioned, and Brian Harrison and James Nicholls stand out, and in North America David Courtwright and Jessica Warner are exemplars of this academic discipline. Additionally, many sociologists, psychiatrists and psychologists working in the addiction field have become interested in the longer view provided by history in helping to inform particular models of how consumption varies in relation to mind-altering substances and as to how different consequences arise including the phenomenon of addiction itself. The work of Robin Room in particular comes to mind<sup>17</sup> and also that of Griffith Edwards<sup>18</sup>. Such historical research has also produced some challenging “grand theories” of addiction, which try to redress the balance of the overly biological North American paradigm by restoring the social dimension to the problem – a good example of this is Bruce Alexander’s “The Globalisation of Addiction” (Alexander, 2000 and Alexander, 2010).

In Chapter 2 of this thesis I offer up a review of the key literature that focuses on the main area of interest of my thesis – namely the role of medicine, and Scottish medicine in particular – in conceiving of and responding to what we would now call alcohol use disorders.

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<sup>16</sup> See Seddon, 2010 and Dalrymple, 2006 for examples.

<sup>17</sup> See [www.robinroom.net](http://www.robinroom.net)

<sup>18</sup> Edwards, 2000 and Edwards, 2004 are of particular note.

Having raised the issue of potential biases in the writing of medical history I should here admit to my own inescapable position of being a clinician who has worked in the field of addiction psychiatry for some thirty years, a field whose history I seek to document and analyse in the pages which follow. I am also a serving member on the committees of Scottish Health Action on Alcohol Problems and of the educational charity, the Medical Council on Alcohol. I am certainly in favour of more governmental action to curtail the extent of hazardous drinking today and I have campaigned for the introduction of Minimum Unit Pricing for alcohol, which will go ahead in Scotland in 2018.

Additionally it should be noted that one of my main examples in this thesis is that of the history of Glasgow psychiatry in relation to the question of alcohol and I have a longstanding interest in the history of psychiatry in the West of Scotland in general which I draw on in focusing down on the issue of where the “alcohol question” stood in relation to psychiatry from 1855-1925. Both Yellowlees and Henderson are figures that I have been aware of for some time as a result of this interest and they prove to be important figures in the history which I explore in this work.

However, I have no great investment in the disease theory of addiction per se and recognise that taking a positivist view in this area would leave me open to ridicule and attack on the basis that the ontological status of addiction is unresolved and probably irresolvable. Part of the fascination of this subject is that it lies at an intersection between medical science and social theory, and therefore the social constructionist viewpoint needs to be considered in understanding the findings in this branch of medicine. The more extreme claims of medical science in relation to the “hijacked brain” can then be viewed with scepticism and with the knowledge that we have been here before, albeit without the supposed advantage of brain imaging.

### **1.3 The Scottish story in the early nineteenth century**

#### **1.3.1 The origins of Scottish temperance**

The association of Scottishness and drunkenness certainly runs as a common thread throughout modern British and world history. Perhaps the fact that scotch is the only example of the embodiment of a national identity in a form of alcohol has a lot to do with this connotation. Certainly, a mystique has been built up around Scottish whisky as a quality product with a romantic history and many popular accounts exist to bolster this. This romanticisation can be traced back to whisky entrepreneurs and advertising campaigns from the late nineteenth century and early twentieth century. However, an alternative history exists of whisky as a cheap and readily available form of alcohol in nineteenth century Scotland, underpinning medical and social problems to an extent that outstrips our current problems, which are more underpinned by cheap cider and vodka.

Irene Maver (2003), in her entry on Scotland in the International Encyclopedia on Alcohol and Temperance in Modern History, tells us that it was in the 1820s that alcohol was first properly “articulated” as a widespread social problem in Scotland, with temperance proposed as the solution. The early temperance movement arose particularly from religious movements in west central Scotland and had precursors in the United States. The movement in west central Scotland very quickly influenced the setting up of similar movements in England. The temperance response in the second quarter of the 1800s is particularly strong in west central Scotland and John Dunlop is worthy of note as a pioneer in this regard. The Scottish dimension is certainly to the fore during these years.

In 1834 the Enquiry into Drunkenness Select Committee Report is the first of a series of nineteenth century parliamentary enquiries on the “alcohol question” that have a particular Scottish slant. It is significant for Scotland that the duty on spirits was reduced in 1822 such that the price more than halved and the usage of spirits more than doubled. The increase in consumption that followed was arguably the trigger for John Dunlop to act, along with others, in setting up the first Scottish temperance organisation. Dunlop was influenced by a trip to France, which made him realise that citizens in his native Scotland were more prone to public drunkenness. As a good Presbyterian this was a wake-up call to action. Dunlop was also aware of the earliest movement in the United States to promote temperance, which focused on “ardent spirits”. Some commentators refer to the early temperance movement as the “anti-spirits” movement, given this emphasis on the strongest forms of alcohol as the root of any problems.

In 1829 Dunlop set up his Temperance society in his native Greenock while Dunlop’s aunt, Lilius Graham, set up a parallel women’s organisation in Glasgow. Both Graham and Dunlop were evangelicals and were linked to the church movement of Thomas Chalmers that was later to divide the Church of Scotland. Dunlop linked at an early date with William Collins (senior), usefully a publisher, to form the Glasgow and West of Scotland Temperance Society in 1830. This acted as an umbrella organisation for more local societies. Temperance pamphlets were printed in abundance and circulated widely.

Alcohol had become such a public concern that John Dunlop was invited to give evidence to a 1834 UK Select Committee of the House of Commons. Given the interest of parliament and the opportunity to advocate for political intervention, one telling remark, was that:

“... the real essence of the temperance reformation does not lie in direct legislative measures... The principal reforming power lies in introducing a universal change of opinion among the inhabitants

and their becoming satisfied that ardent spirits are unfit for daily use, they are too high a stimulant...”

At this point, Dunlop was aiming to educate and transform individuals and not calling for central intervention.

The temperance movement was not unique to Scotland – it arrived in Ireland around the same time – but it undoubtedly gained a powerful foothold in Scottish society and political culture at an early date, and from this beginning it was to sustain a lengthy campaign that became more radical in nature over time. This is a story I take up and explore in more detail in Chapter 3 in relation to the interface with the medical profession.

### **1.3.2 The early asylums**

The early asylum era in Scotland spanned the last two decades of the eighteenth century<sup>19</sup> and the first half of the nineteenth century, and an examination of the asylums set up during this period in relation to the question of alcohol addiction, either as a mental problem in its own right or in relation to alcohol as an aetiological factor in mental illness, seems to show a general lack of awareness of this issue during their inaugural years.

If we take as an example the Glasgow Asylum for Lunatics which opened in December, 1814 -later Glasgow Royal Asylum for Lunatics from 1824, resiting from Dobbies Loan to Gartnavel in 1843- then we find virtually no mention of alcohol as an aetiological factor in lunacy in the first twenty years. The annual reports from 1814 to 1830<sup>20</sup>, available as one bound volume, classify the mentally ill into the furious, the melancholic, the fatuous, the imbecilic and the idiotic. Variations on these terms appear with time such as maniac, infuriated maniac, and alternating melancholic and furious or irascible melancholic. In none of the initial intake is alcohol mentioned and the aetiology of lunacy is mainly given to be unknown though some speculation is made. In the 1823 Annual Report a Pro Forma is published with a list of questions for those seeking to have someone admitted to the asylum. Among these questions is one that asks if the individual suffers from intemperance or habitual vice. These questions were not present in the 1814 version.

We can trace the early story further in these annual reports. The next volume covers the period from 1831 to 1849<sup>21</sup>. Certainly intemperance is mentioned for the first time in the 1832 Annual

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<sup>19</sup> Sunnyside Royal Hospital, the first of the Royal Asylums opened in 1781.

<sup>20</sup> HB 13/2/216

<sup>21</sup> HB 13/2/217

Report, which covers the year 1831, as a cause of lunacy. It is mentioned alongside religious excitement and religious devotion of the “wrong kind”.

In the 1834 report can be found this long passage which I quote in its entirety as it is an important scene setter for Chapter 6, later in this thesis: -

“Among the exciting cause of mania, we regret that we still have to mention the abuse of spirituous liquors. The mental affection termed delirium tremens, or, in common language *blue devils*, generally soon subsides under proper treatment, and comparatively few of its victims require to be placed in a mad-house. When, however, there exists sufficient predisposition, it would appear that lunacy may be occasioned by any cause which serves to produce and to keep up for a length of time a hurried state of the circulation. Hence any feverish attack, whether from cold or from contagion, and still more frequently that excitation bodily and mental which is occasioned by the excessive use of ardent spirits, have often induced a durable alienation of the mind. Yet the evil effects of intoxication, as a cause of lunacy, have we think been exaggerated, and we deem it to be our duty to offer some corrigent of an allegation which might in no small degree tend to render the unfortunate inmates of a Lunatic Asylum, objects of censure rather than compassion.”<sup>22</sup>

The apparently anonymous author of this, almost certainly, Dr. John Balmanno, Physician to the Asylum, on behalf of the Directors of the Asylum, goes on to suggest that American and Scottish temperance reformers are exaggerating the effects of intoxicating liquors in producing lunacy. He mentions the Record of the Scottish Temperance Society for December last, i.e. December, 1833 as saying that half of roughly five hundred patients admitted to the Lunatic Asylum at Liverpool in the last four years “were known to have lost their reason by drunkenness.”

This is doubted and in the passage that follows an analysis from the Glasgow Asylum is offered and linked to changes since an 1828 Act of Parliament for regulating Mad-houses in Scotland which “stopped the previous common practice...of placing inveterate drunkards in one of the islands of Lochlomond...” (See below). The author, later stated by Yellowlees and others to be Balmanno, analyses the cases of lunacy attributable to drunkenness and produces the following table in which D stands for Drunkenness as a cause<sup>23</sup>. The table is reproduced here: -

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<sup>22</sup> Ibid., Page 5 of the 1834 Annual Report of the Glasgow Royal Asylum for Lunatics

<sup>23</sup> Ibid., Page 6 of the 1834 AR of GRAL.



YEARS.	Males.	Females.	Total.	Males D.	Females D.	Total D.
1824	38	37	75	0	0	0
1825	45	30	75	2	0	2
1826	38	34	72	0	0	0
1827	48	24	72	1	0	1
1828*	44	44	88	2	1	3
1829	43	41	84	3	4	7
1830	37	47	84	2	1	3
1831	50	39	89	2	2	4
1832	47	50	97	0	1	1
1833	47	36	83	5	2	7
	437	382	819	17	11	28

Figure 2. : Dr. Balmanno's analysis of drunkenness as a cause of lunacy.

The asterisk against the year 1828 indicates that the Mad-Houses Scotland Act passed on 28<sup>th</sup> June of that year. Balmanno is suspecting a connection with the very modest increase in admissions attributed to alcohol, with= that particular Act, which seems unlikely. The overall rate of lunacy for the decade attributable to drunkenness from this table is 3.4 percent, with the male rate higher at 3.9 per cent than the female rate of 2.9 per cent.

The passage in the 1834 Annual Report concludes: -

“Drunkenness, even where it does not produce permanent derangement of the mind, is doubtless a temporary madness, and while it lasts, it is often as fully fraught with dangerous consequences, both to its victim, and to all who come into contact with him, as any species of mania whatsoever. The drunkard is a physical, as well as a moral pest, destroying the comfort, as well as injuring the respectability of all related to him.”<sup>24</sup>

Balmanno then goes on to suggest that a “House of Seclusion, expressly for drunkards” could “operate as a more impressive and effectual check to their debasing vice, than any other means which have yet been devised.”<sup>25</sup> He bases this conclusion on his experience of a few cases who have done well after their admission to the asylum and who feared recommitment if they were to return to drinking.

This apparent absence of concern for alcohol in the early years of the Scottish Royal asylums is despite a general and growing awareness of alcohol as an area of political concern. e.g.:

<sup>24</sup> Ibid., Page 6 of the 1834 AR of GRAL.

<sup>25</sup> Ibid.,Page 7 of the 1834 AR of GRAL.

“Nothing was so common in the morning as to meet men of high rank and official dignity reeling home from a close in the High Street, where they had spent the night in drinking... Intemperance was the rule to such a degree that the exception could hardly be said to exist”

Robert Chalmers, *Traditions of Edinburgh*, 1825

Also for the period 1831–1851, according to a report to parliament on arrests for drunkenness:

“Glasgow [was] three times more drunken than Edinburgh and five times more drunken than London”

The impression is gained of a growing awareness of alcohol as an issue in relation to Lunacy or Insanity. The concern grows further after 1857 – a year of enactment of specific Scottish lunacy legislation. The choice of 1855 for the starting date of my research is based on the start of the inquiry that led to this legislation – an inquiry that acknowledges the issue of alcohol addiction. The medical evidence presented in this and subsequent inquiries form the basis of the analysis in Chapter 4. Without necessarily referencing the ideas of Thomas Trotter-see below-it is from this point that the idea of alcohol addiction as a disease starts to gain ground.

### **1.3.3 Lodging habitual drunkards**

One curiosity from around this time is an account by the Parish Minister at Luss for the New Statistical Account of Scotland (1845), referring at least to the 1830s if not earlier, and which contains the following passage:

“Islands. —

The islands of Loch Lomond included in the parish of Luss are, Inchlonaig, Inchtavanach, Inchconachan, Inchmoan, Inch Galbraith, Inchfriechlan, and a few other very small islets.

Inchlonaig, now occupied as Sir James Colquhoun's deer-park, is remarkable for the great number of very old yews which are growing in it. It contains about 150 deer.

It is inhabited by one family, who board persons that have been addicted to drinking.

Inchtavanach, is not very distant from the west margin of the loch, between Ross-dhu and the village of Luss. It is steep and mostly covered with copse-wood. It is inhabited by one family, who farm part of it, and admit as boarders persons given to intoxication.”

This is revealing in that it suggests an early form of help for individuals “addicted to drinking”. However, the detail of how this system worked doesn’t seem to be well documented. The only other reference I have found to this is that above from the Glasgow Royal Asylum Annual Reports to the 1828 Regulation of Madhouses Act with an obvious discrepancy as to whether the practice had indeed ended in 1828.

It does seem likely that these islands on Loch Lomond were being used to separate individuals from alcohol in order to enforce a period of abstinence. We unfortunately have no further information on how this system operated. There is also the possibility that some memory of this system lay behind Clouston’s remark at the end of the century that the only possibility of a cure for alcoholism lay in sending individuals to an island where “whisky is not known”.

We also know little of how those prone to drunkenness were received or treated in the early hospital provision of the late eighteenth and early nineteenth century. Most accounts from this period suggest that doctors may have given general advice on an individual basis to patients who were overindulging, perhaps pointing them towards milder forms of alcohol.

### **1.3.4 Whisky nation**

A Glaswegian Temperance reformer in 1855 stated that Glasgow was the headquarters of teetotalism in a “whisky-injured Scotland”.<sup>26</sup> For the purposes of this thesis it was an apt phrase reflecting the realities of the time when whisky was indeed the preferred drink of the majority of drinkers in Scotland, both rich and poor. Paton in 1992 contrasts Scottish drinking in the nineteenth century with that of the English and states that “the most obvious distinguishing feature of Scottish drinking was the preference for spirits”.<sup>27</sup> He gives Inland Revenue figures from 1870 looking back at the year 1852 which show that in that year:

“...the Scots drank 2.36 gallons of proof spirits per capita and 7.2 gallons of beer while the English consumed 0.57 gallons of spirits and 30.6 gallons of beer.”<sup>28</sup>

On the face of it the Scots, with worse statistics for public drunkenness at the time, seemed to be on average drinking less. Discounting a role for illicit alcohol not counted by the Inland Revenue- secret stills had more or less faded by this point after the 1822 Distilling Act made them

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<sup>26</sup> Morris, S. History of the Temperance and Teetotal Societies in Glasgow from their origin to the present time. (Glasgow, 1855).

<sup>27</sup> Paton, 1992-Page 12.

<sup>28</sup> Ibid.

uneconomical by lowering the price of licit whisky-it is likely that the Scots showed greater polarization of drinking behaviour between the extremes of teetotalism and intemperance.

As we know today “alcohol” (specifically ethanol or ethyl alcohol) comes in many forms –beer, cider, wine, gin, vodka, whisky etc. – and they are all held to be roughly equivalent in their ability to damage health, if we compare like for like in terms of the dose of alcohol taken. Thus, units of alcohol can be calculated and monitored to reduce harm independent of the form of alcohol taken.

However, in the past these different forms of alcohol were felt to show differential harm with the more potent types of alcohol being singled out for opprobrium by both medical authorities and the early temperance movement. We can think of Hogarth’s contrast of Gin Lane compared to Beer Street. Additionally, both Lettsom and Rush gave us a gradient of harm in relation to potency and singled out “ardent spirits” as too strong a “stimulant” for daily use.

In these terms, Scotland is then very different in comparison to our English neighbour in relation to the predominance of whisky in Scotland in the nineteenth century when contrasted with that of beer in England. As we will see in the course of this thesis the Scotch<sup>29</sup> liked their scotch. Whisky or scotch features as the problematic form of alcohol in the majority of the clinical cases I have analysed from the nineteenth and early twentieth centuries, just as today white cider and cheap vodka are the forms of alcohol favoured by those with severe problematic drinking.

As always price and availability are the main drivers of consumption and in turn alcohol-related harm. Whisky became cheap in the nineteenth century before it was marketed as the luxury commodity that it is mainly marketed as today. If we go further back in Scottish history then whisky was something that could be produced illicitly and in defiance of the British crown in the aftermath of the Jacobite rebellions. The production of “aqua vita” and the knowledge of the process of distillation can be traced even further back in the written record to at least the thirteenth century. Production at the behest of the Scottish Crown is recorded also around that time.

## **1.4 Scottish temperance and Scottish medicine, 1855-1925**

In the first main section of this thesis (Section II) I will first present the temperance history of this period, and then follow this with a history of Scottish medical views on the alcohol issue from the same timespan, as represented in the public sphere, taking us from the mid-nineteenth century up to the interwar years. In Chapter 3 I set out to examine Scottish temperance in more detail during

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<sup>29</sup> A now dated word for the Scottish people.

these years with the main purpose of setting a backdrop to the parallel medical history that is the mainstay of the thesis.

There was a flurry of legislation and inquiries in the second half of the nineteenth century pertaining to the alcohol question in Scotland. (See Chapter 3).

This reflects the fact that the temperance movement was beginning to have a strong influence on politics and popular culture within Scotland during this period, leading eventually to particularly restrictive licensing provision in Scotland in comparison to England and Wales that lasted to the second half of twentieth century.

When one looks at the Select Committee reports on habitual drunkards and inebriates, the role of medical opinion, particularly that of early Scottish psychiatrists, stands out. These medical men are both campaigning for separate provision for habitual drunkards and inebriates – i.e. separate from the asylums –and being allowed to give privileged expert opinion on the wider aspects of the alcohol problem. The views and experience of psychiatrists like Yellowlees and Clouston were particularly important. Their expertise derives from the impact of alcohol misuse on admissions to the asylums. In this regard, James Wood describes some aspects of the distinctiveness of Scottish psychiatry in his 2012 thesis. I dedicate a chapter of the thesis, Chapter 4, to the role of Scottish medical men as expert witnesses in this particular public role, as well as looking at the varied ways in which the alcohol problem was manifesting itself in the clinical arena. David Yellowlees, for example, privately published a paper (On Intemperance and Insanity) in which he stated:

“It is surely within the truth to assert that half the existing cases of insanity are due directly or indirectly to this social curse”

Yellowlees documented the “decreased production of insanity in men” during strikes in Glamorgan when the men drank less and commented that “ignorance and self-indulgence can make prosperity a curse instead of a blessing”. Yellowlees further stated that “intemperance has a threefold relation to insanity: it may be a cause, an early symptom or a result. These relations are often associated and often confounded”.

I am particularly interested in how Scottish psychiatry dealt with these confusing relationships between alcohol and insanity and explore this in depth in the course of the thesis. In the course of the thesis I focus down on the views of selected prominent medical men. They did not arrive at their particular views on this topic independently of each other and I describe in Chapter 4 some of the connections that existed within the professional networks that operated during the time period that I cover.

As this was a period of rising alcohol consumption, an analysis is undertaken to look at the impact of this on the asylum admission statistics in this period. The relationship of Scottish medical men to the foundation of the Society for Study and Cure of inebriates (SSCI) in 1888 is also notable. Its president was Dr. Norman Kerr, a Glaswegian, and his textbook on inebriety was widely read.

The developing medical claim for special understanding is undermined by the role of the temperance movement in the reform of individuals as well as its role in campaigning for political change. Temperance lantern slide shows would show transformation in individuals who were saved by the power of the group or by God's grace without any doctors' bills having to be paid. The self-help approach as seen in the Twelve Step groups of today was already in place in this formative period. Throughout the nineteenth century the medical relationship with the temperance movement in Scotland was one of ambivalence for several reasons. Then, as today, the medical profession was inevitably dealing with the problems of alcohol misuse in both the general hospital and the asylums during the period under consideration, as I hope to show in this thesis.

Following on from this examination of Scottish medicine in the public arena on the "alcohol question", I then go on to explore specific examples of the medical response in action in Sections III and IV of the thesis. The emphasis will be on Scotland and I won't engage with the obvious debate around whether one can readily separate out the Scottish component of this history from the rest of the UK. Hopefully in what I describe the sense of a distinct Scottish dimension to this problem will emerge

### **1.5 1855-1900: The clinical impact of increasing consumption**

At the beginning of this period, delirium tremens is by far the commonest cause of admission to the Delirium Ward at the Royal Infirmary of Edinburgh and this thesis presents a detailed analysis of data derived from the surviving casebooks of that ward in the 1850s and 1860s, by way of illustrating the "coalface" of the alcohol problem in relation to medical practice (Chapter 5). An interest by Scottish physicians in clinical manifestations of alcoholism and the syndrome of delirium is detailed. The case records reveal changing diagnostic terminology: delirium tremens, alcoholismus and mania a potu are all seen in this short period. The death rate was surprisingly relatively low in these years. Specific remedies were given to help with the detoxification process and admission was on average for four or five days.

In Chapter 6 I look at the other important clinical arena that allows for exploration of the interaction of medicine with the alcohol question, namely that of the asylum. Asylum annual reports record statistics year on year of cases recorded as alcohol insanity. These cases are mainly

men and the exact nature of these cases, in diagnostic terms, has always been unclear – confusion continues to this day as to the relationship between excessive alcohol misuse and severe mental illness of a more persistent nature. I will explore in detail the issue of cause and effect as it was understood then and make a comparison to what we now understand about aetiology in this area.

In Chapters 5,6,7 and 8 case examples from the time are used and I give the names of the patients involved. I am aware of the debate around whether names should be given and my decision to use the names is based on the fact all examples are from over a century ago and that the records are in the public domain.

## **1.6 1900-1925: The era of the inebriate reformatories and decreasing consumption**

A major part of this thesis looks at the medical aspects of the Inebriate Reformatory system as it operated in Scotland. I critically assess to what extent a medical model was applied in this supposedly therapeutic system. In order to compare the actual practice within these institutions with what was intended, I present data derived from a reading of the official records held by the National Archives of Scotland for the period 1878 to 1929 – this covers the periods before, during and after the operation of the reformatory system within Scotland (Chapter 7). Additional information was sought from local archives and the national press of the time. The Glasgow Certified Inebriate Reformatory at Girgenti provides my main example of a reformatory in operation (Part IV, Chapter 8). The records of Girgenti House are held in the Glasgow City Archives in the Mitchell Library in Glasgow.

A secondary aim of my thesis is to evaluate the success or otherwise of this particular response to the “alcohol question” at that time and draw lessons for our current concern with this issue, particularly in relation to some recent proposals for enforced treatment. There are a number of contemporary reviews evaluating the impact of the reformatories and other reviews over the subsequent years, which evaluate them in retrospect, and I will describe these.

## **1.7 Postscript on 1926-present day**

### **1.7.1 1926-1947: The low ebb<sup>30</sup>**

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<sup>30</sup>Berridge describes these years as “a period of decline” for the Society for Study of Inebriety: Berridge, V. (1990) The Inter-war Years-A Period of Decline *British Journal of Addiction* 85, 1023-1035

An interesting era characterised by prohibition and the restriction of alcohol. The cases of alcoholism dealt with medically were low in number and the Inebriate Reformatories were all closed. This era is often characterised as the era of the “five As” in terms of treatment. These treatments are: aversion, apomorphine, Antabuse, (psycho) analysis and Alcoholics Anonymous. The use or beginnings of these treatments in the Scottish context will be explored in the first part of Chapter 9, along with medical teaching on the issue of alcohol, particularly in the psychiatric texts of the time. The theories of Henderson, as derived from his mentor Adolf Meyer, are much more accepting of alcoholism as a concern for psychiatrists and also as a condition which can be a reason for mental hospital admission in its own right. The work of Professor Sir David Kennedy Henderson, therefore, proves an important and influential source for this period.

### **1.7.2 1948-2018: The alcohol question returns**

In this section of Chapter 9, I give a brief overview of the last seventy years from the secondary literature and my own involvement in the field to help draw out the areas of relevance for the present in the Conclusion and Discussion to follow (Section VI/Chapter 10). Notably the National Health Service came into operation on 5<sup>th</sup> July 1948 and, the NHS would be later called upon to develop services for alcoholism.

This period is also characterised by a move from a disease-centered to a population-based approach to the alcohol question, in parallel with the doubling of per capita alcohol consumption since World War Two. This population approach has again, at times, been a threat to specialised medical treatment for alcoholism but for different reasons and without any sign of the problem abating. The current position – where Scotland is seen to be a world leader in trying to act at a population level given the scale of our problem and the support given by medical bodies – will be described at the end of this thesis in the context of the history that I have outlined.

The advent of a Scottish Parliament has allowed for a distinct Scottish approach to emerge once again just as Scottish distinctiveness led to more radical measures in the nineteenth century. The prime example of this is the decision by the Scottish Parliament in 2012 to introduce a minimum unit price for alcohol. This policy will finally be implemented in 2018 by the Scottish Government after extensive legal challenge by the Scottish Whisky Association. (Curiously whisky will be unaffected but most vodka and cider will increase in price). Scotland will become the first nation to have such a measure at a national level, distinct from taxation, as the price increase that will result for cheaper forms of alcohol will go to the producers and retailers rather than the government. It is predicted that the policy will lead to an ebb in Scottish alcohol consumption and alcohol-related harm in the years ahead.



## **1.8 Conclusions and discussion**

This work intends to explore, therefore, continuities and discontinuities within the Scottish medical view of alcoholism in earlier and later periods. One grand theory of interest to this thesis is that of Skog, who has suggested that alcohol consumption and associated problems rise and fall in “long waves” throughout history (Skog, 1986). A parallel idea can be found in *Wet and Dry Generations in the Anglo-Saxon World* by Robin Room (2014). Essentially this theory states that if the problems from alcohol pass a certain threshold, government and population intervention becomes unavoidable; and if the problems decline, laws and social mores are eventually relaxed leading to the start of further rise in alcohol consumption. In the context of these long waves, I argue that the level and nature of medical concern with the issue also changes and this is well illustrated in the Scottish example under consideration here.

## Chapter 2

### Literature review of relevant scholarship

#### 2.1 Introduction

This chapter further sets the scene for, and give context to, the findings that I will present below on the relationship of the medical profession in Scotland to the alcohol problem, both in the clinical world of the hospital, at the bedside, and in the arena of public debate.

Looking at the literature of the last fifty years on the history of alcohol and drug problems, several general themes emerge. Firstly, there are a number of collections of papers, some from conferences in this field, that look at the impact of alcohol and drugs in specific places at specific times and these pieces of scholarship are the potential building blocks for grand theories.

Examples of such grand theories also exist; consider the work of Bruce Alexander (*The Globalisation of Addiction*, 2008) which emphasises social determinants of addiction and the more biological emphasis of David Courtwright in his book: *The Forces of Habit* in which he introduces the idea of “limbic capitalism” (Courtwright, 2001).

As well as these scholarly attempts at synthesis from existing articles and papers (the building blocks,) other writers attempting a grand theory are clearly writing history with an overt agenda (e.g. Theodore Dalrymple’s *Romancing Opiates*, 2006) and adopt a more overtly polemical style. These works are similar to the temperance movement’s self-aggrandising, early writing on its own history but today the advocacy is more often for liberalisation of drugs rather than for restriction.

Other overarching works are more nuanced and balanced in providing an overview of the field and show how societal attitudes to alcohol and other drugs change over time. The recent work of Berridge, *Demons*, (2013) is an example of this type of more neutral synthesis<sup>31</sup>.

The literature that is most pertinent to this thesis is that which examines the specific case of alcohol in the British Isles in the modern era and in particular literature which focuses on, or touches on, the medical viewpoint from a Scottish or British perspective. Also relevant are histories which document the evolution of medical concepts and treatments, and which explore and critique the medical claim to special expertise in the field of inebriety/alcoholism. This chapter reviews the ways in which patterns of alcohol use have been explained in the historiography of problematic

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<sup>31</sup> For a review of Berridge’s “Demons” see Smith, 2014.

drinking.

## 2.2 Cyclical patterns of alcohol use in history?

It has been suggested that alcohol consumption and associated problems rise and fall in “long waves” throughout history (Skog, 1986). If problems pass a certain threshold, government intervention becomes unavoidable. If the consumption and problems decline, then laws relax, leading to the start of another rise. This is an idea, which I will examine in this thesis given that the period under study shows such extremes of consumption-both high and low.

One consequence of changing legal and societal views on alcohol use over time may be that the severe heavy drinker could be viewed differently (more deviant) in a society where moderation is the norm, and as less deviant in a situation where the culture encourages intoxication. In the latter example, there could be more resistance to pathologising and stigmatising the heavy drinker as being qualitatively different. This is an idea that I will explore in relation to the changing medical conceptualisations of the sustained heavy drinker during the period under study.

This idea of a threshold of alcohol consumption that, once reached, provokes government or medical action is also relevant in scholarship that analyses an earlier alcohol epidemic, namely the eighteenth century Gin Craze. (See Dillon, 2002; Warner, 2003) The causes of this drinking epidemic and its subsequent resolution have been well delineated. During the late seventeenth century taxes on gin were reduced in order to increase demand for this drink. Drinking gin signified loyalty to the new Protestant monarch, William of Orange. Additionally, the Distilling Act of 1690 was designed to fill the vacuum left by the ban on French brandy, and create a market for home-grown corn. However, it had the unforeseen and rapid consequence of the “gin epidemic” of the eighteenth century.

James Boswell described “spree drinking” in the early eighteenth century and gin consumption doubled in the period 1707–1727. By 1742 the British population of less than seven million were consuming nineteen million gallons of gin annually. In response to this upturn in the use of spirits there was increasing public concern over the consequences of such conspicuous consumption of cheap gin.

However, initial legislation and taxation proved ineffective as it was ignored and not enforced. The 1743 Act (Tippling Act) with more modest taxation strongly enforced and subsequent legislation limiting outlets eventually had the desired effect. In the words of one scholar:

“Due to the fine tuning of taxation and the success of the anti-spirits campaign after decades of experience with high consumption, the gin epidemic faded” (Musto, 1997)

However, the consumption of alcohol in general remained high and it was in this context that the seminal medical treatises of both Thomas Trotter and Benjamin Rush – an American who undertook medical training in Edinburgh – were to appear in the late eighteenth century.

## **2.3 Literature of specific interest - overview**

The secondary literature most relevant to the primary research presented here looks at the developing medical concepts of habitual drunkenness, delirium tremens, inebriety, dipsomania, mania a potu, alcoholism, alcoholic insanity and alcohol dependence in the wake of Trotter and Rush. Literature on the impact of these ideas both in the political arena, including concerns over public health raised by the temperance movement, and in the clinical world of general medicine and within the emerging discipline of psychiatry is of particular interest.

In relation to the history of the clinical concept of alcoholism the books of Sournia (1990), Valverde (1998), Tracy (2007) and (particular chapters in) Herring et al (2013) are of particular interest as well as the papers by Bynum (1968), Porter (1985), May (1997) and Ruuska (2013). The work of Ruuska is of particular note as he is able to describe, in some detail, the seminal contribution of Magnus Huss (1849 and 1851), who gave us the term alcoholism. Huss was not translated into English but was translated from Swedish into German at an early date giving his work broad influence including in Britain.

It is arguable that the problem of alcohol has been relatively neglected within the field of the history of psychiatry. This is particularly so if we accept the 1872 claim of Yellowlees in his *Insanity and Intemperance*, given in Chapter 1 above, that half of male cases of insanity in Glamorgan were down to intemperance. This is an idea that I will explore in detail in Chapter 6.

Men predominated in asylum statistics, but Yellowlees' reference to men stands in stark contrast to the fact that the inebriate reformatories set up in the British Isles in the early twentieth century were to take mainly women, despite the initial intention that both sexes would be represented. There is a detailed body of historical work, often with a feminist perspective, which explores this striking finding. There is also now a reasonable number of detailed histories of the inebriate reformatory movement and of individual inebriate reformatories in America, Ireland and the UK, to which I refer below and critically review.

I will also explore, in the course of this thesis, some of the literature of the time and in particular

that of the newly founded Society for the Study of Inebriety<sup>32</sup> (see Berridge, 1990) and its journal, *The British Journal of Inebriety*, which over the years has contained a number of papers specific to the Scottish situation in relation to the rest of the British Isles. Also, the various parliamentary departmental committee reports on inebriety prove a rich source of material – particularly that of 1895 in which both Yellowlees and Clouston gave evidence. (See Chapter 4).

## **2.4 Literature of specific interest - detailed account**

### **2.4.1 The concept of alcoholism and its implications**

In his introduction to the English translation of Sournia's "The History of Alcoholism" (1990) Roy Porter points out how this topic has been relatively neglected and he praises Sournia for giving us "the first fully-documented, cross-cultural, chronological account, published in English, of one major facet of the history of drinking-the story of alcohol abuse."

A large section of Sournia's work (Part II: Alcoholism: Vice or Malady? and Part III: Modern Alcoholology) documents the medical interest in alcoholism from the eighteenth century until the 1980s. The emergence of a post-enlightenment 'progressive' ideology that medicalised habitual drinking is seen in the context of "numerous departments of life" – including sexual and criminal behaviour – that were being brought into the field of medicine with medical men claiming privileged expertise in explaining these behaviours. The early pioneers in this field of alcohol medicine are given as Benjamin Rush in the USA and Thomas Trotter in Britain –both students of William Cullen in Edinburgh at separate times – and they are credited with bringing the problem of heavy drinking into the domain of "mental" medicine. However, Porter in his own work (Porter, 1985) had already shown that the views of Trotter and Rush were not radically different from Lettsom, Cheyne and Mandeville at an earlier point in Georgian Britain.

#### **2.4.1.1 Enlightenment Scotland and the idea of heavy drinking as a "disease"**

In 1804, Edinburgh physician Thomas Trotter published his revised and expanded 1788 M.D. thesis – *An Essay, Medical, Philosophical, and Chemical, on Drunkenness*. As mentioned above (p.19) he reiterated his view that:

"In medical language, I consider drunkenness, strictly speaking, to be a disease, produced by a remote cause, and giving birth to actions and movements in the living body that disorder the

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<sup>32</sup> The founding President Dr. Norman Shanks Kerr was a Scotsman and Glasgow medical graduate though he subsequently practiced in England.

functions of health . . . The habit of drunkenness is a disease of the mind.”

This is a clear early statement of medical interest in this area and essentially my thesis is an exploration of the extent to which this idea succeeds in Scotland in the period under study. It is also an idea worth setting in a broader medical historical context, which I will explore in this Section.

Roy Porter (1985; 1988) has shown that this statement was not entirely original and did not arise in a vacuum. Porter points to the writings of Lettsom twenty years before Trotter and Cheyne fifty years before that on alcohol “cravings”. (“Drams beget drams”) Even before Cheyne there was Bernard Mandeville (1730) with his version of the drunkard’s progress spoken by his character “Misomedon”, again showing that the idea of enslavement to alcohol was well recognised. Porter also cites Samuel Johnson as an authority and common experience of addiction in general.

Porter has no doubt, however, that Trotter’s work is a “landmark”, but poses the question as to what made Trotter so truly original. He believes that Trotter’s originality isn’t in Trotter’s claims to be the originator of a disease theory of addiction,<sup>33</sup> but in the fact that Trotter sees habitual drinking as a medico social problem and as a therapeutic challenge. The medical claim to an interest in this area was thus restated and developed.

Trotter was born in 1760 in Melrose, Roxburghshire and went to Edinburgh Medical School 1777 before his first spell as a navy surgeon between 1779 and 1783. On returning to Edinburgh Trotter took classes that included those of William Cullen and submitted his M.D. in 1788. It was well received by Cullen. In fact, Cullen presided over the Viva examination of the M.D., which was held in public. Cullen’s teachings on habituation to alcohol are also quoted by Trotter. An example given by Cullen and quoted by Trotter is of a family used to drinking whisky at 1 o’clock before lunch who didn’t take this dram when not at home but were aware of missing it due to the force of this habit and the ritual that surrounded its use.

Trotter then returned to the navy medical service from 1788 to 1802 and this service was to give additional material for his essay, published in 1804. Curiously, Trotter designated this publication as a second edition of the previous unpublished M.D. thesis and quoted from his own thesis within the book. Compared to the M.D. this “second edition” is much expanded<sup>34</sup> and reflects Trotter’s navy experience where drunkenness amongst sailors was unsurprisingly an issue of concern. Porter points out, though, that this focus of Trotter on dealing with alcohol was rubbing up the navy

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<sup>33</sup> Strangely Trotter ignores Rush’s pamphlet from 1790 in the second edition though he can obviously be forgiven in this regard in the original thesis. The Rush publication was to go through numerous editions.e.g. Eighth Edition, Rush 1814.

<sup>34</sup> It was roughly ten times as long.

establishment the wrong way. Trotter had led a campaign to reduce the number of gin shops in Plymouth at the turn of the nineteenth century with some success but with an inevitable loss of popularity in some quarters. Porter also points out Trotter's anti-naval establishment gesture in the dedication of his published essay: a dedication to an admiral of the fleet would have been expected, but instead it is dedicated to Edward Jenner

Porter gave a detailed analysis of the essay in his preface to the 1988 facsimile. Additionally, its relevance to the later nineteenth century and to today is also expertly explored in the more recent *Physician to the Fleet – The Life and Times of Thomas Trotter, 1760–1832* (Vale and Edwards, 2011). The book dedicates Chapter 13 to a study of the essay and its subsequent influence, with some points of disagreement with Porter's analysis but mainly concordance. This analysis also benefits from the viewpoint of a clinician<sup>35</sup> who himself contributed in a major way to our modern conceptions of problematic use of alcohol – although it should be read carefully for potential bias for the same reason.

Some key points from the Vale and Edwards reading of the essay are as follows. Firstly, they describe it as modern in outlook with regard its conception of the psychological processes that underpin addiction. This is contrasted with the “far more mechanistic”<sup>36</sup> view that was to be adopted in explaining inebriety in the late nineteenth century. The major work by Norman Kerr (1888) on this topic failed to cite the precedence of his fellow Scot, Trotter, in this field. Arguably Trotter's work was mainly forgotten in the course of the nineteenth century despite several early editions (1807, 1810 and 1812) and publication in the United States and translation into German and Swedish<sup>37</sup>.

A second interesting point where the accounts of Vale and Edwards appear to diverge from those of Logan (1983) is over the issue of how Trotter's work was received by the temperance reformers. Explaining the “intellectual amnesia” that surrounded Trotters work, Vale and Edwards say towards the end of their analysis that:

“It is possible also that the temperance movement, when it began to emerge in the 1830s, looked with disfavour on the positive things [Trotter] said about drink-for these people, drink, not drunkenness, was the enemy.”<sup>38</sup>

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<sup>35</sup> The late Griffith Edwards was for many years editor of the journal *Addiction* and was along with Milton M. Gross the originator of the concept of the Alcohol Dependence Syndrome (1976). Professor Edwards was gifted an expensive and rare “first” edition of Trotter's book by the Society for Study of Addiction for his distinguished service.

<sup>36</sup> Vale and Edwards, 2011-p.173.

<sup>37</sup> *Ibid.*p.156

<sup>38</sup> *Ibid.*p.173

By contrast Logan<sup>39</sup> states that:

“Trotter's study was most popular with the mid-Victorian temperance movement, not because of its emphasis on disease rather than crime but through its advocacy of total abstinence as the treatment goal for alcoholics.”

However, Logan gives no evidence for this statement, though certainly Trotter was advocating immediate abstinence for those who were habituated rather than gradual withdrawal as advocated previously by Lettsom. Porter fails to comment on this specific issue of whether there was a temperance view on Trotter's work.

A third specific point of note is that Vale and Edwards suggest that Trotter was not implying that the habit of drunkenness was disease in a nosological sense, but that he was suggesting it to be a “dis-ease” in the more general sense of a “lack of comfort”.<sup>40</sup> This diverges from the account of Porter who reminds us that Trotter places drunkenness within a nosology produced by Cullen. Drunkenness is given the status of a species of disease within the class of *Vesaniae*, with affinities to *amentia*, *insania* and *mania*.<sup>41</sup> However, both Porter and Vale and Edwards highlight that Trotter asserted that drunkenness (*ebriety*) was a cause of *melancholia* – a fact that is now well established (See Schuckit et al, 1997).

Further points of agreement are around the contents of Trotter's chapter entitled “The Catalogue of Diseases induced by Drunkenness” which is seen as giving a comprehensive list of diseases that we would now recognise as attributable to alcohol. However, that list includes a phenomenon most curious to the modern eye, namely the purported tendency of habitual drinkers to spontaneously combust. Vale and Edwards respectfully fail to mention this while Porter tells us that Trotter “devotes [a] full thirty pages of his text” to this particular topic. Convergence is again reached in the assessment of Trotter's chapter on “The Method of correcting the Habit of Drunkenness and of treating the Drunken Paroxysm”. Vale and Edwards point out that few modern texts deal with the phenomenon of alcohol intoxication *per se* and both analyses give praise to the insights of Trotter around the need for the physician to gain the respect of the patient, and also need to gain a personalised understanding of why they drink to excess in order to give tailored and effective counsel to the patient. This insight was to be forgotten and later regained in the history of alcohol medicine that is outlined in the body of this thesis.

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<sup>39</sup> Logan.1983-p.416

<sup>40</sup> Vale and Edwards, p.171.

<sup>41</sup> Porter, 1988-p.xxiv.



### 2.4.1.2 Scholarship on changing terminology in the nineteenth century

Further development in the nineteenth century was to come through the Swedish physician Magnus Huss, who first coined the term “alcoholism” (alcoholismus or alcoholismus chronicus)<sup>42</sup>. The first use of this term in British medical literature is in 1860. Earlier use was seen in France.

The changing diagnostic terms and the meaning of these terms is an area that medical historians have only recently started to explore in detail in relation to the eventual emergence of the concept of addiction. (Berridge, Walke and Mold, 2014; Hellman, Berridge, Duke and Mold, 2016)<sup>43</sup>. This recent research has shown a considerable variation in terminology between countries and the use of “inebriety” is a term with an “Anglo-American bias”<sup>44</sup> related to an attempt to apply legal measures to the chronic heavy drinkers and to set up reformatory/asylums for the drinkers that are under medical supervision. The term dipsomania is seen to have a different lineage based in psychiatric thinking of the time.<sup>45</sup> The use of the evolving terms for alcohol addiction and its mental consequences in Scottish medical practice is something I explore in detail in Section III in relation to the usage of these varied, and sometimes confusing, diagnoses over time in both general medical and psychiatric practice.

An early and important paper on this area of the evolution of alcoholism diagnosis is that of Bynum in 1968 – *Chronic Alcoholism in the First Half of the Nineteenth Century*. In this review, based on Bynum’s unpublished M.D. thesis, Bynum shows how physicians rather than psychiatrists in the early nineteenth century took the lead in advancing the disease concept of alcoholism, culminating in the seminal publication by Magnus Huss in 1851 on chronic alcoholism. Bynum reviews the classical French and German literature that predates Huss and shows how Huss arrives at the idea of chronic alcoholism as a form of chronic poisoning of the nervous system. Huss incorporates the older terms of dipsomania and involuntary monomania and provides fifty detailed case descriptions along with post-mortem findings where applicable. The term alcoholism, rather than inebriety, tends to predominate in the continental European discourse thereafter. This is confirmed for Austria, for example, by the recent research of Berridge and colleagues using internet searches of recently digitised medical journals from the period of the 1850s–1930s<sup>46</sup>.

A more recent review of note in English by Ruuska (2013), which builds on the scholarship of Bynum and Porter and shows a detailed analysis of the work of Huss and his forerunners. Ruuska

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<sup>42</sup> See Ruuska, 2013.

<sup>43</sup> This research was funded by the European Union through the ALICE RAP project.

<sup>44</sup> P.4, Hellman et al, 2016.

<sup>45</sup> Ibid.

<sup>46</sup> Ibid.

challenges the overly simplified historiography to date that sees Trotter and Rush as the originators of the disease theory of alcoholism in a biomedical sense. This account, Ruuska argues, plays down the understanding of both authors of the sociocultural underpinnings of heavy drinking. Certainly Trotter (1804) emphasises that when he states that in striving to help the individual enslaved to alcohol, the physician must “scrutinise the character of his patient, his pursuits, his modes of living, his very passions and private affairs”.

Porter’s introduction to Sournia also points to Sournia’s awareness of the fact that heavy drinking has always been part of human society, but the recognition of this as a medical problem is comparatively recent – and in a way the recognition of the “alcoholic” is to some degree a case of social negotiation. In fact alcoholism/alcohol dependence continues to evolve as a concept, as shown by recent controversy around changes made in D.S.M.V around addictive disorders, with the dropping of the concept of “dependency”. Section II of this thesis presents a case example of just such a social negotiation in action in late nineteenth century Scotland.

The conceptual challenges of granting heavy drinking a disease status are well explored by Valverde (1998) and May (1997), particularly in relation to the individual’s responsibility for their own actions. This is further explored from a philosophical viewpoint by Resnek (1991) who defends the disease status of alcoholism<sup>47</sup>. The analysis of Valverde stands out in dissecting the issues and paradoxes around freewill and determinism that surround the concepts of alcoholism and addiction, drawing heavily on Foucault’s idea of governmentality. The central paradox remains that an inability to resist and control alcohol must be overcome, but is only able to be overcome through an act of the very will that is deemed impaired. I will draw on Valverde’s work at various points throughout the thesis regarding the medical thinking that I will use to illustrate the theories of Scottish doctors relating to alcohol addiction and inebriety.

## **2.4.2 Literature specific to the Scottish situation**

The particular Scottish dimension to the “alcohol question” is underlined in several entries in the two volumes of *Alcohol and Temperance in Modern History – An International Encyclopedia* (Eds. Blocker Jr. et al, 2003). The entry by Irene Maver on Scotland is particularly noteworthy. Additional useful sources are provided by Elspeth King (1979) and by Sydney Wood (2013). The thesis by Logan (1983) is also notable as it compares the responses of different professional groupings within Scotland-clergy, doctors, lawyers-to the alcohol question.

I expand on this topic in Chapter 3 based on my reading of the broad secondary literature including the work by Harrison (1971) and Nicholls (2011) – as far as these can be applied to Scotland from

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<sup>47</sup> Resnek, 1993:Pages 169-173.

their primarily English focus.

### **2.4.3 Literature on Scottish medical involvement with alcohol**

The recent work by James Wood (2011) argues a case for the Scottish psychiatric concern with inebriety becoming strongly enmeshed by concerns with degeneration theory and racial hygiene. I will explore this point through my own research in Chapters 4 and 6.

A major source for this thesis – and a source that gives the strongest link over time – are the papers to be found in the pages of the *British Journal of Inebriety*/*British Journal of Addiction* which spans the period from 1884 until the present day uninterrupted and presents a number of articles that are specifically reflecting on the particular situation in Scotland. These articles and other contemporaneous articles (e.g. Carswell, 1901; Carswell, 1903) give an insight into medical thinking at the time. They also reveal the ambition to extend compulsory treatment for inebriety to include those who are not in front of the courts. The “criminal” inebriates are seen as less receptive to reformation as compared to the “non-criminal”. This long-term ambition is echoed in central records which include detailed plans for an expanded, standalone Scottish State Inebriate Reformatory near Houston, Renfrewshire – the need for which disappeared with the dramatic fall-off in alcohol consumption and problem drinking during and after World War One.

One of the founders of the SSCI/SSA and its first president, Dr. Norman Kerr was a Glasgow-trained doctor. He was also chair of the medical temperance society during his undergraduate years as a Glasgow medical student. The involvement of medical men in the temperance campaign was a minority interest (Logan, 1983) and the ambivalence towards recommending abstinence from alcohol reflected a long tradition in medicine, which saw alcohol as also possessing health-giving properties (Paul, 2001). An official history of the SSA exists and can be found in the work of Berridge (1990). Also, Berridge (2013) and Clemis (2013) both provide chapters in “Intoxication and Society” (Eds. Herring et al, 2013), which outline the development of British medical expertise in the years before and after 1830 respectively.

The “low ebb” of the inter-war years has been little studied or written about, perhaps because at first sight there is little to discuss given the relative absence of the problem. A search for international literature on treatment institutions in this era finds very little – an article in Polish on treatment in Weimar, Berlin, for example. It is arguable that there are important threads to be traced through these years linking the concepts of the post-World War Two years and those that existed before World War One. Certainly Levine comments that the continuities are greater than are often assumed between the two eras. (Levine, 1978; Levine, 1984).

The main interest in this period is the spread of Alcoholics Anonymous from its inception in the 1930s in the United States to eventual worldwide reach. Certainly A.A. is being mentioned by the 1950s by T. Ferguson Rodgers, Professor of Psychological Medicine at Glasgow University, in his lectures to medical students. It arrives in Scotland at the end of the period under study and a detailed look at the impact of A.A. is beyond the scope of the current study. Rodgers was also immersed in psychoanalytic theory, which formed its own ideas on the origins of alcoholism during the period c.1910–1940.

#### **2.4.4 Literature on delirium tremens and alcoholic insanity**

The main recent publication in this area is that of Osborn (2014). His “Rum Maniacs –Alcoholic insanity in the Early American Republic” opens the question as to how separable are the diagnoses of delirium tremens and alcoholic insanity in the nineteenth century, and to what extent they are synonymous. I will explore this through the work presented below on the Delirium Ward at the Royal Infirmary of Edinburgh (Chapter 5) and presentations to the Scottish asylums labelled as “alcohol insanity” (Chapter 6). Osborn’s book is a most welcome addition to a sparse strand of research in this realm of medical history. The story of delirium tremens is a fascinating one and potentially when this history is fully mapped out it will shine a light on the two-hundred-year history of the medicalisation of the habit of heavy drinking and its mental consequences. The book is an expansion of a paper that was published in 2006 in *Social History of Medicine*, and which won the Roy Porter Student Essay Prize entitled “Diseased Imaginations: Constructing delirium tremens in Philadelphia, 1813-1832”<sup>48</sup>.

The doctor of today is trained to identify alcohol dependence. The doctor believes that the existence of such dependence in a patient means that if they suddenly stop drinking they will be at risk of an alcohol withdrawal state. This alcohol withdrawal state can display a wide range of severity, and may pass a threshold and become an alcohol withdrawal state with delirium. The latter term is not one that is widely used by the layperson. However, if they were told that this condition was previously known as delirium tremens and by the abbreviation of the “D.T.s” then recognition would be highly likely. As Osborn describes in his history of the condition other names were in competition for the syndrome, both before and after its description and coinage as delirium tremens by the English physician, Thomas Sutton in 1813. Brain fever, mania a potu, mania a temulentia, delirium vigilans and delirium potatorum were synonyms<sup>49</sup> that didn’t stand the test of time beyond the end of the century, by which point delirium tremens was common currency.

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<sup>48</sup>*Social History of Medicine*, Vol.19, No.2 pp 191-208.

<sup>49</sup> Pp 45-46

From the perspective of the British Isles there is much to compare and contrast in relation to the detail of Osborn's account of Alcoholic Insanity in the Early American Republic. (Osborn's subtitle is a reference to a further synonym for the D.T.s namely acute alcoholic insanity. However, in this nosologically confused area much chronic insanity was later to be attributed to alcohol in the world of the asylum.) Before the rapid adoption of the diagnosis of delirium tremens by the medical school in Philadelphia, Osborn presents us with the story of Dr. Benjamin Rush – signatory to the American Declaration of Independence, and an early pioneer in the study of alcohol and its medical effects, often referred to as the “father of American Psychiatry”.

The connection to the Edinburgh of the Scottish Enlightenment is strong for Rush and the subsequent American physicians who crossed the Atlantic in pursuit of medical knowledge around Europe. Medical journals and textbooks were little delayed in crossing from Europe to the state of Pennsylvania, which is the main setting for Osborn's research. Osborn presents us with a theory that the Philadelphian medical interest in delirium tremens coupled with new concepts of mental science imported from Europe that were based on physiology and phrenology went on to supplant the “Republican medicine” of Rush and influenced the popular culture of the time in a major way.

Any initial scepticism around the idea of such significant reach into the popular culture of the time is allayed by Osborn, who amasses such detail that the case becomes convincing. The works of many novelists and writers are cited, including a long poem called “The Rum Maniac” from which the monograph derives its title. The most famous example of a writer given is that of Edgar Allan Poe. The connection between Poe's dark romantic writings and the spectral illusions and hallucinations found in the D.T.s is emphasised. Osborn links Poe's death in 1849 at age forty years to his drinking, pointing out that he was in one of the beds reserved for inebriates in the Washington Medical College in Baltimore. Certainly, delirium tremens seems a likely contributor to his death along with other medical conditions that may have been at play.

We also learn of popular plays running night after night in many cities, such as “Ten Nights in A Barroom” (1858). This was adapted from the 1854 novel of the same name by T.S. Arthur, a friend of Poe, and it was performed throughout America for many decades as a warning against habituation to alcohol and the dangers of the D.T.s. This and another play, “The Drunkard”, were theatrical gold in the late nineteenth century. The stories could also be related using lantern slides and the hallucinatory experience of the D.T.s gave license for theatrical special effects.

Another finding from Osborn's research is that class, race and gender differences existed in how the labels of delirium tremens and intemperance were applied over time to individuals in the Antebellum period. These differences are to be found both in relation to causes of death and also in regard of diagnoses given in private and hospital practice when contrasted with the practice of the almshouse. These distinctions were to later disappear after the American Civil War with the

application of delirium tremens to the rich and the poor. Large datasets of death records and admission records are analysed to demonstrate the point that the D.T.s was initially a diagnosis for the well-to-do, given by physicians who were trained in the latest ideas arriving from Europe. A certain degree of brain development that wasn't to be found in the poor was held to be necessary for the condition to develop. This differentiation between the rich and poor was later to dissolve as the middle classes became swayed by temperance ideology. D.T.s was then more likely to be applied to the poor.

Given the richness of detail in the book it is difficult to cover all its aspects. I will leave Osborn's ideas on the cultural meaning of the many narratives of D.T.s and intemperance to one side – this has been well covered in earlier reviews of this work with an entirely favourable consensus emerging. From my own perspective as a Scottish clinician treating patients presenting with alcohol withdrawal, and as someone who has read into the history of the disease, a few questions arise in my mind in relation to one important aspect of the story. I feel Osborn's book might have said more about the issue of whether the condition is an intoxication phenomenon or a withdrawal phenomenon in individuals who are sustained heavy drinkers. One retelling of this history maintains that the intoxication hypothesis predominated for over a century prior to the resolution of the issue in favour of withdrawal aetiology as a result of the famous experiment conducted by Isbell and his colleagues on human guinea pigs (1955) in the Addiction Research Centre in Lexington, Kentucky. Osborn is aware of the controversy but it is difficult from his account to know which view predominated in his period of study.

On page 142 of "Rum Maniacs" we learn that the Philadelphian physician Benjamin H. Coates wrote of the D.T.s in 1827, saying that:

"this disease is the result, not of the application, but of the sudden intermission, of the use of these articles".

"These articles" were of course ardent spirits. However, if we move up to Boston we can find the physician, John Ware, say in an article of 1831 that:

"It is a common belief, that Delirium Tremens is immediately occasioned by abstinence from ardent spirits. I feel very certain, that in a large proportion of cases, it has nothing to do with it."

He also says:

"The symptoms of this affection frequently ensue shortly after a course of excessive indulgence. In this case it is not that the discontinuance of the indulgence occasions the disease but that the access of the disease creates a distaste for liquor and is the occasion of the discontinuance of its use."

Osborn doesn't cite Ware and to be fair the condition was written on frequently in North American medical journals. However, it would be useful to know more on the balance of this controversy at this time in North America.

Certainly, on this side of the Atlantic, battle raged between professors. For example, a professor in Belfast who supported the discontinuation hypothesis attacked the intoxication hypothesis as propounded by Thomas Laycock in Edinburgh. The intoxication hypothesis was in turn defended by Laycock, Regius Professor of Medicine in Edinburgh, who felt his position had been misunderstood. He explained that whilst he believed alcohol might be directly responsible for the Delirium Tremens he also kept an open mind to the possibility that substances other than alcohol in alcoholic beverages might be responsible for the DTs.

The theoretical position taken in relation to this argument had implications for treatment. Laycock advocated treatment without alcohol and without opium, and seemed to have much improved outcomes with a very low death rate at the Royal Infirmary of Edinburgh when compared to previous practitioners in the same hospital who used such "stimulants" and "narcotics" in treatment. Osborn leads us expertly into the murky area of death rates and of treatments administered, but it remains difficult to be sure of the true death rate from uncomplicated and untreated delirium tremens, which, to this day, is perhaps given as being at a higher rate than the evidence would support.

Certainly, as Osborn shows us, the treatment could be worse than the disease. For example from the early days when the stomach was viewed as central to the condition of D.T.s, emetics were often administered. If you received Klapp's cure for instance, this was taken to an extreme with the goal being to get the patient to vomit black or light brown material with the consistency of tar<sup>50</sup>. This was old medicine and eventually such cures were suppressed by a flurry of concern over fatalities.

Other thoughts are on the transatlantic comparisons that Osborn allows us to make. Philadelphian physicians were quick to join the temperance cause, setting up early temperance societies in the state. In Britain medicine lagged behind in this regard and doctors came much later to the temperance cause. This goes some way to explain why the United States led the way in relation to early medical treatment of inebriety<sup>51</sup>. Dr. Samuel Woodward, an asylum superintendent in Worcester, Massachusetts, was seminal in arguing for separate inebriate reformatories as early as 1833. These reformatories were to address the habit of drinking rather than its consequences. Also

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<sup>50</sup> pp.48-49

<sup>51</sup> pp.158-162

pivotal in the USA, and described by Osborn, was the Washingtonian self-help movement which arguably was a prototype for Alcoholics Anonymous in the next century.

Overall the book is rich in published anecdotes – this helped sustain the public fascination with D.T.s in the early nineteenth century. The man in the D.T.s who self-castrated is a good example of why someone with this condition needs to be observed and safeguarded. The patient in the almshouse who cuts off his hand to be given rum speaks to the potential force of the compulsion in addiction. However, the book lacks a bibliography and the valuable references provided by Osborn need to be tracked down through the index and the endnotes. Even so, this book is commendable as it takes us into an important area that has been poorly explored in the medical historical literature of the last 75 years. (John Romano's 1941 paper on the topic in the *Annals of Medical History* is the main forerunner and not yet available electronically.) Archival resources exist to allow for studies similar to Osborn's to be conducted in other places for the nineteenth and early twentieth century. This may help us fill in some of the gaps that remain in understanding the history of the D.T.s. Osborn has paved the way and revived this field of study. It is an aim of this thesis to take up the task of adding to this literature in relation to delirium tremens and some associated conditions through an examination of Scottish practice in the nineteenth and early twentieth century.

#### **2.4.5 Literature on inebriate reformatories**

The background literature on the operation of the inebriate reformatories is relatively small and when looked at from an international perspective the realisation of such treatment institutions varies by date – the United States had them earlier than Britain and Australia<sup>52</sup>, and most other countries in Europe and in the wider world had them later than Britain. The gender balance and the degree of voluntarism of those confined to such institutions is also seen to be variable in time and place.

The idea for an inebriate reformatory can be traced back to Benjamin Rush and his 1810 publication “Plan for an Asylum for Drunkards to Be Called the Sober House”. This idea wasn't taken up at such an early date as in the United States. The idea was further developed from the perspective of asylum practice in North America by Samuel Woodward in his “Essays on Asylums for Inebriates” in 1838. Again the idea wasn't implemented at the time but it was later taken forward by the pioneer Dr. J. Edward Turner with the 1864 opening of the New York State Inebriate Reformatory to patients. The troubled history of this institution in its fifteen years of operation is well described by John W. Crowley and William L. White in their 2004 monograph “Drunkard's Refuge – The Lessons of the New York State Inebriate Asylum.” This monograph is

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<sup>52</sup> See Crowley and White, 2004; White, 1998; Tracy, 2007.



also striking for its emphasis on how the disease model of inebriety and consequently the idea of medical treatment was vehemently opposed in some quarters within the American temperance movement. No synergistic or complementary relationship is allowed between temperance and medical theory by such authors as J. E. Todd in his 1882 “Drunkenness a Vice, Not a Disease”. In Todd’s view medicine should not be providing an excuse for the drunkard and such drunkenness.

The predominance of women in British and Scottish inebriate reformatories is explored in several papers and theses (Gutzke, 1984; Hunt et al, 1989; McLaughlin, 1991; Weiner, 1990; Zedner, 1991; Beckingham, 2010; Hands, 2013; Reidy, 2014) with some literature of relevance from work on other countries in relation to asylum admissions (Prestwich, 1993). The consensus emerges that women are treated as special cases, with female drinking seen as more deviant but also their treatment/punishment is tempered by sending them to “semi-penal institutions” (Barton, 2004).

Greenland (1960) gives an early assessment of the successes and failures of the inebriate reformatory era. This can be compared to the account by the Chief Inspector of Inebriate Reformatories in his “obituary” to the system just before demitting from office – this is found in the records held by the National Archives for Scotland. The issue of what to do with the “criminal inebriate” continues today as a routine debate in cases before Scottish criminal courts, as does the issue of disposal to treatment, punishment or some hybrid of the two. The research presented in Section IV on the operation of the inebriate reformatories is of some relevance to today’s debates on whether alcohol treatment and testing orders might be a useful sentence for those who commit crimes whilst intoxicated.

## **2.5 Conclusions**

There is a broad but manageable background literature on medicine and alcohol in relation to Scotland, which I will reference in the course of this thesis. Literature on the evolution of the disease concept of alcoholism/inebriety shows an important connection back to the Edinburgh of the Scottish Enlightenment, with further development of the key ideas happening in Europe and in the United States. The movement for medical temperance occurs earlier in the United States and additionally the first inebriate reformatory opens there in the mid-nineteenth century. The transatlantic influence is one reason for the later British developments in this area of practice.

## **SECTION II**

### **Scottish temperance and Scottish medicine, 1855-1925: the general picture**

## Chapter 3

### Scotland and temperance in the nineteenth and early twentieth century

#### 3.1 Introduction

If we accept the idea that Scotland was the “most drunken nation on earth” in the Victorian era – as suggested by one scholar referencing a nineteenth century Scotsman newspaper editorial<sup>53</sup> – and then follow the changes in alcohol consumption and drink culture through to the 1930s when a parliamentary committee on licensing pointed to Scotland as a model of sobriety to be emulated by England and Wales, then we are faced with a major challenge in explaining this turnaround in Scottish drinking culture.

As I will outline in this chapter, changes in the availability and price of alcohol go a long way in explaining the fluctuations in consumption in Scotland, as has also been the case in more recent times. Both availability and price are much influenced by government through licensing legislation and through taxation or duty. However, unique to the period under consideration in this thesis, in comparison to the more modern period from the 1970s in Scotland, is the phenomenon that was the temperance movement. There is no equivalent today of a mass popular movement that is both campaigning for legislative change to solve the alcohol question alongside attempting to influence individuals in their personal behaviour around alcohol. Such campaigning today seems confined to the domains of public health and health promotion, with a largely laissez-faire attitude from the UK government towards alcohol. The new Scottish parliament, particularly with the SNP governments since 2007, has taken a more assertive stance against alcohol-related harm in response to the fact that Scotland is once again differentiating itself from the rest of the United Kingdom in relation to greater indices of alcohol-related harm.

Although not the primary focus of my research it is important to outline these historical changes here as in the chapters that follow I wish to relate my survey of changing medical engagement and thinking on the alcohol question to the general condition of Scotland in relation to alcohol and to the progress of the temperance movement.

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<sup>53</sup> See Sydney Wood, The Drunken Scot in Victorian Times, History Scotland, May-June, 2013, pp.16-23.

### **3.2 “The most drunken nation on Earth?” - Victorian Scotland in international comparison .**

In the years just prior to Victoria coming to the throne in June 1837, and in the initial years of her reign, drinking in Scotland seemed to be a problem for all classes. Dunlop, in his “Artificial Drinking Usages of North Britain” (1836), illustrated some of the reasons for this. Alcohol had become embedded in civil society such that the expectation was for individuals to join in with drinking during their daily commerce, and if someone demurred from this they would be met with opprobrium and in some cases physical violence. Popular culture, derived from eighteenth century ideas of “conviviality”, applied virtually irresistible peer pressure to all in the adult population. Robert Burns’ statement that “freedom and whisky gang the gither” was widely accepted. Add to this the rehabilitation of whisky by George the Fourth on his visit to Edinburgh – he requested Glenlivet – and the suppression of this particular form of alcohol in the wake of the Jacobite rebellions was now in the past.

This situation of heavy drinking across all classes was to change in the Victorian era with the forces of population growth, urbanisation and industrialisation – all of which was underpinned by immigration from Ireland and migration from the Highlands to the central belt of Scotland. These trends were to transform the alcohol question from an issue that spanned all of Scottish society to an issue that divided more along class and gender lines within that society. The differentiation between “rough culture” and “respectable culture” was to become more distinct with the latter in this period coming to embody what we sometimes refer to today as “Victorian values”.

Concerns over the efficiency of the urban working class being undermined by alcohol came to the fore with the growth of heavy industry. Monday absenteeism was a noticeable early issue in this regard. Additionally, Victorian emphasis on the family and the move from the traditional extended family towards nuclear families brought into relief the need for the urban male wage earner not to undermine his stable home by squandering the family’s money in the public house. This particular morality tale of the contrast between the sober and drunken husband was reproduced endlessly in the late Victorian era in paintings and literature as well as temperance pamphlets.

### **3.3 The march of temperance**

The strong early temperance movement in west central Scotland and then Scotland as a whole led to an early “victory” – the implementation of particularly restrictive licensing provision in Scotland in 1853 that lasted to the second half of twentieth Century (1976). Popularly known as the Forbes McKenzie Act, this followed from an earlier inquiry on public houses in Scotland that found a proliferation of small establishments. The decision to restrict licensing to larger premises and to

have Sunday closing was to prove successful (at least in the short term) in reversing some of the problems around alcohol. It certainly made Sunday a much more sober day and reduced the problem of Monday absenteeism secondary to alcohol.

The later support of the early socialist movements in Scotland for drink control was presaged by the Chartists' support for temperance in the mid-nineteenth century. The combination of liberal politicians, early socialists and religious groups for temperance, and its subsequent more radical variant of teetotalism as the century moved on, was to prove a powerful campaigning lobby. The support of the church could be measured by the number of ministers who were proclaimed teetotalers, which was to increase from single figures in 1830 to 50% by the end of the century. The initial export of temperance ideology from Scotland to the North of England was in turn succeeded by the more radical ideology of teetotalism being brought back to Scotland from England, splitting and dividing the Scottish temperance movement. Teetotalism was to become the predominant force

The strong influence on politics and popular culture manifested itself in many ways. It became a central issue for the Liberal Party, for example. When William Collins Jr. became the Lord Provost of Glasgow in 1877 he had become affectionately or dismissively known (depending on your stance on alcohol and teetotalism) as "water Willie". He gained a knighthood on stepping down as Lord Provost in 1880. The following year a fountain was erected in his honour at Glasgow Green by supporters of temperance with the dedication:

"Erected by temperance reformers in recognition of valuable services rendered to the temperance cause by Sir William Collins, Lord Provost of the City of Glasgow 1877-1880. 29 October 1881."

James Keir Hardie, who grew up in central Scotland in the 1860s and 1870s and was exposed to this mixture of temperance and evangelical Christianity, was to carry these convictions forward into his work in forming the Scottish Labour Party, the Independent Labour Party and then the Labour Party itself. His mother steered him to the Good Templars as a protection against his step-father's drinking and Hardie was to say later that his socialism owed more to the teachings of Jesus than those of Marx and Engels.

The concern for the welfare of children in relation to the potential for alcohol to destroy lives is underlined by the popularity of the Band of Hope in Scotland from the 1850s until relatively recent times. Dunlop and others' battle for hearts and minds for their cause was aimed from an early date at those still to be exposed to alcohol, with the wish that many would become lifelong abstainers. Certainly, by the end of the Victorian era the cause of temperance and teetotalism appeared to be more associated with progressive politics and offer prospects for self-improvement alongside

societal improvement. From our viewpoint today, this strand to the anti-alcohol movement has more abiding appeal than the ideologies that were to become associated with the medical thinking at the time. These were more pessimistic in their outlook, namely degenerationism and eugenics<sup>54</sup>.

The key pieces of legislation in these particular years pertaining to Scotland brought forward by the temperance reformers through the agency of the liberal Party in the UK parliament are listed here<sup>55</sup>:

- 1853: Public Houses – Select Committee Report (Forbes Mackenzie Act)– Sunday Closing
- 1858: Intoxication (Scotland) – Accounts and Papers
- 1872: Habitual Drunkards – Select Committee Report
- 1876: Cameron's Publicans' Certificates (Scotland) Act abolishing Quarter Sessions reversals of licence refusals.
- 1878: Licensing Law Report
- 1878: Intemperance – Select Committee Report
- 1879: Habitual Drunkards Act, placing alcoholics in retreats for one year minimum
- 1882: Cameron's Passenger Vessels Licences Amendment (Scotland) Act on Sunday sale of liquor.  
Beer Licences Amendment Bill facilitating licensing restriction
- 1883: Corrupt and Illegal Practices Prevention Act
- 1883: Payment of Wages in Public Houses Prohibition Act
- 1886: Legislation on Sale to Children
- 1887: Public Houses Hours of Closing Act
- 1893: Treatment of Inebriates – Departmental Committee Report
- 1895: Further Departmental Committee Report on Inebriates
- 1898: The Inebriates Act
- 1879–1900: Inebriates Acts
- 1901: Intoxicating Liquors (Sale to Children) Act
- 1903: Licensing Amendment (Scotland) Act, extending the 1887 Early Closing Act to exempted cities.

As can be seen they represented a sustained attempt to address the “alcohol question”.

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<sup>54</sup> See Wood ,2011 for a description of how these ideologies coalesced in Scottish medicine and psychiatry. As before the temperance and medical strands would make use of each others thinking despite apparent contradictions. Logan.1983,p.424, points out that the work of Clouston was particularly referred to by the temperance movement and Clouston himself was a temperance advocate.

<sup>55</sup> Adapted from Logan, 1983,p.300

### **3.4 Temperance uses of medicine**

From an early date the temperance movement was keen to highlight any medical evidence that either bolstered their claims that spirits were harmful to health and later, with teetotalism and abstinence to the fore that all alcohol was in and of itself toxic. Scottish medical men in the early nineteenth century were reluctant to fully endorse the cause and some of the early pamphlets highlighting medical reasons for moderation and abstinence were by non-medical writers who emphasised and mustered the relevant medical evidence. By the middle of the nineteenth century Trotter's book had become a favourite of the movement as it emphasised the need for abstinence as a cure for the disease of drunkenness.

As the movement grew in influence and numbers in the late nineteenth century, doctors finally seemed to come on board in increasing though still modest numbers. Logan documents that in 1879 43 medical men were part of the Scottish Temperance League and by 1915 this had reached 107<sup>56</sup>.

### **3.5 The late nineteenth century peak as the tipping point for change**

If we look again at our overall graph for alcohol consumption (Figure 1), despite the momentum being built up by the temperance movement the overall consumption of alcohol was continuing to rise. As already discussed the love of whisky was felt to underpin the higher statistics in Scotland for alcohol-related crime and alcohol health harm.

More stringent measures were therefore required, and these were enacted one by one with the main lever being increasing duty on alcohol and as can be seen in the graph of consumption, a sustained fall began in the consumption of both beer and spirits from around 1900 through to the 1930s.

### **3.6 World War One as an accelerator for change**

The concerns around the fitness of soldiers to fight in the Great War was to accelerate this change with further increased taxation and laws against "treating" servicemen by buying alcohol. After the war, public houses were to greatly reduce in number due to the targeted legislation, and as a result publicans had to be compensated in many cases for loss of livelihood. The government set aside funds for this purpose. A final trigger was the entry of the United States into the War in 1917, leading to the passing of the Volstead Act and the introduction of national prohibition in the United

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<sup>56</sup> Logan, 1983, p.429

States. Unlike in Britain, the predominance of brewers who were German immigrants coupled with anti-German feeling was the last straw in the mounting pressure for prohibition.

In Britain in the wake of the war, Edwin Scrymgeour was elected to parliament in Dundee in 1922, displacing Winston Churchill as a sitting MP on the single issue of prohibition. However, his subsequent bill failed – parliament felt that the “local option” or veto to allow for dry towns and areas was sufficient and many areas in Scotland went on to utilise this provision.<sup>57</sup>

### **3.7 The problem resolved?**

The inter-war years were years of apparently sustained quiescence in relation to the problems around alcohol. Whilst undoubtedly a totally sober nation had not been achieved, certainly the nineteenth century perception of a drunken Scots nation had been reversed – such that some commentators today contrast the sobriety of these years with the current situation in Scotland to illustrate the point that high alcohol consumption is not an inevitable national characteristic.

Certainly, as we will see below, the alcohol question and alcoholism and its consequences became much less of a concern for Scottish psychiatrists.

### **3.8 Conclusions**

This brief chapter has set out some of the necessary background knowledge required around alcohol consumption and the temperance movement in Scotland, in order to set the scene for the account that follows on medical engagement with the alcohol question in the clinic, in the hospital and in the public arena.

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<sup>57</sup> See Sydney Wood, 2012.



## Chapter 4

### Scottish medicine and the “alcohol question”, 1855-1925

#### 4.1 Introduction

In this chapter I set out the claim that Enlightenment Scotland brought forth ideas, either directly or indirectly, that were crucial for the evolution of nineteenth and twentieth century Scottish medical ideas about the nature of habitual drunkenness. The medical community claimed that doctors had unique expertise in this area and could give guidance on how best to respond when the “vice” of intemperance crossed the line and became the “disease” of inebriety – a belief that grew from this seed, albeit belatedly, from the middle of the nineteenth century onwards in the era of the asylums.

In particular I argue that the inevitable overlap between high levels of alcohol consumption and presentations with psychological illness became more apparent as institutional provision grew for “insanity” and “lunacy”, and thus alienists and physicians with an interest in the mental presentations of physical illness came to the fore as specialists in this area. Subsequently the nature of the core condition was to be discussed in journals and textbooks by such specialists in psychological medicine and inebriety. Views as to the nature of alcohol addiction, and how best to treat the condition, were to change over the course of the twentieth century.

#### 4.2 Professional Networks within Scottish Medicine, 1855-1925

An important point to consider in relation to the account, which follows in this chapter and also in Chapters 5-9 is that the medical men involved in this portrayal are selected as exemplars, at a time of change, when specialisation was to the fore. Also over the period we can see intergenerational interaction with pupils going on to become medical teachers in turn and either perpetuate or challenge received wisdom on the issue of alcohol.

Physicians in many cases opposed the separation of teaching on psychiatry from general medicine but by the end of the nineteenth century we see this being supported in Scotland. This is perhaps less surprising when we understand, for example, that Dr. David Yellowlees was a friend of Professor William Tennent Gairdner (1824-1907), Professor of Medicine at the University of Glasgow and that friendship dated back to medical training in Edinburgh in the 1840s and early 1850s when Gairdner was senior to Yellowlees. (Yellowlees obtained his M.D. in Edinburgh in 1857 and also became LRCS (Edin) that same year. He went on to work at the Edinburgh Royal Asylum). Both sustained an interest in issues around alcohol-most likely a legacy of these

Edinburgh years-and both were to give concordant evidence to the 1895 enquiry described below. Both men were devout Christians in the Scottish Presbyterian tradition<sup>58</sup> and though not temperance campaigners they had a natural tendency to praise sobriety and to see intemperance as a vice. Their relationship appears as one of mutual support and regard. Interestingly Gairdner writes an account of the Edinburgh Royal Infirmary in the 1850s-reproduced in Gibson, 1912-but makes no mention of Laycock who obtained the chair of Medicine in 1855,a post which Gairdner had also applied for with much support. Subsequently Gairdner obtained the Regius Chair of the Practice of Medicine in Glasgow, which he occupied from 1862 to 1900.

Undoubtedly rivalries also exist and there is an ability shown by some of the protagonists to question received authority along with a striving towards scientific method<sup>59</sup>-see the account of Gairdner's experiments with alcohol therapy in the next section- or the introduction of new ideas-see Henderson's challenge to received wisdom on an overly pessimistic view of inebriety as described in chapter 9.

Dr.John Cunningham, the Medical Officer at the Girgenti Inebriate Reformatory, illustrates a different career path in that he was a local practitioner in Ayrshire who became a specialist by opportunity when Glasgow chose to site the city Inebriate Reformatory in his area. He was able to call on the support of Dr.John Carswell in Glasgow and Dr.James Craufurd Dunlop in order to become legitimized in this specialist role. This is discussed in Chapter 8.

#### **4.3 Scottish Medicine and the use of alcohol as a therapy**

The early nineteenth century temperance movement set out to win the approval of the clergy and especially the medical profession. In the latter instance they were confronted with an almost universal medical opinion that "moderate" use of alcohol was conducive to health and longevity. In addition there was the promotion of alcohol as therapy in the medical systems of the time, such as Brunonianism – a system of treatment of sthenic and asthenic disease by the followers of the Scottish physician Dr. John Brown. Brown was yet another student of Cullen and developed some of Cullen's ideas into his own theories, although with disapproval of his eventual system by Cullen himself. Cullen would prescribe and recommend alcohol under various circumstances but was conservative in this regard compared to many of his contemporaries. Trotter likewise saw no problem with alcohol in moderation and could detail many health-giving benefits.

Brown's ideas were very influential on the Continent with a more limited following at home. While

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<sup>58</sup> For Gairdner's life and selected papers see Gibson, 1912.

<sup>59</sup> See W.F.Bynum (1994) *Science and the Practice of Medicine in the Nineteenth Century*. (CUP) for a discussion.

Brunonianism was at times mocked for being overly liberal in its prescription of alcohol for particularly asthenic diseases, it was at one end of a spectrum of medical practice at the time. This is well explored by Risse (1988; 2010)<sup>60</sup> and the issue of the long tradition of Bacchic medicine is more broadly described by Harry W. Paul (2001)<sup>61</sup>.

The legacy of this late eighteenth century period was such that medical belief in using alcohol in moderation for health purposes and as part of the diet was maintained for most of the nineteenth century, and this is reflected in the initially cool relationship of Scottish medical practitioners to temperance reform.

In fact the practice of using alcohol in relatively high doses as a medicine in severe illness, sometimes combined with opium, persisted well into the second half of the nineteenth century in Scotland. As well as the ideas of Laycock, described in chapter 5, that such treatment was the prime suspect in causing increased mortality in cases labeled as having delirium tremens it is possible also to point to experimental work by Gairdner in relation to typhus, which showed that treatment without alcohol improved survival in typhus<sup>62</sup>. In fact Gairdner was able to show that the higher the dose of alcohol used the higher the mortality rate. The group with no or little alcohol – Gairdner’s preferred treatment – had a 10% mortality, that with usual “stimulation” of 40 ounces of wine and seven ounces of spirit per day had a 17.5% mortality and those given half an ounce of brandy hourly had a 25 percent mortality. In this way, through experiment, Gairdner helped to resolve the issue of using alcohol as a treatment, which had been a divisive topic among his teachers during his time at the Edinburgh Medical School.

#### **4.4 Scottish medicine and Scottish temperance - a tale of ambivalence**

We must now turn to the interaction between the Scottish medical profession in general and the growing concern over the effects of alcohol on civil society as represented by the temperance movement.

This relationship has been explored at length by Logan (1983)<sup>63</sup> in her section on Doctors<sup>64</sup> within

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<sup>60</sup> Guenter B. Risse (1988) *Brunonian Therapeutics: New Wine in Old Bottles Medical History*, Supplement No.8, 46-62; G. B. Risse (2010) *Hospital Life in Enlightenment Scotland* (Createspace). In the earlier publication Risse details the variation in the use of tonics by physicians, including Cullen, at the Royal Infirmary of Edinburgh in the last quarter of the eighteenth century.

<sup>61</sup> Paul, Harry W. (2001) *Bacchic Medicine – Wine and alcohol therapies from Napoleon to the French Paradox* (Clio Medica 64)

<sup>62</sup> See pp134-135 of Reinartz and Wynter, 2014 for an account of this important work conducted in the Glasgow Fever hospital 1861-1862.

<sup>63</sup> Logan, Norma Davies (1983): *Drink and Society: Scotland 1870-1914*

- Ph.D. Thesis, University of Glasgow,

<sup>64</sup> Ibid.pp.415-436

a chapter that deals with various professions' responses to the temperance movement and the "drink question". Logan's view is that the early ambivalence of Scottish doctors to temperance arises from a number of sources but principally from the expectations of their patients, particularly the clientele who could afford the fees for individualised treatment that took into account their lifestyle and circumstances. Doctors were members of a society that had a "wet" culture in the early nineteenth century and inevitably reflected that culture in their own habits – urban doctors particularly risked social ostracisation if they became strident advocates of temperance and teetotalism. This early ambivalence presented a problem for temperance advocates in that they wished to set out medical evidence that supported their cause. As a result, many of the early publications in this area are by non-medical men mustering medical evidence in an attempt to convince individuals that alcohol was contrary to health.

An aspect of this history that is often overlooked, but which is brought out by Logan, are how the branches of what we would now call alternative medicine – such as hydropathy, homeopathy, herbalism and phrenology – were quicker to ally themselves with the temperance cause. This created a distrust from mainstream, allopathic medicine. Dietary advocates for vegetarianism and veganism were additionally part of this alliance. There were mainstream doctors in Scotland who were exceptions to this rule from an early point, and they were only to grow in number in the last quarter of the nineteenth century and into the twentieth century. Logan tabulates this increase from figures given in the Scottish Temperance League Register and Abstainers' Almanac – these show that the numbers increase steadily year on year, from 43 in 1879 to 107 in 1915: a 150% increase. This apparent sea-change coincides with a shift in medical opinion that partly follows some of the political successes of the temperance movement, and which also arises from concerns of the new medical discipline of psychiatry and the observations and practice within the burgeoning asylum estate.

Also, it should be noted that by this period it has become more commercially viable for a doctor to be both personally abstinent and to work in an environment – hospital or clinic – that is principally for abstainers and which rejects the use of alcohol as a medicine. In this same period we can see that life assurance companies started to differentiate the actuarial risk for abstainers as being different from those who continued to drink as empirical evidence emerged that excessive drinking and its associations reduced life expectancy.

## 4.5 Medical teaching on alcohol - the changing picture

The recognition of the ability of alcohol to cause both physical and mental disease can be traced, to a degree, by examining the changing representation of this issue in general textbooks of medicine and psychiatry, in the medical journals and in specific monographs over time.

I will give one example here from the late nineteenth century. The textbook *Clinical Lectures on mental diseases* by T. S. Clouston ran to many editions and was published on both sides of the Atlantic. It is very much based on Clouston's own experience as Physician Superintendent of the Royal Edinburgh Asylum for the Insane. In the fourth edition of 1897 Chapter 12 is on alcoholic insanity<sup>65</sup>. Clouston sets out views very similar to Yellowlees though with some slight differences in classification. Alcohol is said to be a cause of insanity, either indirectly or directly, in over 20% of cases. Clouston classifies "five forms" namely delirium tremens, chronic alcoholism, mania a potu, alcoholic dementia and dipsomania. Unlike Yellowlees he doesn't mention a "true insanity of intemperance" but rather describes instances where repeated episodes of delirium tremens or chronic alcoholism and alcohol dementia result in a permanent insanity with paranoid features.

Both in his textbook and in his evidence to the 1895 Departmental Committee described below, Clouston mentions recent findings in microscopic neuropathology that show histological changes attributable to alcohol. This is in keeping with his view that prolonged abstinence is required to allow any chance of recovery from these conditions. It is in his textbook under the section on treatment that Clouston suggests the remedy of "an island where whisky is unknown" coupled with a regime of work and supervision designed to "redevelop the conscience".

Certainly, Clouston has the problem very much in the province of psychiatric concern and practice though, like Yellowlees and others, he is willing to argue for separate provision for the inebriate provided insanity is not fully established.

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<sup>65</sup> Pp.479-492

#### 4.6 Medicine, alcohol and the public arena

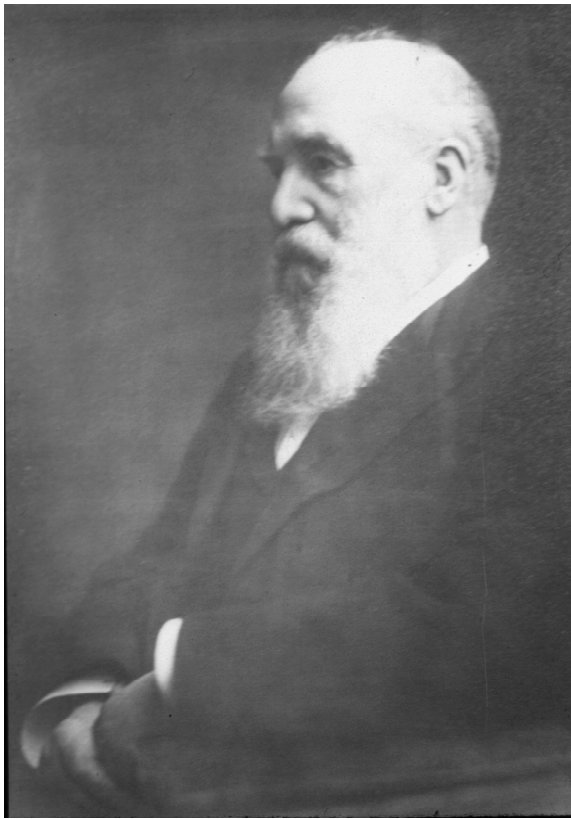


Figure 3. Dr. David Yellowlees.



Figure 4. Dr. Thomas S. Clouston.

As a consequence of increasing medical interest in the subject of alcohol as a cause of illness, and in giving explanation to the underlying habit of addiction through the concept of inebriety, medical evidence was sought by parliamentary committees of enquiry. This process reached its zenith with the 1895 publication of the work of the Departmental Committee on habitual offenders, inebriates, &c. (Scotland)<sup>66</sup>. This report highlights the centrality of a medical role in these proceedings, albeit with balancing perspectives from the legal and penal authorities and representatives of civic representatives and religious and charitable institutions. The seven-person committee of enquiry appointed by George Trevelyan, Secretary of State for Scotland, in June 1894 consisted of six men and one woman. The Chair, Sir Charles Cameron, Baronet, was both an M.D. and a Member of Parliament. The Secretary, J. F. Sutherland, was the Medical Officer of Glasgow Prison and also a Deputy Commissioner for Lunacy in Scotland. A third member, R. Farquharson, was also medically trained and an M.P. The other three men were a professor of law and sheriff, a politician (the Under Secretary of State for Scotland) and the Prison Commissioner for Scotland. The one

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<sup>66</sup> 1895 [C.7753] [C.7753-I] Departmental committee on habitual offenders, inebriates, &c. (Scotland). Report from the departmental committee on habitual offenders, vagrants, beggars, inebriates, and juvenile delinquents. [The minutes of evidence, appendices, and index are published separately.]

woman was an educationalist.<sup>67</sup>

The sixty-four-page main report has an appendix of 694 pages of evidence gathered. This presents within it a survey of how habitual drunkards and inebriates were being dealt with in the Scotland of the time. The Committee sat to take evidence in Glasgow, Edinburgh, Perth, Aberdeen and Dundee over twenty-four days in November and December 1894, and took evidence from 139 witnesses in these cities. A final sitting in London in late January 1895 lasted three days and heard from a final twelve witnesses. The committee also visited thirty-five institutions in Scotland relevant to their deliberations and one in England.<sup>68</sup> Eighteen of the witnesses were medical men and two witnesses were matrons of prisons. This is on a par with thirteen “clergymen of different denominations”, eighteen chief constables<sup>69</sup> and the twenty “honorary and paid officials” of relevant institutions and societies. Of the eighteen medical men two were Commissioners in Lunacy, six were physician superintendents of asylums, four were medical officers of prisons and six were classified as “Physicians and Medical Experts”.

Much is to be learned as to the medical views of the time from a reading of this evidence, though it must be read in the context of a campaign to establish Certified Inebriate Reformatories that would stand apart from asylums for the insane. For instance, in the evidence of Professor W. T. Gairdner taken on the 14<sup>th</sup> November, 1894<sup>70</sup> he seems to defer to the Chair, Sir Charles Cameron, in praising the chair’s earlier attempts to introduce a Bill for civil detention of habitual drunkards in 1879, based on the Dalrymple Commission of 1872 – however, this proposal invoked overwhelming opposition in Parliament on the grounds that it would infringe civil liberty<sup>71</sup>.

Gairdner is able to expound at length his own view that the debate on whether habitual drunkenness and inebriety represent vice or disease is a futile one. Initially, he believes the habitual drinker chooses to drink on a repeated voluntary basis and to that degree is culpable, but that this eventually becomes an involuntary “enslavement” requiring outside intervention against the wishes of the individual. The “enslavement” results from alteration in the “structure and function” of the body and, therefore, the mind that amounts to disease. The only possibility of a cure is to reverse these changes by removing the exciting cause of strong alcohol. This can only be achieved through compulsion. Gairdner is repeatedly pressed by the Committee on how long a separation is needed. Gairdner is unsure due to “want of experience” but reiterates “at least a year”. He doesn’t seem to feel that the United States’ experience with inebriate reformatories can act as a guide and maintains this is something we will have to discover for ourselves in the Scottish situation.

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<sup>67</sup> Miss Flora C. Stevenson, Hon. F.E.I.S., Member of the Edinburgh School Board.

<sup>68</sup> Wakefield Prison.

<sup>69</sup> Ten from Cities and Burghs and eight from Counties.

<sup>70</sup> Pp.27-34 of the Minutes of Evidence.

<sup>71</sup> Ibid., page 28.

As with other testimony in these proceedings we get access through anecdote to the real world of practice that is less apparent in the journals and textbooks of the time. Gairdner, for example, tells of a Glasgow hotelier who commissioned him to try to engage with a hotel resident who would check in during drinking binges, abandoning his family to pursue his drinking. The hotelier feared the man would die in his hotel. Gairdner could not persuade the man to submit to treatment and expressed his frustration that no means of compulsion was available in this situation. A contrasting story is given of a medical acquaintance in Edinburgh intervening in a case of delirium tremens that he happened upon by chance. The doctor came across a gentleman banging on the door of a bank well before opening time in response to delusional ideas within a delirium. Rather than involve the police the doctor arranged for committal to the Morningside Asylum<sup>72</sup>. In a few days, the man was recovered and declared sane again and released. However, given the implications of the committal the man decided to sue the doctor involved. He lost the case but the doctor was liable for £1,000 in legal costs. A high price to pay for being a medical good Samaritan.

The testimonies of David Yellowlees and Thomas Clouston are good exemplars of the near-consensus from the physician superintendents of the Royal and District Asylums at that time. Both are central figures in forming the Scottish medical profession's view on the relations between intemperance or inebriety and insanity or lunacy and how these conditions should be treated and managed. Both are in favour of separate institutions. Looking at Yellowlees' evidence, much space is taken up by the issue of who would pay for care in inebriate reformatories, and clearly the Committee is already concerned about the potential failure of inebriate reformatories in relation to a dispute over funding. Both Clouston and Yellowlees are sceptical that American experience with reformatories for inebriates can act as a guide to whether such institutions will necessarily translate well to the Scottish context. Clouston urges caution over some claims of a 50% success rate for inebriates under existing voluntary arrangements in Scotland that treated inebriates as a "better class". He recommends a cautious introduction of a range of measures including reformatories on an experimental basis to then inform further developments. Clouston is well aware how prevalent a problem habitual drunkenness is in Scotland at this point in time, and the scale of investment that would be needed to divert the inebriates in the criminal justice system into an alternative set of provisions.

It is of interest to analyse how they portray the relationship between the two categories. The thoughts of Clouston on nosology and aetiology are captured above in the section on medical teaching from his popular textbook, and he isn't asked much about his views on this point by the Committee. Yellowlees is, however, asked about nosology in this area and the main point of interest to this thesis is in how this evidence reveals the medical theories of the time. Yellowlees

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<sup>72</sup> Royal Edinburgh Hospital.



outlines his theory that a weakened brain can “loosen self control” and lead to drunkenness. Also, that the “vice” of heavy drinking can lead to brain disease, the latter being the situation in “the vast majority of cases”. Additionally, Yellowlees does not think there is any other condition that he can name that is “more definitely hereditary than habitual drunkenness”. He also calls this the “drink disease” and differentiates this from “mere intemperance”. An interesting passage follows<sup>73</sup> in which Yellowlees responds to this question:

“Apart from delirium tremens, mania a potu or chronic alcoholism, would you describe to the Committee the general physical and mental infirmities not amounting to insanity produced by excessive and prolonged drinking?”

In his response, Yellowlees references delirium tremens and mania a potu en route to answering this question by paradoxically describing “alcoholic insanity”, arguably reflecting a confusion that existed then and to some extent continues to this day:

“what is properly called the insanity of intemperance, alcoholic insanity strictly so called, where the patient from long drinking becomes suspicious, is quite certain that so and so intends to do him harm, that somebody slandered his wife, that people whisper base things into his ears, that someone discredits him in public estimation, that someone put something into the Mail about him, and that he knew all about it”.

This clearly reflects a belief that alcohol can induce a more prolonged and potentially permanent form of insanity, which can be differentiated from the short-lived reactions represented by delirium tremens (acute alcoholism) and mania a potu (pathological intoxication). The existence of such an illness is today disputed and if it exists it is held to be rare. At this point in the late nineteenth century there was a belief that such cases were commonplace and this belief system is often misunderstood in recent scholarship on this issue<sup>74</sup> – I will go into in more detail about this in Chapter 6.

The Committee is much concerned over the issue of how long a period of treatment is required to allow for a chance of recovery, since this was to become the basis of the recommendation for detention measures for criminal inebriates. For Yellowlees this was at least six months and similarly for Clouston a year or longer. Clouston mentions involvement in some cases where the inebriate has agreed to a period of guardianship and then is sent to Orkney, Shetland or Colonsay,

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<sup>73</sup> Page 53, Paragraph 1442. Of the Minutes of Evidence, 1895

<sup>74</sup> For example see Matthew Warner Osborn, *Rum Maniacs: Alcoholic Insanity in the Early American Republic*, Chicago: London, University of Chicago Press, 2014. which seems to be unaware of this broader use of the term alcoholic insanity treating it as largely synonymous with delirium tremens.

such that when they decide they want their freedom back they can't return to mainland Scotland due to lack of funds and are often trapped.

A curiosity or two can also be found among the minutes of evidence on which the 1895 report was based. In Glasgow, for example, an American M.D. is in business selling what he says is a cure for inebriety, called the “metabolic treatment” or “metabolic cure”. Dr. A. J. Currie, M.D. (U.S.A.) is described as the Superintendent of the Institute for the Treatment of Inebriety in Glasgow. From his testimony<sup>75</sup> he is conducting an office-based practice in George Street in Glasgow. The secret “cure” is given as a hypodermic injection of a fluid four times a day for twenty-one days along with a “simple tonic” by mouth. For his wealthier patients, often treated in their home, a fee of twenty guineas is charged – but it is implied that this is negotiable and that a series of pauper cases were also treated in George Street for free or a “very small amount”. Additionally, some of these cases from the “poorer classes” were test cases funded through a philanthropic Justice of the Peace, or in one case of a couple through the husband’s concerned employer. They were in some instances said to be the “worst of the worst” of criminal inebriates and one exemplar was said to have achieved two and a half years of abstinence after the “metabolic treatment”. Two other witnesses in Glasgow gave testimony to this cure. One was an involved lawyer, Mr. John Y. King<sup>76</sup> The other was a local doctor – Dr. Alexander Nairne, L.R.C.P.&S., Glasgow – who had broken off his association with the “metabolic cure” after being brought before the General Medical Council on a charge of “infamous conduct” due to his work with Dr. Currie. Neither King or Nairne were privy to the formula for this “cure”. It was suspected to contain at least strychnine, and perhaps also morphia and cocaine. Another possibility entertained by the committee in their undoubtedly hostile questioning was that it was only water and purely a placebo. They cited an analysis of the Keeley Cure, which had found it only consisted of water and did not contain the gold claimed by Dr. Keeley in the United States. They felt this was ruinous to the Keeley Cure at that time<sup>77</sup>. The Committee was sceptical about the claimed 50% success rate of the cure and scathing that no “true scientific test” was to be allowed by independent researchers and that the injected mixture could not be revealed or analysed.

The committee also took evidence in Dundee of a trial of another secret “cure” – “the Tyson Cure”, which involved ingesting a liquid twelve times a day for twenty-one days. Again, strychnia was suspected as one of the ingredients and again, despite some positive claims in the initial stages of treatment, it was deduced that by nine months the majority had relapsed – although “it was asserted

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<sup>75</sup> Pp.349-352; Paragraphs 10,901-11,028.

<sup>76</sup> Ibid.pp.291-296; Para.9135-9264.

<sup>77</sup> The Keeley cure continued to grow, however, until the 1920s with Keeley Institutes appearing around the world. See Tracy, Sarah W. *Alcoholism in America: From Reconstruction to Prohibition*, Johns Hopkins University Press: 2005, pp. 114–118 for an account.

‘that in no cases had the lapses been due to a return of the craving’”.<sup>78</sup> There was also the claim that these cures brought about an “aversion” to whisky but again the committee was sceptical about this as well as the distinction between relapse due to “craving” or due to a return to old social habits that involved convivial drinking.

Thomas Clouston was another witness who was asked his opinion at the Edinburgh sitting. Clouston’s opinion on the “Gold Cure” (also known as the Keeley Cure), the “metabolic cure” and the “Tyson cure” could not have been clearer:

“my own opinion is that they are gross quackery, every one of them”.<sup>79</sup>

The last paragraph on the section of the main report on secret “cures” concludes that: “Everything we have heard leads us to believe that no reliance whatever is to be placed upon these secret cures, which in our opinion are absolutely worthless”.<sup>80</sup>

One other concern of the time was with “impure alcohol” and the possibility of rapid intoxication using cheap whisky or alternatively by “Finish” drinking. “Finish” was defined as “a solution of shellac in methylated spirits, used in furniture polishing”. This seemed to be particularly used by female inebriates just released from custody and the report notes that “a couple of penceworth suffices to produce insensibility”.<sup>81</sup>

The medical evidence given to the Committee on the issue of treatment is brought together in the main report under the heading of The Theory of the Cure of Inebriety.<sup>82</sup> Medical opinion is unanimous in bearing out the popular opinion that the effect of inebriety is to destroy the will power of the victim in a manner which can only be remedied by ‘prolonged abstinence from drink’. This abstinence can only be ensured in “the great majority of cases” by “effective physical control” supplemented by “appropriate medical treatment, for restorative purposes”.

Thus, in the end the idea of a prolonged period of detention as a treatment for inebriety is said to be the view of “practically... the whole of the medical profession”.

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<sup>78</sup> Page li of Report from the Departmental Committee on Habitual Offenders, Vagrants, Beggars, Inebriates and Juvenile Delinquents (1895).; Para.D.

<sup>79</sup> Page 103, Para.2920 ,Of the minutes of evidence, 1895.

<sup>80</sup> Ibid.,p.lii; Para C.

<sup>81</sup> Ibid.,p.xlvii, Para.A

<sup>82</sup> Ibid.p.lii, Para.D

## 4.7 Conclusions

By the end of the nineteenth century, therefore, a medical theory of habitual drunkenness and inebriety has become established which is very much biological in its orientation. The emphasis on the disease of inebriety being seated in the brain is a departure from the earlier views of Trotter, who was more willing to consider and emphasise the psychosocial dimension in coming to an understanding of causation in the individual patient. The idea of brain changes, which had transformed “vice” into “disease” underpinned by a weakening of the will was the basis for the medical advocacy of enforced treatment at this time.

The interface between inebriety and insanity or lunacy was clearly problematic despite attempts to deny this problem. Although a clear separation of the two categories was sought, the idea that inebriety could in the end lead to permanent insanity meant that such a distinction was never likely to be achieved.

## **SECTION III**

### **1855-1900: The clinical impact**

## Chapter 5

### Alcohol and medical practice - the Delirium Ward at the Royal Infirmary of Edinburgh, 1856-1867

“I dreamt a dream the other night I couldn't sleep a wink/The rats were tryin' to count the sheep and I was off the drink” (Delirium Tremens by Christy Moore)

#### 5.1 Introduction



Figure 5. Professor Thomas Laycock, 1812-1876



Figure 6. The Royal Infirmary of Edinburgh.

The raw data of archival research can shed light on evolving concepts and practice in the field of addiction medicine. Of particular interest are the records of the Victorian era when alcohol consumption rose to levels higher than those seen today. Medical encounters with individuals

drinking excessively can be found in surviving case records of the time. This is certainly the case in Scotland at the beginning of our period of interest.

This chapter presents an analysis of five surviving casebooks of the Delirium Ward of the Royal Infirmary of Edinburgh. They cover admissions from May to July over the years 1856–1867 when Professor Thomas Laycock (Figure 5), his colleagues and their team oversaw Ward X of the Royal Infirmary of Edinburgh (Figure 6) “in quarterly rotation”<sup>83</sup>. Laycock, a lecturer at University of York before becoming Regius Professor in Edinburgh in 1855, wrote extensively on delirium tremens. He believed it to be an intoxication rather than a withdrawal phenomenon to be treated by assisting the elimination of the toxin, predominantly alcohol, but possibly other substances in alcoholic beverages, by a variety of medical interventions.

Laycock, although a general physician, is among those doctors who are celebrated among the pioneers of British neurology. F Clifford Rose’s book, *History of British Neurology* (2011), gives an outline of Laycock’s contribution to neurology in general.<sup>84</sup> While many of his theories of the structure and function of the nervous system are now discounted he was viewed as a hardworking and influential clinical teacher in his academic career. In York he influenced Hughlings Jackson and in Edinburgh he also seems to have been received well as a teacher though held to be “old-fashioned” in his views. His own training had included periods in Paris and an M.D. obtained in Gottingen. This may explain the early adoption of “alcoholismus” as a diagnostic term in Edinburgh before it appeared in a medical journal in Britain given Laycock’s ability to read the German literature and the translation of the works of Huss into German and French. His published work on delirium tremens is only a small portion of his roughly three hundred academic publications on a wide range of topics with the overarching theme of trying to relate disparate diseases back to the nervous system.

His views on delirium tremens have much in common with his “near neighbour”, Dr. Alexander Peddie, another Edinburgh physician who published on alcohol-related diseases. Both Laycock and Peddie lived in the same residential area in Edinburgh. Peddie is said to have brought the use of the stethoscope back to Edinburgh from Paris. Laycock cites Peddie as a supporter of his toxaemic or methystic theory of delirium tremens (and vice versa). Peddie worked at Minto house in Edinburgh, which although a private hospital would take the poor and thus the income of the institution would be supplemented by providing medical training. He also had a private practice for wealthier patients. One important difference that does seem to emerge in comparing Laycock to

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<sup>83</sup> The Dublin Quarterly Journal of Medical Science  
November 1, 1871, Volume 52, Issue 2, pp 300-309

<sup>84</sup> Rose (2011), pp.150-152

Peddie is that Laycock seemed to shun the public arena whereas from an early date Peddie is active in advocating legislative measures for the control of the oinomaniac or dipsomaniac<sup>85</sup>.

## **5.2 General notes on delirium tremens**

### **5.2.1 Description of the condition**

This condition was first described and named in 1813 by the English physician Thomas Sutton and from an early point its aetiology proved controversial. Thus, Ware in 1831 stated:

“It is a common belief, that Delirium Tremens is immediately occasioned by abstinence from ardent spirits. I feel very certain, that in a large proportion of cases, it has nothing to do with it.”

And:

“The symptoms of this affection frequently ensue shortly after a course of excessive indulgence. In this case, it is not that the discontinuance of the indulgence occasions the disease but that the access of the disease creates a distaste for liquor and is the occasion of the discontinuance of its use.”

The condition was sometimes also known as acute alcoholic insanity. Other terms used interchangeably soon after its description included mania a potu and delirium temulentia. It was also held to be like a previously described illness under the heading of “brain fever”. The theory that delirium tremens was an intoxication rather than a withdrawal phenomenon was controversial from the outset. Laycock was to enter into this debate in a very detailed way, drawing on the cases treated at the Royal Infirmary of Edinburgh.

### **5.2.2 Theories of causation**

The intoxication or methystic aetiology theory predominated up until the 1950s and the publication by Isbell and colleagues of their experiments on “volunteer” subjects in The Narcotic Farm at Lexington, Kentucky<sup>86</sup>. Only then was the “expert” opinion, previously in favour of the intoxication rather than the withdrawal hypothesis, overturned. The Isbell paper showed the condition to be indeed an extreme form of the alcohol withdrawal syndrome. However, whatever caused it, it was a distinctive and recognisable syndrome and one way or another related to the consumption of alcoholic beverages. Indeed, as noted above, it had been described in the eighteenth century but not as distinctly as by Sutton, who gave the condition the name that was to

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<sup>85</sup> See Valverde, 1998, Page 48.

<sup>86</sup> Isbell, Harris, H. Franklin Fraser, Abraham Wikler, Richard Belleville, and Anna J. Eisenman. An Experimental Study of the Etiology of Rum Fits and Delirium Tremens. *Quarterly Journal of Studies on Alcohol* 16.1 (March 1955): 1-33.



last. D.T.s features frequently in admissions to asylums and general hospitals in the nineteenth century and was even seen in artist-sufferers such as Charles Altamont Doyle<sup>87</sup>, who reflected the experience in his work.

### 5.2.3 The issue of death rate

Also of note in the literature on this subject is the frequently quoted high death rate of up to 35% prior to modern treatment. For example:

“Despite appropriate treatment, the current mortality for patients with D.T.s ranges from 5–15%, but should be closer to 5% with modern ICU management. Mortality was as high as 35% prior to the era of intensive care and advanced pharmacotherapy. The most common conditions leading to death in patients with D.T.s are respiratory failure and cardiac arrhythmias. Patients at greatest risk for death are those with extreme fever, fluid and electrolyte imbalance, or an intercurrent illness, such as occult trauma, pneumonia, hepatitis, pancreatitis, alcoholic ketoacidosis, or Wernicke-Korsakoff syndrome”.<sup>88</sup>

Also, in a recent Spanish Cohort study:

“539 episodes of hospitalization for Alcohol Withdrawal Syndrome in 436 patients (mean age 45.0, SD 12.0, 91.3% males), 71.1% of whom presented with delirium tremens. A total of 29 patients died, yielding a 6.6% mortality rate (95% confidence interval, CI: 4.2–9.1%). Eighteen of these patients died after being admitted to the intensive care unit (ICU).”<sup>89</sup>

Finally, and very succinctly, from an Oxford Specialist Handbook<sup>90</sup> just published:

“Delirium tremens is a potentially life-threatening condition. Before the days of effective sedation and ready access to intravenous fluid replacement, the mortality rate was 35%. Effective diagnosis and management in the modern world should reduce this to under 1%.”

As I will show below from an analysis of the Royal Infirmary of Edinburgh Casebooks, at first sight the death rate from cases labelled delirium tremens seems much lower than the historic estimate of mortality that is quoted above, and even lower than the modern estimates. However, the

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<sup>87</sup> See Beveridge, 2006.

<sup>88</sup> Ref: [emedicine.medscape.com/article/166032](http://emedicine.medscape.com/article/166032)

<sup>89</sup> Ref:-Alcohol Alcohol. 2010 Mar-Apr; 45(2): 151-8. Analysis of the factors determining survival of alcoholic withdrawal syndrome patients in a general hospital. Monte R, Rabuñal R, Casariego E, López-Agreda H, Mateos A, Pértega S.

<sup>90</sup> Page 188 in Addiction Medicine, 2nd Edition By Saunders et al, 2016.

death rate was discussed at the time as being particularly low – Laycock was to explain this in terms of his method of “expectant treatment” which aimed to avoid the use of alcohol, opium or the two in combination as laudanum (other than in rare cases where other medical conditions compelled their use but only at the smallest of doses). This approach was compared to figures from the RIE during periods where these drugs were used more liberally, as well as the use of this approach elsewhere where higher death rates were recorded for delirium tremens. For Laycock this confirmed his theories on aetiology and treatment. He denied seeing the onset of the disease in those who arrived “alcoholised” and who were then observed detoxifying over several days. The treatment was “expectant” in the sense that uncomplicated delirium tremens was known to be time-limited and therefore would resolve after a few days, perhaps five days on average. Some of the cases that I have analysed were used by Laycock for his own publications on this topic in 1858 and 1871, allowing for an interesting comparison and also aiding in the interpretation of the case records.

### 5.3 Information in the Delirium Ward casebooks/Analysis of Admissions to the Delirium Ward-1856-1867

#### 5.3.1 Index of Admissions

INDEX to JOURNAL of				WARD, No.		
No.	PATIENTS' NAMES	ADMITTED.	PAGES OF JOURNAL.	DISEASES.	DISMISSED.	EVENT.
I	William Gilbert	May 30 <sup>th</sup>	1	Delirium Tremens	June 9 <sup>th</sup>	Cured
II	John Macrae	31 <sup>st</sup>	3	Delirium Tremens		Cured
III	John More		7	Melancholia: by prostration		Went to Home
IV	Janet Buinet	— 28 <sup>th</sup>	9	Hysteria		Cured
V	Archibald Hay	June 7 <sup>th</sup>	11	Delirium Tremens	June 14 <sup>th</sup>	Cured
VI	James McDonald	June 3 <sup>rd</sup>	15	Hemiplegia		
VII	Ann Campbell	June 7 <sup>th</sup>	18	Delirium Tremens	June 9 <sup>th</sup>	By Discharge
VIII	William Child	June 12	14	Epilepsy		Cured
IX	Alexander Fairclough	June 14	21	Delirium Tremens	June 18 <sup>th</sup>	Cured
X	Charles Brown	July 22 <sup>nd</sup>	27	Delirium Tremens	July 24 <sup>th</sup>	Cured
XI	David Brown	July 18 <sup>th</sup>	23	Epilepsy	July 18 <sup>th</sup>	Cured

Figure 7. Detail of the Admission's Register for the Delirium Ward, Royal Infirmary Of Edinburgh, 1856.

The five surviving casebooks each have a useful index at the beginning giving all the cases contained within. (See figure 2) . The index gives the name of the patient, date of admission, date of discharge, diagnosis (“diseases”) and outcome (“event”). The cases are numbered within each book using either the Roman system or the Western-Arabic system and there are columns giving the pages of the journal where the case is to be found, although this often only gives a starting page and sometimes omits a page number where the case has jumped forward in the casebook.

At this time, there was no individual case record and the use of such grouped casebooks was standard, presumably as a cost-saving measure and as an aid for teaching and analysis:

The five casebooks in the Lothian Health Service Archive<sup>91</sup> either cover a single year or several years as follows:

Casebook 1: 1856, 1857, 1858, 1859. Professors Bennett and Laycock, mixed

Casebook 2: 1861 Professors Bennett and Laycock, mixed

Casebook 3: 1863 Professor Bennett, mixed

Casebook 4: 1864 Professor Bennett, mixed

Casebook 5: 1865, 1866, 1867. Professors Maclagan and Bennett, mixed

The principle physicians are also given for each casebook. The word “mixed” is an indicator of both male and female patients. The years 1860 and 1862 are absent. The casebooks represent intake over a roughly three-month period in each of the years from either the end of April or beginning of May through to the end of July. The medical teams involved seemed to have had charge of Ward X each year in “quarterly rotation”. Laycock, although not named in the later casebooks, clearly still has an overview since he is able to draw on case material for a later analysis given in 1871, as a response to criticism from Professor Cuming of Queen’s College, Belfast who was adamant that delirium tremens represented a withdrawal syndrome in those habituated to alcohol.

### **5.3.2 Methods of analysis of individual case histories**

For the purposes of analysis, I have extracted a key dataset from all the alcohol-related cases and entered this data into a spreadsheet. The data from the index is supplemented by key data given at the beginning of individual case entries. This mainly adds the age of the patient, their occupation, their marital status, their place of origin and their place of residence, although in a number of cases some of this information is missing. As a worked example of how this operates let us look at the first case admitted:

“Extracted Case Information: LHB1/129/4/1

Example of core dataset:

Case No.: I

Name: William Gilbert

---

<sup>91</sup> LHB1/129/4/1-LHB1/129/4/5

Age: Not recorded.

Occupation: Bookbinder

Marital Status: Not recorded (Assumed married – he has a daughter)

Native of: Not recorded

Resident: Not recorded

Date Of Admission: 30/05/1856

Date Of Discharge: 09/06/1856

L.O.S.: 10 days

Diagnosis: Delirium Tremens

Event: Cured

Physicians: Dr. Thorburn/John Young – Clinical Clerk – working under Professors Laycock and Bennett.”

In this core dataset, therefore, there are the key demographics of the patient, the main diagnosis or diagnoses and the outcome of the admission. Additionally, the date of admission (D.O.A.) and the date of discharge (D.O.D.) (sometimes date of death or date of transfer to another ward or to the asylum) allow for the calculation of a length of stay (L.O.S.).

The next set of data in each case to go with this is based on a reading of the casenote at length to look for key symptoms of delirium tremens, to look for prescriptions given and for other forms of physical treatment and management. These are then coded and rated under key headings given below. Below is the transcript I made from the longhand of the same very first case, which happened to be a case of delirium tremens (N.B. I have omitted dosages of the drugs due to uncertainty around the notation):

“Transcript – Full – William Gilbert:

Friday, 30th May, 1856: Patient applied for admission, because he anticipated an attack of Delirium Tremens of which he has had several. He has been drinking for the last 3 months, during which he has been out of work. He is in a state of great depression and tremulousness, has giddiness and a sense of oppression in his head and is very much alarmed about himself. Does not hear noises in his ears but occasionally sees motes before his eyes. When spoken to gets very excited and tremulous. Pulse rises very high. Ordered.

Ammonia Carbonates

Sol Mur. Morph

Mist Camphora

Saturday 31<sup>st</sup> Slept a little during the night. Still very much depressed and irritable but remained perfectly quiet. The injection of the right conjunctiva is due, he says, to a blow given him by his daughter.

Monday June 2<sup>nd</sup> Yesterday he was still very anxious: had a little giddiness with voices in his ear. Slept little last night: but walked up and down the ward. Today he is very irritable: again felt giddy, and weight in his head. Perfectly rational but talkative. Wished to strike another patient who annoyed him by walking about the ward, but remained quiet when prevented from doing so.

Tuesday 3<sup>rd</sup> Slept very little last night: and was today very restless, tremulousness great: not conscious of where he is; talking incessantly and incoherently. At night pulse 130: very delirious: ordered:

Solution Antimon. Tartar  
Tinct Opii  
Aquae  
techa quaque hora

Wednesday 4<sup>th</sup> Walked about the ward all night seeking his coat. still unconscious where he is, Pulse reduced somewhat; but otherwise the same as yesterday. Takes his food well: bowels kept fairly open.

Thursday 5<sup>th</sup>: Did not sleep last night: but slept for 3 hours this forenoon. Pulse quiet: but he is still restless: believes himself at home. In the evening pulse 90. Still unconscious of where he is: at intervals he is quite rational: but answering correctly, he is off again talking incoherently.

Friday 6<sup>th</sup> Slept well last night: today is perfectly rational: the mixture is continued.

Saturday 7<sup>th</sup> Slept all last night; and several hours during the day. Is still somewhat irritable: and in the evening he felt "nervous" having been distracted by a new patient. Pulse 96.

Sunday 8<sup>th</sup>. Had a good nights rest: and is quite better today: feels very hungry. And is anxious to get a walk in the garden, pulse 92.

Monday 9<sup>th</sup> Quite well. Allowed a pass and returned in the evening much more cheerful and perk. Pulse 84 and taking no medicine.

Dismissed cured

John Young

It is possible from this to look for the symptoms and signs of delirium tremens as used in the famous paper of Isbell et al, namely:

- 1) tremor 2) weakness 3) perspiration 4) nausea 5) vomiting 6) diarrhoea 7) anorexia 8) insomnia 9) hyperreflexia 10) fever 11) visual hallucinations 12) auditory hallucinations 13) disorientation 14) convulsions.

Elevation of blood pressure is omitted from this list (the sphygmomanometer was yet to be invented). I have in addition looked for evidence of: 15) fluctuation in consciousness i.e. lucid intervals intermingled with disorientation. Additionally, I record whether 16) evidence of a raised pulse is recorded and also 17) giddiness or dizziness. Finally, 18) mood symptoms are recorded such as “depression” in the case above. Also in reading the case notes I try to estimate a 19) length of time for the delirium (if found) to be present.

I have also coded for 20) mode of admission, differentiating between self-presentation and being brought to the hospital by others. Several cases fear the onset of delirium tremens and seek to be supervised during its course. Mention of 21) a past history of delirium tremens is also coded. The 22) use of alcohol is noted in relation to the timing of the presentation. As can be seen in the case of William Gilbert he has been drinking for the past three months but beyond that there is no real quantification of his drinking. Another item of interest is whether there is a 23) perceived precipitant to the drinking and the presentation. Thus, the statement that William Gilbert has been out of work for the last three months is of interest although we don’t know if that is a cause of or result of his drinking.

A separate column records the 24) use of medication and 25) the key medicines. The use of 26) other physical treatment is captured as well as 27) the use of restraint including the padded cell, as shown in the case entry captured in Figure 3.

In total, each patient has potentially forty key pieces of information enterable in the database where the data are present and alongside this any qualitative information of interest is extracted in the form of free text. However, the individual case records are highly variable in length and also vary as to whether a comprehensive physical examination is recorded. They can be very short in nature, as shown in these two alcohol case examples shown in the original longhand entries from the clinical clerk. For the purposes of the Thesis a strict definition of Delirium Tremens would by necessity include hallucinations and confusion. Using such a strict definition doesn’t alter the very low death that is found under the ‘anticipatory’ regime used by Laycock.

A ready source of comparison is available for these cases in relation to demographics and outcome in that 135 cases are admitted for a variety of non-alcohol related diagnoses. These cases have been captured only at the level of the basic dataset for comparison and no attempt is made to analyse the clinical signs and symptoms beyond the diagnoses given. However definite group differences emerge in relation to gender, age and outcome.

In approaching this analysis as a clinician, involved in my day to day practice in dealing with alcohol withdrawal states, with or without delirium-as they are now classified-I am well aware of the great variation in the syndrome and the tendency of the condition to last several days once established even with recourse to alcohol. The variation in the condition is present in these records. The surprises are around explanation of the condition, i.e. the methystic hypothesis, and the treatment given. Additionally I approached these records expecting to find high death rates for Delirium Tremens as this is received wisdom and the biggest revelation is the low death rate with the conservative regime of management.

## **5.4 Results from the analysis of the Delirium Ward casebooks**

Of the 313 admissions to the Delirium Ward in the thirty months represented in the RIE casebooks (10 x 3 months) 178 were alcohol related (57%), predominantly recorded as delirium tremens but latterly also alcoholism/alcoholismus (Huss) (a term first used in these notes in 1859, a year prior to its first use in a British medical journal).

Here is a breakdown of the diagnoses given by Casebook:

Casebook 1: Delirium Tremens +/- : 25 cases; Intoxication/Inebriation: 8 cases; Alcoholism: 9 cases. Total: 42 cases.

Casebook 2: Delirium Tremens +/- : 16 cases; Intoxication: 8. Total: 24 cases.

Casebook 3: Delirium Tremens +/- : 21 cases. Total: 21 cases.

Casebook 4: Delirium Tremens +/- : 21 cases. Intoxication/Poisoning: 2 cases.  
Total: 23 cases.

Casebook 5: Delirium Tremens +/- : 42 cases; Alcoholismus: 22 cases; Delirium a Potu: 1 case; Intoxication: 3 cases. Total: 68 cases.

Overall total: 178 of which 125 given the diagnosis of delirium tremens – 126 if we include the synonymous term delirium a potu. The term alcoholism and then alcoholismus seems to come in and out of vogue in these few years around the time of its first mention in a British medical journal.

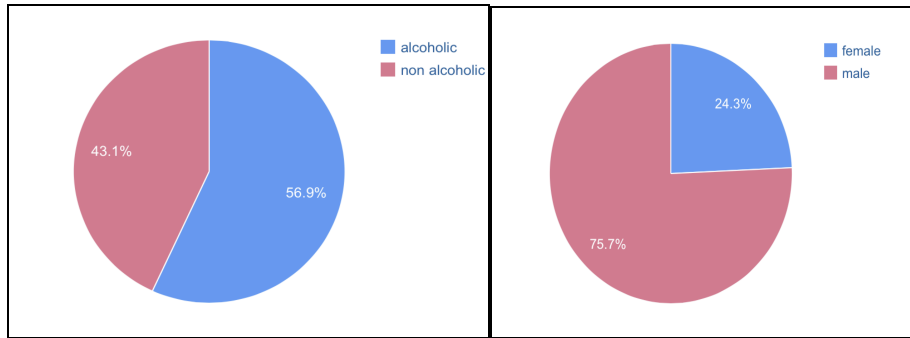


Figure 8. Pie charts showing i) classification of cases into alcoholic (blue) and non –Alcoholic (red) and ii) proportion of men (red) and women (blue) in total cases of delirium.

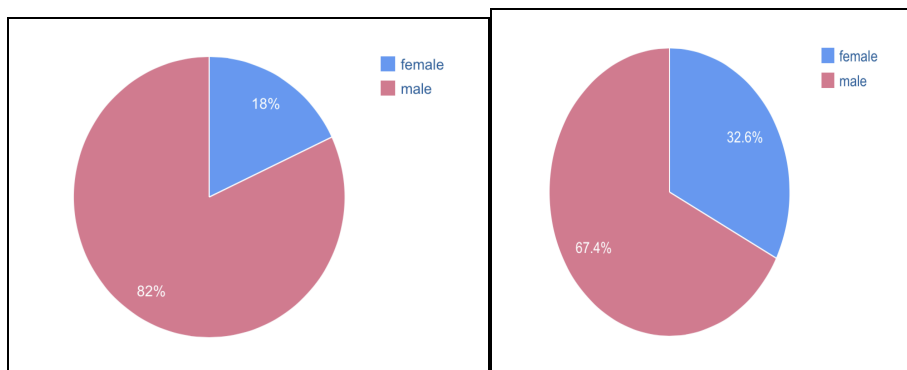


Figure 9. Ratio of men (red) to women (blue) in alcohol (on left) and non-alcohol (on right) cases admitted to the delirium ward.

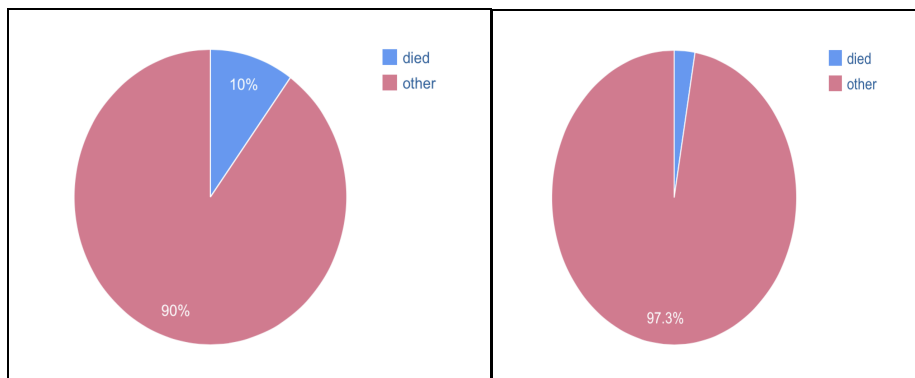


Figure 10. Death rates (blue) in non-alcohol (on right) and alcohol (on left) cases in the delirium ward showing the surprisingly low rates of death for the alcoholic cases.

Of these 178 admission episodes – a few for the same individual over time – thirty-two were for females (18%). Ages ranged from 20 through to 70 in the overall sample with a mean of around 35 years. A significant number worked in the alcohol trade. A typical length of stay was seven days.



The patient self-presented or came with relatives in most cases. Treatment was with a variety of drugs such as opium, strychnine, ammonia and emetics and purgatives. As well as using drugs to sedate there was a belief that some of these drugs helped with the elimination of alcohol from the body. A padded cell was used on occasions where the patient became violent, as was strapping to the bed when required. Alcohol was never given in any significant quantity – this was in keeping with Laycock's beliefs in relation to extreme intoxication as the cause of D.T.s. A number of patients self-discharged after a very short period of time before being fully "cured".

The most striking finding, given what is believed about historical mortality, was that there were only five deaths out of 178 alcohol-related admissions (2.8%). In one man who died aged 23 years, the post-mortem showed consolidation of his right lung.

## 5.5 Some illustrative cases

### 5.5.1 The use of restraint

Monday July 8  
 At 8 15 p.m. the patient became  
 very violent & abusive & threatened the attendants  
 He got out of bed & became uproarious –  
 by overturning the chairs & table in the ward &  
 uttering abusive language – I prevented him repeating  
 himself & the patients in the ward. he was at once  
 removed to the padded cell for the night with  
 some little difficulty – as his struggles were most violent  
 his struggles <sup>in escape</sup> there seem to have been also very violent  
 as on visiting the patient in the morning – the  
 whole padding was found torn off from the door  
 Tuesday July 9<sup>th</sup> Is quiet this morning, ordered to  
 return to the ward –  
 paper was slept for some hours to day.

Figure 11. Detail from case record of patient from Delirium Ward who required the use of the padded cell-the note is transcribed below.

“Monday July 8

At 8-15pm the patient became very violent and abusive and threatened the attendant. He got out of bed became uproarious-overturning the chair and table in the ward and uttering abusive language-To prevent him injuring himself and the patients in the ward he was at once removed to the padded cell for the night with some little difficulty, as his struggles were most violent. His struggles to escape then seem to have been also very violent as on meeting the patient in the morning-the whole padding was found torn off from the door.

Tuesday July 9<sup>th</sup>. Is quiet this morning, ordered to return to the ward-Patient has slept for some hours to-day.”

### **5.5.2 A episode of poisoning of two women by the same bad alcohol-The two Muirheads:**

“Jane Muirhead single aged 31 years-Leith and Jane Muirhead married aged 30 years, residing in High Street and a sister in law to the above. Both were admitted into Ward X July 16<sup>th</sup> 1864 under Dr.Bennett’s care.

J.Muirhead “single” states that on the morning of the 16<sup>th</sup> left home (Leith) at 5-30 feeling quite well.Walked to Edinburgh and immediately commenced her usual work, along with her sister-in-law J.Muirhead married who had only to walk from the High Street .Both women work at a Paper Staining Manufactory in Carruthers Close off the High street. Worked for three hours then they were allowed their breakfast hour from 9-10.took a very hurried meal (Which consisted of a fresh penny roll each,a small bit of cheese and a cup of tea) As they wanted to go to the Railway Station to meet the arrival of an excursion from Glasgow where they expected to meet the married J.Muirhead’s sister . This person not arriving, both returned to their work at Carruthers Close and continued working till 12 O’clock. About 11am all the workers 7 girls beside the two Muirheads took some small beer “Skichim” which is sold in the close for a halfpenny a bottle. The Muirheads admit to have taken the greater quantities.”

They both become violently unwell with fever, vomiting and high pulse rate and this is believed to have come from an adulterant in the beer.<sup>92</sup>

### **5.5.3 Two short duration cases admitted to the Delirium Ward.**

A fair number of the cases labeled alcoholic have admissions of only a day or two to the hospital. The man described on the left here was in for only two days and the gentleman on the right for one. Both were discharged recovered once they had slept and treated with simple remedies such as aqua frigida. (Cold water).

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<sup>92</sup> See Burns, 1995,Bad Whisky for nineteenth century concern over adulterated alcohol.

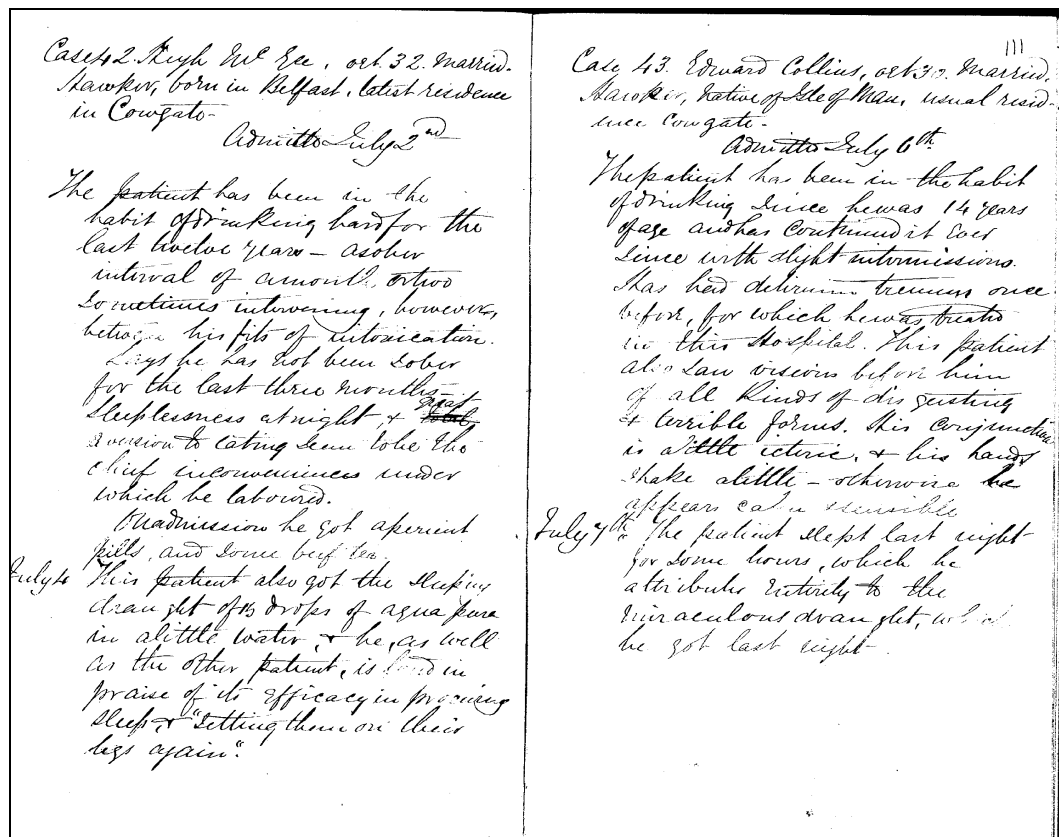


Figure 12. Two short duration cases admitted to the Delirium Ward. (July, 1858)

Here are the two cases in Figure 12. transcribed. Firstly the case on the left: -

“Case 42. Hugh McGee. Age 32. Married. Hawker, born in Belfast, latest residence in Cowgate.

Admitted July 2<sup>nd</sup>, 1858.

The patient has been in the habit of drinking hard for the last twelve years - a sober interval or a month or two sometimes intervening, however protracted his fits of intoxication. Says he has not been sober for three months. Sleeplessness at night and great aversion to eating seem to be the chief inconveniences under which he has laboured.

On admission he got aperient pills and some beef tea.

July 4<sup>th</sup>: This patient also got the sleeping draught of 15 drops of aqua pura in a little water and he, as well as the other patient, is loud in praise of its efficacy in providing sleep and setting them on their feet again.”

And the case on the right: -

“Case 43. Edward Collins. Age 30. Hawker. Native of Isle of Man. Usual residence Cowgate.

Admitted July 6th, 1858.

The patient has been in the habit of drinking since he was 14 years of age and has continued it ever since with slight intermissions. Has had delirium tremens once before, for which he was treated in this hospital. This patient also has visions before him of all forms of disgusting and horrible forms. His conjunctivae (sic) is a little icteric and his hands shake a little-otherwise he appears calm and sensible.

July 7<sup>th</sup>: The patient slept last night for some hours, which he attributes entirely, to the magical draught which he got last night.”

## **5.6 Thomas Laycock, alcohol and delirium tremens.**

Laycock’s papers on delirium tremens (1858, 1871) are worthy of further consideration here as they draw on the experience captured in the casebooks of the Royal Infirmary of Edinburgh and lay out his ideas on aetiology, treatment and mortality at length. These papers reveal detailed thinking about the individual cases and show that each case was considered in relation to a possible multifactorial aetiology. One surprise in the later paper is the assertion that there may be other substances in alcoholic beverages which act as “stimulants” upon the brain to produce the distinctive disease of delirium tremens.

Most striking is Laycock’s analysis of mortality rates from delirium tremens and the apparent strong benefit from his method of “expectant treatment”, i.e. avoiding the prescription of alcohol, opium or the combination of the two other than in the minutest of doses. He also describes the use of special forms of water to aid sleep and how this is particularly effective if the resident physician turns up at bedtime to administer this. As with other authors on this subject Laycock recognises that the achievement of sufficient uninterrupted sleep is often a prelude to the resolution of the illness.

Below, Figure 13, is the table given by Laycock (1858) on the issue of mortality in the years that predated his method of treatment and where the use of alcohol was still the norm.

**TERMINATION OF CASES OF DELIRIUM TREMENS, TREATED IN THE  
ROYAL INFIRMARY, EDINBURGH.**

	Males.		Females.		Total per Cent. of Deaths.
	Cases.	Deaths.	Cases.	Deaths.	
1st July 1839 to 1st October 1841,	64	7	11	1	10·6
1st October 1841 to 1st October 1842,	32	5	4	0	14·0
1st October 1842 to 1st July 1843,	32	5	8	2	17·5
1st July 1843 to 30th September 1844,	26	11	8	3	41·0
1st October 1844 to 30th September 1845,	29	12	9	2	36·8
1st October 1845 to 30th September 1846,	50	16	10	2	30·0
1st October 1846 to 30th September 1847,	61	23	9	2	35·7
1st October 1849 to 30th September 1850,	46	10	4	0	20·0
<b>Totals,</b>	<b>340</b>	<b>89</b>	<b>63</b>	<b>12</b>	<b>25·0</b>

Figure 13. Table of deaths of cases of Delirium Tremens in R.I.E, 1839-1850.

This can be contrasted with the table below, table 14, given in a later paper in 1871, which covers many of the years for which I have conducted the analysis. The difference in mortality rates is indeed striking and hard to explain other than in relation to Laycock's belief that conservative management is what brought about the difference.

*CASES returned as "Delirium Tremens," in the Royal Infirmary, Edinburgh,  
for Ten Years, 1859 to 1869.*

Year	No. of Cases	Died	Per Cent. of Deaths
1859-60	74	1	1·37
1860-61	54	2	3·6
1861-62	58	1	1·72
1862-63	69	3	4·35
1863-64	69	1	1·45
1864-65	73	7	9·6
1865-66	92	2	2·17
1866-67	86	5	5·81
1867-68	49	4	8·36
1868-69	44	—	0·0
<b>TOTAL</b>	<b>668</b>	<b>26</b>	<b>3·89</b>

Figure 14. Table of deaths of cases of Delirium Tremens in R.I.E, 1859-1869

## **5.7 Conclusions and discussion**

It is striking that clinical observation can be misleading, as is seen in the history of theories on the causation of delirium tremens (alcohol withdrawal with delirium). The intoxication theory predominated, albeit with some dissent, for 150 years until resolved by the human experimentation reported by Isbell and his colleagues in the 1950s (An Experimental Study of the Etiology of “Rum Fits” and Delirium Tremens). The intoxication theory was being used in the clinical practice of nineteenth century physicians in Edinburgh, who would use treatments designed to eliminate the toxin alcohol. The very low death rate in this case series casts doubt on the oft-quoted idea that prior to specific treatments to suppress withdrawal the death rate from delirium tremens was greater than 20%. The difference most likely relates to selection of cases to minimise comorbid physical illness but this series suggests that in the absence of other conditions and of aggressive treatment which may compound the illness, the death rate is low in delirium tremens.

For the purposes of the thesis the most interesting finding is how interested and engaged Scottish physicians were in this particular alcohol-related illness, how readily patients could gain admission to these wards and the apparent lack of moral judgement and opprobrium attached to the description of the individual cases. The case series gives some insight into the range of heavy drinking behaviours to be seen at the time. In very few cases is any advice given on or mention made of the need for future abstinence, although a past history of delirium tremens is seen as a risk factor for future recurrence. One or two cases mention resumption of attendance at temperance societies but this isn’t routinely given as advice.

## **5.7 Postscript: causation resolved**

The famous experiment by Isbell and colleagues, which resolved the issue of aetiology of alcohol withdrawal delirium (delirium tremens), involved the use of “human guinea pigs” at the Addiction Research Centre in Lexington, Kentucky in 1950s America. Ten male opiate addicts were dosed with high levels of alcohol, varying in dose and duration, for at least several weeks and while maintaining normal nutrition. The alcohol was abruptly stopped and the time course of withdrawal symptoms was observed without medical intervention prior to either the onset of seizures or delirium. From this we now hold that alcohol seizures appear within 24 hours of abrupt alcohol cessation and the delirium around 72 hours from the cessation of drinking in those prone to these conditions. Once delirium is established the further use of alcohol is unlikely to relieve it, and this fact perhaps underpins the nineteenth century confusion on this topic.

## Chapter 6

### Alcohol and psychiatry - the question of alcoholic insanity, 1855-1925

#### 6.1 Introduction

Porter (1985) has shown that the idea of habitual drunkenness as a “disease of the mind” was not a novel idea as claimed by Thomas Trotter (1804), but in fact represented a continuity with the ideas of a number of medical authorities writing throughout the eighteenth century in Georgian Britain. Porter (1987) also shows how Black (1810) attributed fifty-eight out of 863 cases of insanity at Bethlem Royal Hospital in London to “drink and intoxication” using Bethlem’s own system of recording causation. This gives a figure of 6.7% of cases attributed to alcohol. Thus, both the habit of drunkenness and the association of alcohol excess with “madness” was well recognised at the field of psychiatry’s inception and before the widespread development of therapeutic asylums in Britain.

As we will see in this chapter, the attribution of insanity to alcohol was at even higher levels in the admissions to Scottish asylums by the end of the nineteenth century, with the attribution of such a cause found more often in men than in women and with the higher rates of alcoholic insanity found in pauper lunatics. Additionally, both the overall number of cases and the proportion was seen to be rising at the end of the nineteenth century – up to 20% of cases being so attributed by the 1890s – and this correlated with rising levels of alcohol consumption. Alcoholic insanity formed the single biggest category of “known” causes in both the diagnostic and aetiological tables being produced at that time in the main Scottish asylum annual reports. In one of the few general histories of psychiatry to acknowledge the “alcohol question” in relation to the history of mental illness, Shorter (1997) comments that:

“During the nineteenth century several major components of ‘madness’ were on the rise, in particular neurosyphilis, alcoholic psychosis, and apparently, though this is less certain, schizophrenia.”

We now know there was a connection between neurosyphilis and alcohol – the association has been documented in the work of Margaret S. Thompson in relation to the Royal Edinburgh Asylum in her paper “The Wages of Sin” (1988).

In further surveying the general European scene in relation to the rising tide of insanity at the end of the nineteenth century and the alcoholic component within this “epidemic”, Shorter (1997) concludes that:

“In Britain, psychiatry was steeped in alcohol.... It is evident that in the second half of the nineteenth century pathological drinking became a problem of considerable psychiatric proportions”.

We will see that both David Yellowlees in Glasgow and Thomas Clouston in Edinburgh developed an interest in this topic and their views are described and explored at length in this chapter. Both published on this topic as well as giving lectures to medical students. Both men also gave evidence to a parliamentary Scottish Select Committee on the issue of inebriety and its consequences from their position as Royal Asylum Physician Superintendents and university lecturers in insanity. They were not unique in this – by the late nineteenth century many medical authorities were writing on this topic. For example, Savage (1884) wrote from a North American perspective:

“That insanity of a definite kind, and having special symptoms may originate in intemperance, does not in any way affect the fact that insanity is present. Almost every variety of insanity may be started by drink; but there are also special symptoms connected with poisoning of the nervous tissues”.

However, for our purposes in surveying the Scottish medical understanding of this issue of alcoholic insanity, the views of these two psychiatrists, among others, is central and arguably the cities of Glasgow and Edinburgh bore the brunt of this increase compared to other parts of Scotland where the Royal Asylums had rural or semi-rural catchment areas.

In tracing the story of alcohol insanity into the twentieth century we will see how the problem declines as levels of alcohol consumption diminish. In addition we will see how the understanding of alcohol-related mental illness evolves with greater precision of diagnosis and a retrospective evaluation that some of the attribution of insanity to alcohol in the late nineteenth century may have been an overestimation and also reflective of the growing support of medical men for the temperance campaign at the time. For example, Dana (1909) writes that:

“Alcohol causes we are told about 15 percent of insanity, but if we think that by simply wiping alcohol right out of society that at once we would thereby reduce insanity by 15 percent, we would probably be mistaken. For insanity is not usually caused by any single factor, and alcohol does not do its work in a simple way”.



An understanding of what we now believe to be the relationship of alcohol to mental disorder is useful in interpreting the records of the late nineteenth century. This is also the understanding I bring as a modern clinician to a reading of these records. In a slightly simplified fashion we can say that theoretically the relationship can be one of three types:

- 1) The symptoms of the mental disorder e.g. depression may be a direct consequence of the substance misuse and clear with abstinence
- 2) The mental disorder may pre-date the substance misuse and may have directly contributed to the development of the substance misuse (e.g. secondary alcohol misuse/dependence).
- 3) The two disorders may exist coincidentally in the same individual e.g. schizophrenia and alcohol dependence

It is the third of these possibilities – that of coincidence – that seems poorly understood from today's perspective in looking back at these nineteenth century records and accounts. We will see in a later chapter that the idea that one must either be classified as insane or as an inebriate but not as both caused dilemmas once the inebriate legislation was enacted in Scotland.

Also, we can consider, again in a slightly simplified fashion, a list of the main psychiatric consequences, both symptoms and syndromes, of regular heavy drinking as we currently understand them:

- insomnia
- depression
- anxiety
- attempted suicide/suicide
- changes in personality
- amnesia
- delirium tremens
- alcohol hallucinosis
- dementia
- association with other addictions

In today's psychiatric system the conditions most likely to lead to admission to general psychiatric inpatient care are those of alcohol-induced major depression, where suicide risk is deemed high – more rarely it is alcohol "dementia" and amnesia (sometimes termed alcohol-related brain damage or Korsakoff Psychosis) and perhaps rarer still the schizophrenia-like syndrome of alcohol

hallucinosis. Delirium tremens tends more to present to the acute hospital – as it did in the nineteenth century – and be deemed a medical rather than a psychiatric emergency.

It is much more common find alcohol use disorders as a comorbid or confounding condition in those diagnosed with bipolar disorder, unipolar depression, personality disorder and schizophrenia, with 30–50% rates of comorbidity being found in recent surveys at this time when alcohol consumption has again peaked. This begs the question as to what extent the cases of alcohol insanity were being correctly attributed at the end of the nineteenth century, and to what extent a false attribution was being made as to the causation – as can be seen today in the lax use of the term “drug-induced” psychosis (see Poole and Brabbins, 1996).

I will attempt to disentangle this complex issue in this chapter, in how it relates to late nineteenth century practice in Scotland. One clue as to the likely aetiology is the length of illness, as most alcohol-induced psychiatric disorders improve with abstinence (with the exception of some forms of alcohol dementia (A.R.B.D.)). There is certainly a statement by psychiatrists like Yellowlees and Clouston at the time that alcohol insanity was more likely to recover and these cases were most often close to cases of delirium tremens. The strong association of neurosyphilis and alcohol also makes the analysis more difficult – what was being called alcoholic insanity might in fact be hidden or undeclared cases of General Paresis of the Insane (G.P.I.), which are to be later rediagnosed as the latter. This idea is also explored within this chapter.

Inevitably, the theory of degeneration and the heredity influence on both insanity and intemperance also come into the story around alcohol insanity. Wood (2011) explores some of this territory in his Ph.D. thesis “The Natural Guardians of the Race: Heredity, Hygiene, Alcohol and Degeneration in Scottish Psychiatry, c.1860–1920”. Wood explores how many Scottish psychiatrists tied the idea of alcohol degeneration to the anti-alcohol debate with a particularly strong public health campaign within Scotland around this issue.

## **6.2 The views of Yellowlees on alcoholic insanity**

Dr. David Yellowlees was born and grew up in Stirling, and received his early education there. He subsequently studied at Edinburgh University and also in Paris. He graduated M.D. from the University of Edinburgh in 1857, and became L.R.C.S., Edinburgh, in the same year. He was later elected F.F.P.S., Glasgow, in 1875, and received the honorary degree of LL.D. from Glasgow University in 1888.

Yellowlees was Resident Physician and Surgeon in the Royal Infirmary of Edinburgh, and President of the Royal Medical Society of Edinburgh in 1857–58. For the next three years he was

Assistant Physician at the Royal Edinburgh Asylum, Morningside, leading on to eleven years as Medical Superintendent of the Glamorgan County Asylum, which he organised and opened. This set him up for spending the next twenty-seven years at his most prestigious job yet, as Physician Superintendent of the Glasgow Royal Asylum, Gartnavel 1874–1901. In retirement he remained the Hon. Consulting Physician and a Director of this institution. He and his wife were given a tea service and electric kettle on retiral for “partaking of the drink that refreshes but doesn’t inebriate.”

He was also the first Lecturer on Insanity at Glasgow University, a position he held for thirty years – a post initially opposed by Glasgow physicians but later inaugurated with the support of William Tennant Gairdner. He was to serve as President of the Psychological Section of the British Medical Association in 1885, President of the Medico Psychological Association of Great Britain and Ireland in 1890, and President for three years (1891–94) of the Faculty of Physicians and Surgeons of Glasgow. He was an Honorary Member of the American Medico Psychological Association, a Foreign Member of the Moscow Society for Nervous and Mental Diseases, and Fellow of various other learned Societies.

He is of interest for this thesis in a number of regards. Firstly, as indicated in Chapter 1 and worth repeating here, Yellowlees’ privately published a paper “On Intemperance and Insanity” (1874) and stated:

“It is surely within the truth to assert that half the existing cases of insanity are due directly or indirectly to this social curse”

Yellowlees noted the “decreased production of insanity in men” during strikes in Glamorgan and commented that “ignorance and self-indulgence can make prosperity a curse instead of a blessing”.

Additionally: “Intemperance has a threefold relation to insanity: it may be a cause, an early symptom or a result. These relations are often associated and often confounded”.

### **6.3 The impact on the Scottish asylums**

Asylum annual reports from all round Scotland contain tables on what is deemed to be the primary cause of the mental disorder or lunacy. In the late nineteenth century, alcohol is in second or third place in most of these tables when it comes to the aetiology of male insanity. Above it is usually hereditary predisposition and in some cases the most honest assessment of “unknown”. (The designation of “unknown” arguably remains the best category today given our ongoing primitive understanding of the major forms of mental illness, namely schizophrenia and manic-depressive psychosis/bipolar affective disorder.)

## 6.4 Trends in Alcoholic insanity in late nineteenth and early twentieth century Glasgow-the view from the asylums.

*Table 15. —INTEMPERANCE AS A CAUSE OF INSANITY*  
*Showing the Number of Admissions from this Cause, and their proportion to the Total Number of Admissions during the last 35 Years.*

YEAR.	Total Admissions.	FROM INTEMPERANCE.			Per Cent.
		Males.	Females.	Total.	
1853, .....	319	48	17	65	20.37
1854, .....	240	27	18	45	18.75
1855, .....	201	26	7	33	16.41
1856, .....	217	19	13	32	14.75
1857, .....	287	26	18	44	15.34
1858, .....	267	15	13	28	10.43
1859, .....	204	15	12	27	13.28
1860, .....	204	13	4	17	8.33
1861, .....	211	22	8	30	14.21
1862, .....	196	8	9	17	8.67
1863, .....	225	10	4	14	6.22
1864, .....	224	22	6	28	12.5
1865, .....	238	15	4	19	7.98
1866, .....	239	21	7	28	8.25
1867, .....	334	16	9	25	7.47
1868, .....	313	20	1	21	6.70
1869, .....	320	23	4	27	8.43
1870, .....	326	19	6	25	7.63
1871, .....	300	24	6	31	10.33
1872, .....	372	30	11	41	11.2
1873, .....	355	30	13	43	12.11
1874, .....	296	33	7	40	13.5
1875, .....	324	41	11	52	16
1876, .....	228	20	11	31	13.6
1877, .....	219	20	10	30	13.7
1878, .....	202	32	11	43	21.28
1879, .....	180	16	3	19	10.55
1880, .....	113	4	1	5	4.42
1881, .....	161	18	7	25	15.52
1882, .....	152	19	2	21	13.81
1883, .....	147	18	3	21	14.28
1884, .....	233	39	8	47	20.17
1885, .....	188	23	4	27	14.37
1886, .....	200	30	3	33	16.50
1887, .....	153	22	6	28	18.30
1888, .....	167	17	...	17	10.17

Figure 15. Intemperance as a cause of insanity at Glasgow Royal Asylum for Lunatics, 1853-1888.

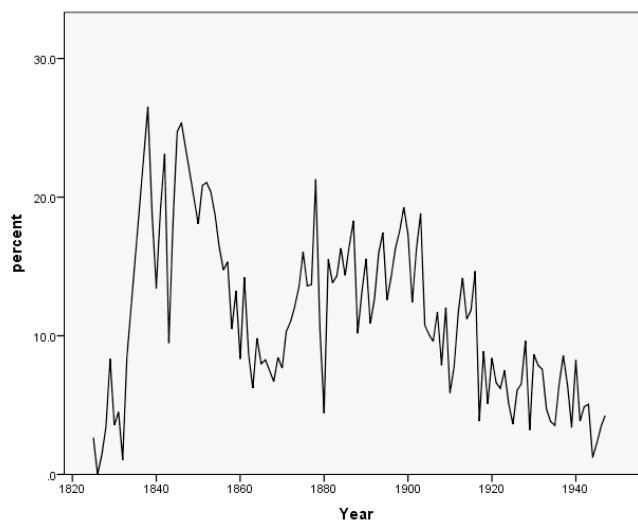


Figure 16. Graph of percentages of cases of insanity at Glasgow Royal Asylum attributed to alcohol as the cause, 1825-1940. Percentage seems to rise and fall in line with population levels of consumption.

It is possible to look at trends in the attribution of insanity to alcohol through the annual reports of the Glasgow Asylums of the late nineteenth century and early twentieth century (e.g. fig 15). These reports also include passages by the Physicians Superintendent of these institutions giving views on the issues of alcoholic insanity and inebriety, including references to the inebriates acts and the inebriate reformatory at Girgenti, as well as some remarks on delirium tremens. Of particular interest, as outlined below, are the continuous records of the earliest hospital, the Glasgow Asylum for Lunatics the topic of alcoholic insanity and the fact that alcoholic insanity was subject to an inquiry by a Special Committee of the Glasgow District Lunacy Board in 1903. The report made to that committee by the Medical superintendent of Woodilee Hospital is outlined and discussed below as are the views of the other Glaswegian Superintendents of the time.

During the years that David Yellowlees served as Physician Superintendent at the Glasgow Royal Asylum for Lunatics (GRAL) at Gartnavel, 1874-1901, several asylums opened in the West of Scotland and Glasgow to deal with both the increasing urban population and the concomitant rising numbers of the insane. The most important of these new asylums in relation to GRAL were Barnhill Asylum, much later Woodilee Hospital, at Lenzie (1875) along with the later Asylums opened at Hawkhead (later Leverndale), Gartloch and Govan (1892-7). The opening of these new Parochial asylums allowed Yellowlees to move pauper lunatics out from Gartnavel and in 1889 pauper admissions end. In 1895 the hospital's East House is upgraded to allow for reception of new fee-paying occupants.

Between them these Glasgow based asylums are mainly drawing the majority of their patients from the same broad geographical area as Girgenti when it opens in 1901 so looking at these particular asylums provides a counterpoint in considering the stated intent of differentiating Inebriety from Insanity and separating the two classes of patients.

From the Asylum Annual Reports of these institutions it is possible to build up a picture of presentations of "probable" alcoholic insanity during the period under study in this thesis and in addition for GRAL to extend this to the twenty years both preceding and following my period of study to look at more general trends. Annual reports are available for Glasgow Royal Asylum for Lunatics, Barnhill Hospital (Woodilee), Gartloch Hospital and Hawkhead Asylum (Leverndale).

In the Glasgow Royal Asylum for Lunatics Annual Reports overseen by Yellowlees his interest in Alcoholic Insanity is to the fore. His Annual Reports produce within the medical statistical tables one particular table dedicated to tracking the numbers of cases year on year where the cause of insanity is attributed to alcohol intemperance. This particular cumulative table is eventually abandoned but by going through each subsequent annual report it is possible to build up a year on year picture on the number of cases of insanity attributed to alcohol. It also possible to trace

through the annual reports changing diagnostic systems and terminology in relation to alcohol addiction and alcohol-related mental disorder.

For most of the nineteenth century GRAL followed the simple classification of Philippe Pinel (Pinelian classification), which was descriptive of the form of the mental disorder. Thus the four main categories were those of Mania, Melancholia, Dementia and Imbecility. The pedigree of this classification goes back at least to Hippocrates and its use by Pinel was an attempt to simplify and standardize away from the complex nosologies that proliferated in the eighteenth century. This classification was to be embellished in the late nineteenth century and early twentieth century under Yellowlees and Oswald but Oswald was severely criticised for failing to modernise when Dr. David Kennedy Henderson became Physician Superintendent in 1921. Terminology and recording changed radically after that date adopting the nosology of Emil Kraepelin (Kraepelinian Classification). For the first time Dementia Praecox (later schizophrenia) and Manic-Depressive Psychosis (much later Bipolar Disorder) are differentiated from the generality of "insanity" in the Gartnavel Annual reports. Under Henderson's stewardship patients are allowed the diagnosis of alcohol and drug addiction and he doesn't differentiate between the two entities in the table on the probable causes of insanity unlike all of the reports up to that point which had listed intemperance (alcoholic) or alcohol excess separately from drugs. The attribution of insanity to a drug cause such as cocaine or the supposedly more available opium was extremely rare.

If we look at the tables year on year of the forms of mental disorder we can look to see how much the supposed aetiological contribution of alcohol in that year to the cases is matched by the alcohol-specific diagnoses given. Often the match is only partial in that more cases are attributed to alcohol than seem to have an alcohol-related form of mental disorder.

If we take the annual report for Glasgow Royal Asylum for Lunatics for the year 1896 in the table of probable causation the insanity is attributed to intemperance (alcoholic) in sixteen cases, twelve men and four women. If we then look at the table giving the forms of mental disorder there are only eight men and three women accounted for in relation to alcohol specific diagnoses. Three of the men are given the diagnosis of dementia, chronic alcoholic, three more are designated as suffering from mania a potu and two with mania, alcoholic. With regards the women none are said to have alcoholic dementia but two are said to have alcoholic mania and one mania a potu. Therefore there are four male cases along with one female case attributed to alcohol as the principle cause but where the form of illness being associated with alcohol isn't immediately clear.

The following is a passage from the Woodilee annual report on the topic of intemperance as a cause of insanity: -

“In 28.7 per cent of the patients admitted during the year the cause was alcoholic intemperance. This percentage, when compared with 23.2 per cent of the previous year, only emphasizes the contention that has been given expression to in previous reports, that the diminished number of admissions and the so-called wave of temperance that was passing over the community are only concomitants of bad trade and diminished prosperity, and afford no indication that a higher plane of sobriety and reason have been reached. During the year, there has been a slight spurt in trade. The increased number of admissions in which alcoholic excess played the causal part reveals, almost as sensitively as a barometer reflects atmospheric conditions, the increase of intemperance that accompanies prosperity in a large civilized community”.

On 6<sup>th</sup> January, 1903 the committee of the Glasgow District Lunacy Board, with reference to “the number of cases of insanity occurring through alcoholic excess, to which attention had been drawn in the annual reports of the medical superintendents of Woodilee and Gartloch Asylums” appoints a Special Committee to inquire into the topic of alcoholic insanity and make recommendations as “to further action on the whole question.”

The Medical Superintendent of Woodilee Hospital, Dr. Hamilton C. Marr lays a report before the “Special Committee on Alcoholic Cases” on 1<sup>st</sup> October, 1903. This is reproduced in an Appendix to the Woodilee Annual report of 1904. The report begins:

“ The consequences of alcoholism are well known and need only to be recapitulated-

1. To the individual-degradation of the intellectual faculties and mental degeneration.
2. For the descendants-the tendency to drink, epilepsy, insanity, physical sufferings, idiocy, and lastly, extinction of the race.
3. From a social point the consequences are increase of mortality, diminution of the number of births, diminution of moral energy and of the rate of intelligence, in all weakening of the life power of the population.

Everything ought to be done that can be done to extinguish the social plague of alcoholism. There is no better medicine for this purpose than prevention. Medicines cure fewer patients than hygiene and wise precaution.”

Marr then goes on to explain how prevention may be brought about through the treatment of both adults already affected by intemperance/habitual drunkenness and by intervening with their

offspring through medical screening of schoolchildren. Successful intervention with adults he states will help offset the risks for future offspring as yet to be born.

He welcomes the Inebriate Acts and acknowledges the setting up of the Certified Inebriate Reformatory by the City of Glasgow Corporation but points out that the majority of habitual drunkards will not qualify as they are unlikely to be convicted four times in a single year of drunkenness. The Lunacy Act doesn't apply, Marr reminds us, and if someone does become insane-i.e. alcoholic insanity of whatever form-then it is often short-lived and once recovered the individual can no longer be detained.

The answer he suggests is to look abroad to Germany and Austria and particularly to the Austrian system of curatel. This is a system that would allow for civil detention for the non-criminal habitual drunkard with importantly the cost falling on the central exchequer rather than the local rate-payer. Even when released from a treatment centre the inebriate is still monitored and in effect has a small committee that acts as a curator to oversee the individual when back in the local community.

The four-page report ends with the following:

“Summary.

1. The conditions of alcoholic cases can best be improved by co-operation on the part of the Lunacy Board, Parish Council, and Corporation, to secure greater powers than at present are afforded for dealing with such cases.
2. The effects of alcoholism on the descendants can best be represented by a strong representation to the School Boards of the necessity for the appointment of specially trained medical men to inquire into the mental and physical capacities of the children, and suggest remedies for the welfare of the weaklings and unfit in school communities.”

This passage from Dr.W.R. Watson at the Hawkhead Asylum is also of interest:

“.. my contention is, that the etiology of insanity ought to be regarded as in the collecting stage.....Always one detects the same elementary fallacy-the confusion of symptom with cause, the inability, or unwillingness, to distinguish between *post* and *propter*.

A striking instance of this slovenly thinking is to be found in the arguments adduced to prove that alcohol is a potent cause of insanity and racial degeneracy. (That it is, I neither deny or assert; I would merely point out the inadequacy of the evidence). Much has been written by the advocates of this view, but it will be found on analysis that the reasoning amounts to no more than this:- “In a



certain percentage of cases of insanity there is a previous history of alcoholic excess, therefore that percentage of insanity is caused by alcohol.”

Stated baldly, this is obviously absurd: it is nevertheless the only daily begetter of a lamentable outcry and various drastic legislative proposals. It seems inconceivable that the necessity for something analogous to a control experiment should have been overlooked. That it has been overlooked, one must conclude, since nobody has attempted to ascertain the percentage of alcoholics in the general population. Until this has been done, it is clearly impossible to estimate the influence of alcohol in the production of insanity. In the community the proportion of drunkards who never become insane is certainly not negligible: that it is unknown is sufficient to tell us that we are not yet in a position to generalise as to the role of alcohol in the production of insanity.”

## 6.5 Examples of alcoholic insanity from Glasgow Royal Asylum for Lunatics at Gartnavel

Table 11.—Showing the Form of the Mental Disorder in those Admitted, Recovered, and Died during the Year 1896, and in those Resident on 31st December, 1896.

FORM OF MENTAL DISORDER.	ADMISSIONS.			RECOVERIES.			DEATHS.			REMAINING.		
	Males.	Fem.	Total.	Males.	Fem.	Total.	Males.	Fem.	Total.	Males.	Fem.	Total.
Congenital or Infantile Mental Deficiency.	...	...	...	...	...	...	...	...	...	...	...	...
" (a) with Epilepsy, . . . . .	...	...	...	...	...	...	...	...	...	...	...	...
" (b) without Epilepsy, . . . . .	3	...	3	...	...	...	...	...	...	4	2	6
Epilepsy acquired, . . . . .	1	...	1	...	...	...	...	...	...	8	1	9
General Paralysis of the Insane, . . . . .	4	...	4	...	...	...	9	...	1	5	2	7
Mania, . . . . .	18	6	24	8	3	11	2	2	4	29	46	75
" Acute, . . . . .	1	3	4	1	3	4	1	...	1	...	...	...
" Chronic, . . . . .	1	1	2	...	...	...	...	...	...	22	16	38
" Recurrent, . . . . .	...	...	...	...	...	...	...	...	...	1	2	3
" Adolescent, . . . . .	1	1	2	1	...	1	...	...	...	...	...	...
" Alcoholic, . . . . .	2	2	4	1	2	3	...	...	...	...	...	...
" A Potu, . . . . .	3	1	4	2	...	2	1	...	1	...	...	...
" Puerperal, . . . . .	...	6	6	...	3	3	...	...	...	...	4	4
" Climacteric, . . . . .	...	2	2	...	2	2	...	...	...	...	1	1
" Senile, . . . . .	1	1	2	...	...	...	1	1	2	3	1	4
Melancholia, . . . . .	11	22	33	6	8	14	1	2	3	31	42	73
" Acute, . . . . .	...	...	...	...	...	...	...	...	...	...	...	...
" Senile, . . . . .	...	...	...	...	...	...	1	1	2	...	...	...
Dementia, . . . . .	5	5	10	...	...	...	3	2	5	88	96	184
" Primary, . . . . .	...	...	...	...	...	...	...	...	...	...	...	...
" Puerperal, . . . . .	...	...	...	...	...	...	...	...	...	...	...	...
" Senile, . . . . .	1	3	4	...	...	...	1	1	2	...	...	...
" Organic, . . . . .	2	...	2	...	...	...	1	...	1	2	1	3
" Chronic Alcoholic, . . . . .	3	...	3	...	...	...	1	...	1	2	1	3
Stupor, . . . . .	...	1	1	...	1	1	...	...	...	...	...	...
Moral Insanity, . . . . .	1	...	1	...	...	...	...	...	...	...	...	...
Totals, . . . . .	58	54	112	19	22	41	22	9	31	206	230	436

Figure 17. Forms of mental disorder, GRAL, 1896.

Work at the Royal Edinburgh Hospital and my own analysis of cases at Gartnavel Royal Hospital shows that there is considerable overlap in insanity that is attributed to alcohol and that caused by G.P.I., with the latter often emerging as the underlying cause through time and observation and possibly in the end at post-mortem. This is perhaps not surprising given the neurotoxic effects of alcohol including on the gait of the individual.

As can be seen in Figure 17 above the forms of mental disorder attributed to alcohol included alcoholic mania, mania a potu and chronic alcoholic dementia. it is curious that alcohol was not seen as a cause of melancholia given the strong effect of the drug on mood.

## 6.6 Theories of degeneration

Morel's Treatise on Degeneration of the Human Species (1857) was to have widespread influence within European Psychiatry, and Scottish psychiatry was no exception to this. The eugenic ideas which followed from this and other sources lead Scottish psychiatrists such as Oswald, Yellowlees' successor at Gartnavel Royal, to ask the question as to whether forced sterilisation of the mentally ill and the inebriate might be necessary to safeguard the future health of the race.

## 6.7 Alcoholic insanity - causation or coincidence?

Table 10.—Showing the Probable Causes of Insanity in the PERSONS  
—58 Males and 54 Females—admitted during the Year 1896. /

CAUSES.	PREDISPOSING CAUSES.								
	Previous Attacks.			Hereditary Predisposition					
	M.	F.	T.	M.	F.	T.	M.	F.	T.
<b>MORAL—</b>									
Business Worries, . . . . .	4	1	5	...	...	...	...	...	...
Business and Domestic Worries, . . . . .	1	...	1	...	...	...	...	...	...
Domestic Anxieties, . . . . .	...	5	5	...	...	...	...	3	3
Shock, . . . . .	1	2	3	...	...	...	...	1	1
Death of Relative, . . . . .	...	1	1	...	...	...	...	...	...
Loss of Money, . . . . .	1	...	1	1	...	1	...	...	...
Disappointed Affections, . . . . .	...	2	2	...	...	...	...	1	1
Religious Perplexities and Excitement, . . . . .	2	...	2	...	...	...	...	...	...
<b>PHYSICAL—</b>									
Organic Brain Disease, . . . . .	1	...	1	...	...	...	...	...	...
Body Illness, . . . . .	6	2	8	1	1	2	1	1	2
General Paralysis, . . . . .	4	...	4	...	...	...	1	...	1
Epilepsy, . . . . .	1	...	1	...	...	...	...	...	...
Intemperance (Alcoholic), . . . . .	12	4	16	8	1	9	1	...	1
Masturbation, . . . . .	4	...	4	...	...	...	1	...	1
Adolescence, . . . . .	1	...	1	...	...	...	1	...	1
Puerperal Condition, . . . . .	...	10	10	...	3	3	...	1	1
Climacteric Period, . . . . .	...	7	7	...	4	4	...	1	1
Old Age, . . . . .	2	3	5	...	...	...	...	...	...
Syphilis, . . . . .	2	...	2	...	...	...	...	...	...
Over Study, . . . . .	1	...	1	...	...	...	1	...	1
Surgical Operation (Removal of Breast), . . . . .	...	1	1	...	...	...	...	...	...
Congenital Instability, . . . . .	2	...	2	...	...	...	1	...	1
Hereditary Predisposition, . . . . .	3	5	8	1	...	1	2	5	7
Previous Attacks, . . . . .	6	5	11	6	5	11	3	1	4
Unascertained, . . . . .	4	6	10	...	...	...	...	...	...
Totals, . . . . .	58	54	112	17	14	31	12	14	26

Figure 18. Table of ascribed causes, GRAL, 1896.

The effect of alcohol on mental health is an issue that still puzzles psychiatry today but it does now seem that other than alcohol hallucinosis which is relatively rare, alcohol-related brain damage and alcohol withdrawal delirium that there is no other “true” alcoholic insanity or psychosis. The over-

attribution of alcoholic intemperance as a major cause of insanity as seen in Figure 18 for example now seems a historical curiosity.

## **6.8 Conclusions**

For both Clouston and Yellowlees, the topics of intemperance and the role of alcohol in causing insanity were central. However, in terms of a simplistic notion of aetiology, as implied in Figures 17 and 18 below, it does appear that the role of alcohol in causing severe and enduring mental disorder was over emphasised, as differentiated from its role in causing more transient mental disturbance such as in delirium tremens.

## **SECTION IV**

**1900-1925: The era of the inebriate  
reformatories**

## **Chapter 7**

### **The Licensed Retreats, Certified Inebriate Reformatories and State Inebriate Reformatory in Scotland, 1900-1925**

#### **7.1 Introduction**

The overall aim of this chapter is to delineate the medical role in relation to the system of inebriate reformatories, which operated in Scotland in the first quarter of the twentieth century, and to critically assess to what extent a medical model was applied in this supposedly therapeutic system.

In order to compare the actual practice within these institutions with what was intended, a critical reading of the official records held by the National Archives of Scotland for the period 1878 to 1929 (and beyond) was undertaken. These central governmental records cover the periods before, during and after the operation of the reformatory system within Scotland. Additional information was sought from local archives, official reports (in particular the reports of the Inspector for Inebriates for Scotland), and also from the national press of the time. A secondary aim of this chapter is to evaluate the success or otherwise of this particular response to the “alcohol question” at that time and draw lessons from this that might inform our current concern with this issue.

In Sournia’s sweeping account “A History of Alcoholism” (1990), which was an English translation of the 1986 French original, it makes no specific mention of inebriate reformatories in a section on institutional care, suggesting that most care was through the asylum “for rich and poor drinkers alike”. A strong medical voice undoubtedly existed within the campaign for a treatment system for inebriety in the late nineteenth century, but when it was realised it proved a short-lived experiment in institutional therapeutic endeavour. The prominence of psychiatrists in the campaign to separate the inebriate from the insane was not to be matched by their practical support for the system once it became a reality.

The medical men involved in this campaign were aware that such institutions had already come into existence in North America (Bauhmoehl and Room, 1987). Most of the American inebriate reformatories were to fail – just as in turn the British, Scottish, European and colonial versions of such institutions were to similarly fail for lack of financial support and a decline in the need for such provision. A full history of these institutions worldwide remains to be written and such a task would be difficult as they took on very different manifestations in the various countries where they were implemented, with the most notable differences being in relation to the gender composition of the reformatories. For the United States the main scholarship is by William L. White in *Slaying*

The Dragon (1998) and also by John W. Crowley in conjunction with White in Drunkard's Refuge (2004).

Previous work in Scotland was conducted by McLaughlin (1991) with recent work by Thora Hands (2013) from a feminist perspective. For England and Wales the work of Hunt and colleagues (1989) and more recently Beckingham (2010) is of note. Also, most recently Ireland has been written about by Conor Reidy (2014) in *Criminal Irish Drunkards: The Inebriate Reformatory system, 1900–1920*.

For one famous psychiatrist looking back over his career, and having been in practise at the time, “special institutions for the compulsory detention of inebriates proved ineffective” (Henderson, 1964). We will return to the work of Sir David Henderson in a later chapter as his views were to prove important in helping later psychiatrists to see alcoholism as very much part of their work.

## **7.2 The prelude to the inebriate reformatory system**

There was a flurry of legislation and parliamentary enquiries in the second half of the nineteenth century pertaining to the alcohol question in Scotland, which served as a prelude to the realisation of the reformatory system. The key reports and legislation can be listed as:

1872: Habitual Drunkards. Select Committee Report

1878: Intemperance. Select Committee Report

1893: Treatment of Inebriates. Departmental Committee Report

1895: Further Departmental Committee Report on Inebriates

1879–1900: Inebriates Acts

This list reflects the fact that during the second half of the nineteenth century the temperance movement was beginning to have a strong influence on politics and popular culture within Scotland. This influence would lead eventually to particularly restrictive licensing provision in Scotland – the local veto – that lasted until the second half of twentieth century (King, 1979).

When we look at the Select Committee report on habitual drunkards, the role of medical opinion, particularly of early Scottish psychiatrists, stands out (e.g. see the evidence of Yellowlees and Clouston in the Departmental Committee Report on Inebriates, 1895). These medical men are both campaigning for separate provision – separate from the asylums – for habitual drunkards and inebriates and giving privileged expert opinion on the wider aspects of the alcohol problem. This is despite the ambivalence of the wider medical community to the temperance movement (Logan,

1983). Their expertise derives from the impact of alcohol misuse on admissions to the asylums. Yellowlees had published privately on this topic and it was also a particular interest for Clouston.

Dr. David Yellowlees, Physician Superintendent at Glasgow Royal Asylum for Lunatics at Gartnavel in Glasgow, said in his evidence to 1895 Departmental Committee enquiring into problem of habitual drunkards and inebriates that:

“Respectable lunatics do not care to be associated with a man who is just a demoralised drunkard and I think in their interest he ought not to be there”.

He was advocating strongly for separate institutional provision.

This is arguably paradoxical given that Yellowlees, was previously Medical Superintendent of the Glamorgan County Asylum and in a 1874 paper on “Insanity and Intemperance” submitted, based on his Welsh experience, that “half the existing cases of insanity are due, directly or indirectly, to this social curse (intemperance)”. It would seem from this that alcohol and its consequences should be seen as central to his practice as a nineteenth century alienist.

The views and experience of psychiatrists like Yellowlees and Clouston were particularly important at this time and their plea for separation was eventually realised in a short-lived and unsuccessful way through the Certified Inebriate Reformatories. Their advocacy was notably during a period of rising alcohol consumption and analysis shows that alcohol was having a growing impact on the asylum admission statistics in this time period.

“The system adopted in prisons for drunkards was utterly inadequate and hurtful. Take Barlinnie, for instance. Nothing was more melancholy than to see a batch of drunkards brought out there from Glasgow for five days...on the fifth day they were sent out, and they were back in the public-house that night. The system did absolute harm by simply giving the class quiet rest, regular food and absence from drink” (Sir Douglas Maclagan, 1892)

### 7.3 The system of Licensed Retreats, Certified Inebriate Reformatories and the State Inebriate Reformatory in Scotland, 1901-1925

Year.	Retreats.			Certified Reformatories.			State Reformatory.		All Institutions.		
	Number.	Accommodation.	Admissions.	Number.	Accommodation.	Admissions.	Accommodation.	Admissions.*	Number.	Accommodation.	Admissions.
1901	1	20	23	1	58	46	18	3	3	96	72
1902	1	20	31	1	58	20	19	5	3	97	56
1903	1	27	46	2	78	31	19	4	4	124	81
1904	1	34	52	4	98	25	30	4	6	162	81
1905	1	34	63	4	98	36	30	9	6	162	108
1906	3	66	78	5	116	44	32	20	9	214	142
1907	2	59	68	5	116	34	44	8	8	219	110
1908	2	59	75	5	116	13	39	6	8	214	94
1909	3	74	89	5	116	8	39	7	9	229	104
1910	3	74	129	5	116	7	39	7	9	229	143
1911	3	74	140	3	48	19	39	7	7	161	166
1912	3	74	123	3	48	12	47	22	7	169	157
1913	2	59	120	3	48	12	47	11	6	154	143
1914	2	59	118	3	48	14	47	7	6	154	139
1915	2	59	111	3	48	17	47	2	6	154	130
1916	2	59	77	3	48	17	37	6	6	144	100
1917	2	59	28	3	48	5	37	3	6	144	36
1918	1	16	10	2	42	1	37	1	4	94	12
Total Admissions, 1901-1918	..	..	1381	..	..	361	..	132	..	..	1874

\* Exclusive of transfers from certified reformatories.

Figure 19a. Capacity of Scottish Inebriate Reformatories 1901-1918.

Scottish Retreats and Reformatories, 1906 (5 <sup>th</sup> report Inspector Inebriates for Scotland)			
Invernith Retreat	34 Males		
Newmains Retreat	16 Females		
Seafield Retreat	16 Females		
Girgenti Reformatory	58 Females		
Greenock Reformatory	30 Females		
Scottish Labour Colony	10 Males		
Lanarkshire Reformatory	10 Females		
Aberdeen Reformatory	8 Females		
State Reformatory	9 Males	and	23 Females
Total Provision	53 Males	and	161 Females

Figure 19b. Gender distribution of accommodation for Scottish Inebriate Retreats and Reformatories for the year 1906.



The Inebriates Acts implemented from 1879 to 1900 gradually put in place a system of legislation for inebriates in Scotland that ran from 1901 to the early 1920s – the rise and fall of institutional provision is demonstrated in Table 1. Inebriate retreats predated the formal legislation but they were brought under the provisions of the earliest Act to allow for inspection and a degree of control over individuals who might enter the retreat on either a voluntary or involuntary basis. Later legislation placed an onus on local authorities to make provision for involuntary admission of inebriates to Certified Inebriate Reformatories (C.I.R.s). Alongside this the State Inebriate Reformatory was to be set up for those who could not be contained within the C.I.R.s and also for those with more serious crimes, such as child cruelty and infanticide, which were felt to be a consequence of the inebriety.

The threshold for treatment and committal for up to three years was low – being in front of the courts on three occasions within three months, or four times in a year, allowed for committal for up to three years.

The Acts allowed for inspection of the entire system and appointed an Inspector for Inebriates for Scotland. The inspector appointed was Dr. James Craufurd Dunlop and he produced eleven reports covering the first fifteen years of the system. The final report was never officially published and covered the years of decline of the system as it petered out without any final decision to rescind the legislation. This report is available among the civil service papers held at the National Archives of Scotland.

In keeping with the centrality of the medicalisation of heavy drinkers under the rubric of inebriety the new system therefore was to have in the central role of Inspector an experienced physician

Like the system itself, his reports started strongly in terms of detail and length but diminished as it became clear that the system was in reverse, and that financial and official support for the system was in decline such that the reformatories would eventually close. The number of pages in the report diminished over time with the period being covered by the reports lengthening. From the outset, Dunlop is sceptical that the overall project will succeed and he bemoans the lack of support from local government and the quality of the inebriates being confined in relation to whether they are “good material” for reformation.

## **7.4 The operation of the State Inebriate Reformatory**

The following is an account of the operation of the State Inebriate Reformatory as derived from research conducted in the National Archives of Scotland. The Minute Book of the State Inebriate

Reformatory is a large single hardbacked book which covers the years 1904 until 1927<sup>93</sup>. It was initially closed until 2003 under the 75-year rule but this was revised and it became open for consultation in 1994<sup>94</sup>.

A visiting committee of high-level officials was appointed from around Scotland to conduct the governance and oversight of the institution. Their first meeting took place on 11<sup>th</sup> January 1904 within H.M. General Prison, Perth. They appointed Lord Mansfield as chair and Dr. MacNaughton, the Medical Superintendent of the Reformatory, was also present at the meeting. Future meetings were to be held annually in the winter months – mainly December or January – but throughout the year there were to be monthly visits by two members of the committee and a rota was devised for this purpose.

## **7.5 Assessments of the overall reformatory system**

From the outset, the system was being evaluated through the reports submitted by the individual institutions to the inspector for Scotland and by the overview from the Inspector in his reports for the entirety of the system. A rudimentary form of statistical analysis was conducted on outcome data from the reformatories and retreats. The main measure of success was continuing abstinence where inquiry was possible in the years that followed the reformatory “treatment”. From this analysis, it was found that within the overall system of Licensed Retreats, Certified Inebriate Reformatories (C.I.R.s) and the State Inebriate Reformatory (S.I.R.) that the best outcomes were from retreats where there was a higher degree of voluntarism. The relative failure of the C.I.R.s and the S.I.R. was put down to the type of inebriate received and arguments were made to expand civil detention to the non-criminal inebriate. This campaign led to a Private Member’s Bill but it was never enacted.

The predominance of women being sent to the reformatories isn’t easily explained, given they were initially intended to be for both men and women and that male inebriety was more prevalent. From the perspective of recent feminist historical scholarship, they were “semi-penal” institutions with domestic features of the type used as a compromise given society’s reluctance to put women in prison. At the time, other explanations were given by the Inspector around the differences in the behaviour of men and women under the influence of alcohol, and a particular emphasis was given to the prevalence of a group of “female drunken pests” who were frequent recidivists in relation to charges of drunk and disorderly behaviour.

From the reports, medical treatment in relation to drugs for inebriety was very limited – one

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<sup>93</sup> HH12/75/1

<sup>94</sup> Thus it was not available to McLaughlin in 1991.

experiment with drug use was undertaken in a reformatory (Girgenti) and some medicines were also used by Dr. John Q. Donald in the retreats. Certainly in Girgenti, the use of a drug cocktail was quickly dismissed as ineffective. The drugs used would not be considered today as useful in either the withdrawal or relapse prevention stages of treatment. The main approach was an example of Moral Treatment, albeit under the auspices of medical authority. The elements of a proscribed daily and weekly routine coupled with either labour (reformatories) or sport and entertainments (retreats) and religious observance and instruction were all in place. Diet was also considered important though financial limitations impeded this in the reformatories, as did religious observance and instruction. The latter, religion, impeded things on a selective basis in some instances – the Greenock reformatory did not allow for Roman Catholic worship and banned visits from priests.

Dr. Dunlop, from his privileged viewpoint as Inspector for Scotland, was able to look at whether the use of early release from reformatories on license was useful as part of the rehabilitation of the inebriate. There is a clear differentiation in his reports in terms of outcome between those placed back with their own families – more likely to resume drinking – and those given a position as either a domestic servant or farm labourer – less likely to resume drinking. The effect of a “new start” and the responsibility of a position of trust on outcome is of interest, and this approach is still in evidence today in some modern treatment systems though undoubtedly underutilised and arguably under-researched as an idea.

If there was scepticism over a strictly medical cure for inebriety, a medical model was definitely applied in the analysis of cases. National guidance on how a medical casebook should be structured was given and most of the elements of a modern medical case history of alcoholism or drug addiction were in place, albeit without a section to encourage quantification of intake. (See next chapter for an analysis of this system in action.) Dr. Dunlop expounds on the medical conception of inebriety at that time within his reports and differentiates between the “curable” and “incurable”. Additionally, he expresses the belief in his first report that all inebriates have an underlying “neurotic diathesis” which persists after treatment and renders them vulnerable to relapse into inebriety. (This viewpoint was to be later developed by Henderson using his viewpoint of Meyerian psychiatry.)

Most of the medical men involved with the nine Scottish reformatories in operation in 1905 were from a general medical rather than an asylum doctor background, and they often became involved due to their proximity to the local institution. A notable exception was the State Inebriate Reformatory in Perth: the second medical superintendent there was recruited from asylum practice but his role was subsidiary to that of the superintendent of the Criminal Lunatic department.

The State Inebriate Reformatory kept detailed individual records of the 132 individuals who passed through the doors but unfortunately only three survive after a conscious decision to destroy the rest. The decision was made to keep one record each from the beginning, middle and end of its period of operation. These records reveal in one case a considerable dispute over whether one woman showing features of insanity should be in the inebriate system at all and in the end, after protracted debate, she is moved to Gartloch Asylum.

## **7.6 The decline of the reformatory system**

Scottish Reformatories started to close in the 1910s, some after only a decade or less, due to disputes over funding. The other main reason for eventual final closure of the system was a lack of referrals in the later period due to the alcohol control measures brought in during and after the Great War. The last to close was the State Inebriate Reformatory as documented in the records held by the National Archives for Scotland.

Dunlop, like others with a vested interest at the time, bemoaned that the system hadn't oriented itself to inebriates more susceptible to "cure". Such a provision would have involved a form of civil detention, for which there seemed little official appetite.

## **7.7 Conclusions**

Within the overall system of Scottish Licensed Retreats, Certified Inebriate Reformatories (C.I.R.s) and the State Inebriate Reformatory (S.I.R.) it was felt that the best outcomes were from retreats where there was a higher degree of voluntarism. The relative failure of the C.I.R.s and the S.I.R. was put down to the type of inebriate received and arguments were made to expand civil detention to the non-criminal inebriate. This campaign led to a Private Member's Bill but it was never enacted. Medical treatment was very limited – one experiment with drug use was found in Girgenti – and the overall approach was an example of Moral Treatment. A recognisable medical model was applied in the recording of clinical detail and in the analysis of cases, however. Some reformatories, such as Girgenti, closed after a decade due to disputes over funding but the main reason for closure of the system was to be a lack of referrals in the later period due to the alcohol control measures brought in during and after the Great War.

The strong medical voice, particularly that of psychiatrists that existed within the campaign for a treatment system for inebriety in the late nineteenth, was not matched by similar support for this system once it became a reality. Most of the medical men involved with the nine Scottish reformatories in operation in 1905 were from a generalist rather than an asylum doctor background and became involved due to their proximity to the institution. A notable exception was the State

Inebriate Reformatory in Perth: the second medical superintendent was recruited from asylum practice but his role was subsidiary to that of superintendent of the Criminal Lunatic department.

This story of the Scottish inebriate reformatories is a strong reminder that nothing is fixed in the relationship between Western societies and alcohol. This is a valuable lesson at the current time when Scotland is in the middle of a strong debate on how to tackle rising health and social problems secondary to alcohol misuse. The recent proposal from one political party for alcohol treatment and testing orders (A.T.T.O.s) has many similarities to the inebriate reformatory experiment and this work sounds a note of caution in relation to the likely success of such a proposal. The relatively unmotivated individual forced into treatment – “involuntarism” – does not seem to have as good an outcome compared to the situation where the individual seeks the help for themselves – “voluntarism”. Also, this work shows that many of the elements of the current medical model of alcoholism were in place one hundred years ago, but without specific medical treatments and a reliance on moral treatment approaches with limited success. Success seemed more likely when the reformatory treatment linked to a suitable work placement and eventually relocation to a new environment.

From the civil service papers, it was discovered that as late as the 1930s there was a fear of a campaign to resurrect the institutions once they closed because the original Acts were never rescinded given the potential expense that this would entail.

## Chapter 8

### The case of the Girgenti Certified Inebriate Reformatory, 1901-1909



Figure 19 – Girgenti House, Stewarton, Ayrshire

#### 8.1 Introduction

This chapter looks at the casebook of inebriate women admitted to this particular Certified Inebriate Reformatory. It presents an analysis of these women's background both medically and socially and asks why they ended up confined and subject to a "therapeutic" regime. The Inebriate Laws and the reformatories were supposedly for both men and women but no men were sent to Glasgow's reformatory in Ayrshire, even though male drunkenness predominated in the city then as now.

As previously stated my overall aim is to delineate the medical role in relation to the system of inebriate reformatories, which operated in Scotland in the first quarter of the twentieth century, and to critically assess to what extent a medical model was applied in this supposedly therapeutic system. A subsidiary aim is to compare the actual practice within these institutions with what was intended in terms of both the legislation and medical theory at the time. There is a dearth of

surviving case material from the Scottish inebriate reformatories and therefore an analysis of the medical casebook from the Girgenti Reformatory gives us a unique and in-depth view of the clinical approach taken with these female inebriates.

## 8.2 Setting up the Reformatory

The Girgenti Certified Inebriate Reformatory (Fig. 1) opened in January 1901, as an institution for the detention and treatment of inebriates convicted in the Glasgow police courts. The initial license was granted on 18th December 1900 for Girgenti to house twenty-eight male and thirty female inmates but this was later changed on 12<sup>th</sup> September 1901 to specify the reformatory as being accommodation for fifty-eight inebriate women. By that date twenty-eight women had been admitted and no men had been sent.

The Girgenti estate had been purchased by Glasgow Corporation for £7,000 with a further £2,000 being spent to prepare the home for “accommodating and treating the class of patients to be committed to the Home”. In 1900, in preparation for the opening of “Girgenti Home”, the Corporation of Glasgow appointed Dr. John Cunningham Esq., M.B., C.M., and J.P. as Medical Officer. He was a doctor already working in the area of Stewarton and Dunlop where Girgenti was situated. So to a degree his appointment is serendipitous but as can be seen below his other interests helped to qualify him for the role.

Cunningham describes himself in June 1906 as having been “engaged in general practice in a wide country district”, “since leaving Glasgow University in 1889”. It is worth listing his various appointments in addition to that of the Medical Officer to the Glasgow Certified Inebriate Reformatory, as given in 1906 when Girgenti was still in operation:

- a) Parochial Medical Officer for the Parishes of Stewarton and Dunlop
- b) Depute Medical Officer of health for the Burgh of Stewarton
- c) Surgeon under the factory acts for the Parishes of Stewarton and Dunlop
- d) Visiting Physician to the boarded-out pauper lunatics in the district belonging to Glasgow and Govan Parish Councils
- e) Justice of the Peace for the County of Ayr
- f) Income Tax Commissioner of Supply for the Northern District of Ayrshire
- g) Member of the School Board for twelve years and Chairman for nine years

The first of these roles involved issuing certificates of lunacy if anyone locally needed to go to an asylum, and assessing people for the wards of the Cunningham Combination Poorhouse. Cunningham had been fulfilling the fourth of these roles since 1894 and therefore already had a

connection with Glasgow and Govan Parish Councils. In his testimony in 1906 to the Royal Commission on the Care and Control of the Feeble-Minded he outlined this role and he reported briefly on his work with boarded-out pauper lunatics. Instead he mainly gives evidence at length through a written statement and an oral testimony, on inebriety, drawing on the experience he has gained looking after the women sent to Girgenti. This gaining of expertise and the resultant testimony is described in Section 8.8 below.

### 8.3 The Reformatory in operation

The fact that Girgenti only took women is not unique in the Scottish inebriate retreat and reformatory estate. Table 1 shows the provision which existed in 1905—161 places for women, just over three times the provision for men at fifty-three places. In the same year the Inspector of Inebriate Reformatories gave an explanation as to why the Reformatories were dealing with mainly women. Given the need for four drink-related convictions in a year before the Inebriate Acts could activate the draconian loss of liberty for three years, the Inspector was quoted in *The Scotsman* as saying “a policeman is like a magnet to a drunken woman” and that “male drinkers are helped home by their companions” leading to this apparent anomaly. The particular stigma that applied to female drinkers, believed by most scholars in this area as the true reason for this striking gender difference, is discussed elsewhere in this thesis.

Not all the places in the reformatories were utilised at any one time. The total admissions to Certified Inebriate Reformatories for the years 1901–1918 was 361 individuals. The 131 cases sent to Girgenti, during the years 1901–1909, therefore, represent over a quarter of the total cases in Certified Inebriate Reformatories in Scotland during the legislation’s years of active use. One full casebook survives for 93 of these cases, Fig. 20., allowing for the detailed analysis I present below.

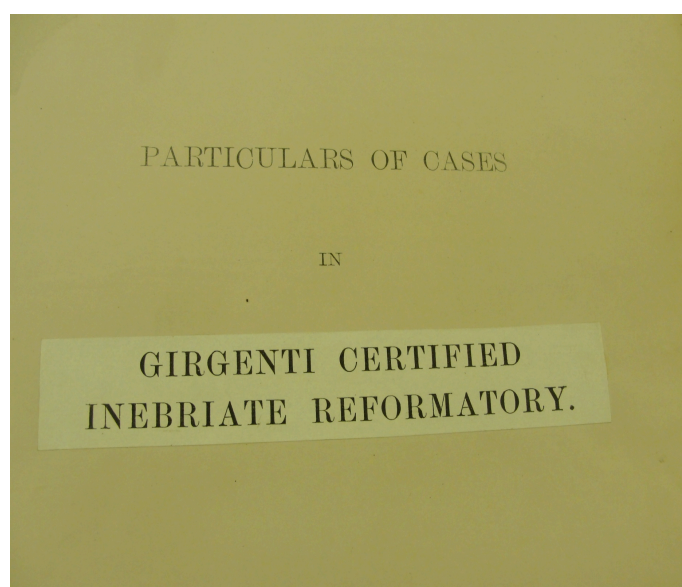


Figure 20. Detail of the frontispiece of the Girgenti Casebook.



## 8.4 Analysis of the cases

[illegible]

Figure 21. First page of a two page case record at Girgenti.

OF CASES					OF CASES														
Case	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
No.	Gender	Age	Marital	Occupation	Education	Religion	Political	Social	Family	Personal	Physical	Mental	Emotional	Intellectual	Artistic	Scientific	Literary	Other	Notes
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No.	Gender																		

figure 22. Second page of a two page case record at Girgenti.

OF CASE.

Intemperance Regular or Periodical.	Frequency of Periods.	Duration of Drinking Habits.		Violent, Cheerful, or Gloomy, when Intoxicated.	Kind of Liquor Drunk.	Ordinary Habits, Social or Solitary.
		Moderate Drinking.	Excessive Drinking.			
<i>Periodical</i>	<i>Frequently months of an interval.</i>	<i>Produce for the last 4 years.</i>	<i>"</i>	<i>Cheerful.</i>	<i>Whisky and Port Wine mixed.</i>	<i>Social</i>

TREATMENT.

REMARKS. *State of Affairs and  
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RESTRAIN

Figure 23. Detail of a case record at Girgenti – illustrates aspects of the drinking history.

The surviving casebook of Girgenti Reformatory – held in the City of Glasgow archive – was examined in detail. The analysis of these records was undertaken using quantitative (descriptive) and qualitative analytical techniques. Basic statistics of this case series are presented.

The surviving detailed casebook was kept by Medical Officer Dr. John Cunningham and gives a wealth of clinical data for analysis on ninety-three of the women sent to Girgenti. Admission and progress notes were written on a two-page proforma (Figs 21–23). The book is filled by the first ninety three cases admitted to Girgenti. There is no casebook for the thirty eight cases that were to follow before the reformatory closed. In total one hundred and thirty one cases were admitted to Girgenti from 1901 to 1909. We have information on these cases from other parts of the Girgenti archive but there is nothing to confirm or refute if there was ever another casebook for these cases that has been lost.

As can be seen in the casebook, what is recorded for all ninety-three cases on admission are basic demographics and vital statistics alongside details from personal, family, medical, psychiatric and substance use history. A careful record was kept of the first three days after admission as provided for in the pro forma. Beyond that, occasional progress notes are made and columns exist for any specific medical treatment given along with the eventual result of the case. In my approach to these cases I had in mind what we would expect from a modern case history and it compares favourably with a few notable differences. The most significant omissions are quantity of alcohol consumed

and the patient's own understanding of their condition.

As an example of this standard case record let us give the basic outline of the first admission:

Mary Gairdner or McMillan was admitted to Girgenti on 29<sup>th</sup> January 1901. Her age was 35 years and she was 4'11" in height and weighed 7 stone 12 pounds. She was a widow, Protestant and Scottish. She had previously worked as a laundry maid. She is said to have no family history of insanity or intemperance. She drinks whisky and drinks to excess. She doesn't smoke nor does she take opium or other drugs. Her drinking is regular (i.e. continuous) and she is described as gloomy when drunk. She is a solitary drinker. She complains of headaches and poor sleep. She is noted on physical examination to have an enlarged liver and a swollen left knee. There is no history of delirium tremens – the exciting cause of her inebriety is given as the fact that her husband drowned at sea. She has had five children of whom only two survive, ages 15 and 11 years. She is said to have low spirits, retching, increased thirst and decreased appetite during the first three days along with marked insomnia. The physical symptoms subside but persistent depression and insomnia remain throughout February and March 1901. She is described as "not a hopeful case" for reform and 14 convictions in the previous two years are noted. She dies in hospital on 31<sup>st</sup> March 1901 from extensive burns after her nightdress catches fire in Girgenti "due to standing too close to the fire to warm herself".

Most of this information would still be collected today in a standard psychiatric assessment though asking whether someone is a violent, gloomy or cheerful drunk is no longer utilised. (Intoxication would be viewed as more variable and unpredictable in today's clinical practice.) Obvious absences in the information are around any attempt to quantify average daily alcohol intake – surprising given earlier asylum records showed quantification – and a lack of exploration of any internal emotional triggers and maintaining factors for excessive drinking. (See Chapter 10, Conclusions and Discussion, for a discussion of this apparent lack of psychological understanding throughout the era studied in this thesis.)

Analysis of the ninety-three records using quantitative techniques applied to the key components of the pro forma history has been undertaken. This data is presented in the narrative below and in a series of tables in this chapter. The case histories give information that, when analysed, reveals that the average woman on admission was 32 years and 9 months old, 5" 1' tall and 8st 13lbs in weight. She has been married though subsequently separated and had on average four children, one or two of whom had died. Family loss through trauma and infectious disease was commonplace. Only one person had been in an asylum previously. The women were almost exclusively whisky drinkers, reflecting ready availability of whisky alongside the black market on the Glasgow streets of the

time. Occasionally other drinks such as porter, port wine, stout, beer and in one case methylated spirits supplement whisky.

The likelihood is that close attention was paid to the patient during the first three days of admission in case of withdrawals. About a third showed mental or physical upset on admission. Family history of intemperance was present in a third. Twenty per cent used tobacco. Twenty-two of the women underwent an experimental drug cure with a mixture of quinine, atropine and aloin without success. The best outcomes were realised through boarding out into domestic servitude for two out of three years.

One particular Girgenti case is of note as the first case to be transferred to the State Inebriate Reformatory:

The first female to be admitted to State Inebriate Reformatory came from Girgenti House. At Girgenti repeated absconding and aggression to staff led to her transfer to Perth on 10<sup>th</sup> October 1901. Isabella Thomson (Fig. 24) was aged 28 years when admitted to Girgenti on 16<sup>th</sup> July 1901. She was case fourteen of the ninety-three cases. She was 5'4" in height and weighed 8 stone 4 pounds. Previously working as a housekeeper she is said to have had little education. She was Scottish Protestant and had been married for ten years. There is said to be no family history of intemperance or insanity. (This later proves to be erroneous compared to a more detailed account by her family to medical staff when she reaches Perth.) She is described as a violent drunk who regularly drinks whisky and stout to excess. She suffers from syphilis. The cause of her inebriety is given as bad company.

The Perth record as well as that at Girgenti shows she worked as a prostitute and a letter from a disillusioned husband in her Perth file states he didn't know when he married her that she was "the worst prostitute in the whole of Glasgow" Her case and her subsequent development of mental disorder tests the system and the attempt to maintain a clear distinction between inebriety and insanity.

### **Grouped analysis**

If we view the detail of the ninety-three women as a single case series then we can look at the characteristics of the overall group, under the headings used at the time, as follows:

- **Name**

All ninety-three cases are named. If there is a maiden name and married name then the maiden name is given first, e.g. Case 80: Catherine McDonald or Smith. Fifty-three women have their

name in this form including one who has an alias. (Jane Brown alias Catherine Breen or Bryson – Case 58). Two other cases have aliases: Case 61 Rose Anne Carroll alias McGuire and Case 63: Annie Mullen alias McGuire. Both were of Irish Catholic background. They are forty women with only a single surname. Of these forty there are two Mary Andersons admitted who are labelled Mary Anderson No. 1 (October 1902) and Mary Anderson No. 2 (May 1902). As one might expect the presence of maiden and married names mainly correlate with what is recorded in relation to marital status.

### **Age**

The youngest patients on admission were two women aged 17 years. Four further patients were 19 years old but otherwise the remaining eighty-seven patients in this series were 20 years of age or over. The ages ranged, therefore, from 17 years through to the oldest patient at 61 years. The average age was 32 years and nine months. The median age and modal age were both calculated at 32 years. The standard deviation for the grouped ages was 9 years.

- **Nationality**

Sixty-two of the ninety-three women are said to be Scottish. Twenty-nine women are recorded as being Irish. In one case the nationality isn't recorded but she is most likely Scottish from the personal history. There are no women who are said to be English by birth and the only other nationality represented is one woman who is Norwegian by origin.

- **Religion**

Of the overall group sixty-four women are recorded as Protestant, twenty-eight are given as Roman Catholic and the woman of Norwegian origin is recorded as being with an "English Church". Ethnicity and religion undoubtedly intersect in the Glasgow and Scotland of the time and we find that fifty-six of the sixty-three Scots, including the case where nationality isn't formally entered but who is most likely Scottish, are Protestant and the other 7 Scots are Roman Catholic. With those of Irish ethnicity the numbers are in the opposite direction with twenty-one recorded as "R.C" and eight cases recorded as "Prot".

- **Education**

Various terms are used to give a measure of the women's educational level. The majority fit into one of three broad categories: being able to read and write; being able to read but not write; and neither being able to read nor write. Four of the ninety-three are unclassified in this regard. Those who can read and write are sometimes further classified as "very little", "average" or "superior", with five individuals being classified as reaching a certain standard of schooling (4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> standards).

So, sixty-two individuals can read and write, with ten having superior education of some form. Four individuals can only read and write “a little” so presumably the other forty-eight are on a spectrum of ability between these two poles. Thirteen individuals can read but not write and fourteen can neither read nor write.

- **Previous residence**

Unsurprisingly all the women are recorded as having resided in Glasgow just before they were transferred to Girgenti through the police court system. Eleven individuals have other areas mentioned in addition to Glasgow in the previous residence column: Edinburgh and Glasgow, Kilsyth and Glasgow, Glasgow and Barrhead, Glasgow and Stewarton, Elgin and Glasgow, Dunoon and Glasgow, Glasgow and Edinburgh, Inverness and Glasgow, London and Glasgow, Old Kilpatrick and Glasgow, and Kilsyth and Glasgow. In the last four cases a specific Glasgow address is given.

- **Occupation**

Under the column occupation thirty-nine different occupations or combinations of occupations are listed. These can be further condensed into broad occupational categories as shown in the table below. The commonest occupation given is that of housekeeper with twenty-two women in this category. (One of these women is also recorded as being a dressmaker and another as a general servant.) Next in terms of numbers is the category of general or domestic servant of whom there are fourteen.

- **Marital and living situation**

The case record allows for placing the patient into one of six categories. They can be recorded as living with their family or living alone. Within each of these two options they can be further sub-classified as married, single or a widow or widower, giving six possibilities. (The proforma case record was designed for either gender.)

Thirty-three of the women living with their family are recorded as married. Additionally, fifteen women living with family are single and two are widows giving fifty in total in the category “living with family”.

Of the forty-three women recorded as living alone eighteen are married, twenty-three are single and two are widows.

- **Personal history**

The majority have a brief family history recorded. In particular, the parents are asked about and in most cases one or both parents have died.

- **Children**

In nearly every case there is a note made under personal history as to how many children the woman has had and whether the child is known to be dead or alive. There are only four women where no mention is made as to whether they have children or not. Of the eighty-nine women, there are thirty-two women where there is a definite statement to the effect that they have no children. One additional woman is said to have had four miscarriages but not to have carried any children to term or close to term. The remaining fifty-six women have had between them two hundred and four children – of these, ninety-six are said to be alive, one hundred and seven have died and in one case the woman is unsure of the fate of a child born some years before when she was working as a farm servant. Among the 107 deaths are six further miscarriages, three children born prematurely and seven children stillborn. Of the ninety-one children born alive who subsequently die the commonest reason given for death is infectious disease. Forty-three are recorded as dead without an age being specified. Of the others, three die in the first day, one other in the first month, three between one and three months and six others between three and twelve months. Ten children die between the ages of one and five years and a further two between five and ten years. Nineteen, in addition, are said to have died in “infancy” or of “diseases of infancy”.

- **Previous convictions**

All will have had at least four drink-related convictions within the last year to qualify for the Inebriate Act to be invoked. Early on lists are provided but this practice fades after two years.

### **General health and specific health conditions**

- **Height**

All the women have their height recorded on admission in feet and inches. The shortest woman is 4 foot 8 inches in height and the tallest is 5 foot 7.25 inches. (Range 56–67.25 inches.) The average woman is 61.61 inches tall (roughly 5 foot 1.5 inches tall). The modal height is 60 inches with a median of 61.5 inches. The standard deviation is 2.38 inches.

Individual heights and weights (below) were entered into a database and converted into centimetres/metres and from stones and pounds into kilogrammes respectively, using a Microsoft Excel 2008 Spreadsheet for Mac. This made for easy calculation of Body Mass Index (B.M.I.) (below) and where data was available on changes in weight then fluctuations in B.M.I. during the time spent at Girgenti could be calculated.

- **Weight**

Each woman had weight recorded in stones and pounds. For easier calculation of weight statistics and B.M.I. this was converted to pounds by manual calculation for entry in the spreadsheet and then to kg using the standard formula as a function within Excel.

The average woman weighed 123.8 lbs (8 stones and 11.8 pounds). The lightest woman was 6 st 8 lbs (92 lbs) and the heaviest was 12 st 5 lbs (173 lbs). The median was 122.5 lbs, the mode was 128 lbs and the standard deviation was just over a stone at 15.5 lbs.

Pounds were converted to kg for each individual to allow for ready calculation of Body Mass Index.

- **Body Mass Index (B.M.I.) on admission**

B.M.I. was calculated by the formula of weight in kg divided by height in metres, squared. Again, Excel was used for ease of calculation and to minimise errors.

The B.M.I. ranged from 17.3 through to 30.9. The average B.M.I. was 22.9 with a standard deviation of 2.46. The median was 22.7 and the modal B.M.I. was 22.2.

If we categorise according to current guidance on B.M.I.:

Underweight: B.M.I. is less than 18.5

Normal weight: B.M.I. is 18.5 to 24.9

Overweight: B.M.I. is 25 to 29.9

Obese: B.M.I. is 30 or more

Then we find that only three women are underweight at the point of admission, twelve are overweight and only one woman is obese, and only just with a B.M.I. of 30.9. The remaining seventy-seven women are of normal weight by this calculation. All are encouraged to gain weight as part of their treatment for inebriety and the majority do put on weight with time.

- **Past medical history**

A small number of women have had syphilis and have had treatment in the Lock Hospital from the records. Some still have active disease and require treatment for this.

- **Physical examination**

Physical examination is recorded for the majority and great store is put on the taking of a temperature.

- **Inheritance of intemperance**



Over half of the women – fifty-one out of the ninety-three – are recorded as having a family history of intemperance. In forty-eight of the fifty-one women with a positive family history there is at least one first-degree relative said to have been intemperate. In the other three cases with a positive family history there is no first-degree relative affected and the individual or individuals listed are second-degree relatives: grandmothers, grandfathers, uncles or aunts.

In thirty-eight out of the forty-eight cases with one or more first-degree relative said to be intemperate, it was the father who was affected. In thirty out of the forty-eight cases there was only one first-degree relative listed as intemperate: twenty-two fathers, five mothers, two brothers and one sister. The commonest relative said to have been intemperate, therefore, is a father, either on his own, or in conjunction with other relatives.

Despite this Cunningham, unusually, reveals himself as a sceptic in relation to the role of heredity in inebriety.

- **Inheritance of insanity**

There is said to be a family history of insanity in only in five cases.

Case 31: Elizabeth McRae or Gilmour is said to have an insane grandmother.

Case 41: Jessie Paton or Orr had a sister Susan who died in the Crichton Asylum.

Case 68: Euphemia McCulloch had an aunt who died in an asylum.

Case 87: Jessie McIntyre or Cameron is said to have had an insane brother.

Case 91: Ann McTaggart had a father who “was insane for a few weeks from financial reasons”.

- **Exciting cause**

One of the most interesting entries in the case record is in one of the boxes at the top of the two-page proforma with the heading “Exciting Cause”. Here, potentially, we have a few words on what is deemed to have brought on the inebriety. In the majority it is ascribed to bad company ,or in a smaller number loss of a husband or an abusive husband. In two cases working with alcohol is given as the cause.

- **Drinking history**

There are a number of components to how these early case records try to describe aspects of each woman’s inebriety. It is notable that no apparent attempt is made in these records to quantify the amount of drink taken by each individual.

- a) **Type of drunk**

The three categories given are Gloomy, Cheerful and Violent. Over two-thirds are

described as “cheerful” drunks with roughly one-sixth each described as either Gloomy or Violent. In a few cases the person is described as “quiet” or “very quiet” when drunk. On occasions this description is linked to the Gloomy category though mainly it emerges as a separate description of a small number of cases.

**b) Type of drink taken**

All the women except one drank whisky either on its own (80%) or with other forms of alcohol (20%). Among these eighteen individuals the drink in addition to whisky or mixed with it varied widely. Mainly the second drink was beer or stout and in some cases porter. Additionally there are mentions for port wine, brandy and in one instance methylated spirits. Despite the highlighting of the issue when the 1895 Inquiry sat in Glasgow none of these women are recorded as “Finish” drinkers.

**c) Regular or periodic drinking**

This part of the pro forma case note is surprisingly hard to interpret with regular drinkers being ascribed frequency of bouts of drinking.

**d) Moderate or excessive drinking**

Again this is a confusing part of the record but it does appear the women give a shorter history of excessive drinking than their criminal records relating to drink would suggest.

**e) Whether social or solitary (or both)**

The majority of women are said to be social drinkers.

**f) History of D.T.s**

Only a small number of the women are said to have a history of delirium tremens. Nine cases out of the ninety-three have a recorded history. This represents 9.7% of the cases, almost one in ten. Of the nine cases, five cases are said to have had one attack, one case two or three attacks and one other has had five or six attacks. In two other cases the number of attacks is not specified.

In case 91, the attack of delirium tremens is said to have occurred “last Sunday” while in police custody, meaning eight days before admission.

**g) Previous reformatory or asylum admissions**

Only one case is said to fall into this category.

- **Other substances**

**a) Tobacco**

There are a small minority of these women using tobacco. Eighteen of these cases are smoking tobacco (19.4%) and two others are using snuff. So twenty out of the ninety three (21.5%) are using tobacco in one form or another.

#### **b) Opium and other drugs**

Only two cases of the ninety-three in the casebook are recorded as using opiates or other drugs. Case 70 is said to take laudanum and chloradyne and case 74 is said to use laudanum occasionally.

#### **Progress and outcome**

An attempt is made to track all of the cases on their return to Glasgow and eventually outcomes, where available, are seen to be mainly poor with this being blamed on the “poor class of patient”.



Figure 24. Girgenti and State Inebriate Reformatory Inmate Isabella Thomson

### **8.5 The Reformatory closes**

Almost from the beginning the closure of Girgenti reformatory was being anticipated. The main issue, was around who would pay the costs and the Lord Provost of Glasgow was in frequent correspondence with the Secretary of State over this issue. By 1909 the last patient had left.

## **8.6 The Annual Reports of Girgenti: Dr. John Cunningham's Medical Reports**

One of the most interesting aspects of Cunningham's engagement with the inebriate women at Girgenti is his attempt to develop his own sub-classification of Inebriety. This is reflected in his annual reports and also in the margins of the patients' register. (Typologies that try to subdivide what we would now call alcohol dependence have a troubled history in more recent times. No one today will diagnose in terms of Jellinek's subclassification and the more recent Type 1 and Type 2 subdivision by Cloninger hasn't become common clinical currency).

Cunningham gives us initially four types of female inebriate: the chronic inebriate, the hysterical inebriate, the moral paralytic and the accidental inebriate. Towards the end of the period of the reformatory he adds the category of weak or feeble-minded. He tells us that he has consulted with various medical authorities on inebriety who encourage him in continuing to use this sub-classification saying it has "much to commend it". Most likely Dr. John Carswell, Lecturer in Insanity at Anderson College was his authority.

## **8.7 The testimony of Dr. John Cunningham to the 1908 Royal Commission on the Care and Control of the Feeble-minded**

One further aspect of the end of the inebriate Reformatory experiment that has been little researched is the way in which some individuals with inebriety became redesignated as being "feeble minded". This transition is highlighted in the 1908 Royal Commission on the Care and Control of the Feeble-minded where many of the witnesses called have been working in the field of inebriety and they appear alongside those involved with the insane and those dealing with the social problems of the poor. On this basis Dr. John Cunningham is called to give evidence both in the form of a written deposition and through oral testimony in front of the Committee of Inquiry. One of the commissioners on the other side of the table is Dr. James Craufurd Dunlop.

## **8.8 Conclusions**

The application of the Inebriates Acts 1879–1899, predominantly to women, is a striking historical finding and requires explanation within the cultural context of the time. When Dr. David Yellowlees, Physician Superintendent at Glasgow Royal Asylum for Lunatics at Gartnavel in Glasgow, said in his evidence to 1895 Departmental Committee enquiring into problem of habitual drunkards and inebriates that:

“Respectable lunatics do not care to be associated with a man who is just a demoralised drunkard and I think in their interest he ought not to be there”.

He was clearly thinking of male drinkers who had entered the asylum system. In his evidence, Yellowlees was advocating for the establishment of inebriate reformatories. He was previously Medical Superintendent of the Glamorgan County Asylum and in a 1874 paper on “Insanity and Intemperance” submitted that at that time “half the existing cases of insanity are due, directly or indirectly, to this social curse (intemperance)”. He was particularly describing this in relation to men and noted fluctuations in admissions, with reductions during strikes by the local miners when they drank less. (Whether British psychiatrists could have done more to support the inebriate reformatories once established or whether it was in their interest to continue to deal with the “demoralised drunkard” and the revenue they brought in is a question I will debate in a later chapter.)

A feminist historical perspective is possibly able to explain this skewed use of inebriate legislation, which was not designed to be gender-specific. There is much written on how the female drinker was strongly stigmatised at this time, leading to a strong bias towards the application of the law to women. The predominance of women being sent to the reformatories may also be explained by the fact that they were “semi-penal” institutions with domestic features, used as a compromise given society’s reluctance to put women in prison. Additional commentaries on this gender bias are found in Prestwich, 2003 and McLaughlin, 1991.

From a modern psychiatric perspective, the case notes at Girgenti show awareness of family history and past personal trauma as a precursor of alcohol misuse in adult life. All the elements of a modern psychiatric history are present to a degree in the casebook but what is striking by its absence is an appreciation of the inner life of the subjects. The aetiological model was biological and deterministic, in keeping with the prevailing medical theories. Despite this, the only pharmacological trial undertaken in Girgenti, was done so with scepticism and soon abandoned, and no other specific medical treatment is offered other than symptom relief for minor ailments.

In general, the involuntary nature of the treatment at Girgenti led to poor outcomes – but despite this the early inebriate doctors such as John Cunningham wished to cast a wider net of civil detention to non-criminal inebriates, who they saw as more hopeful cases. There was recognition at the time that those who sought help in retreats rather than those coerced into reformatories had better outcomes. Those in retreats were also more likely to be male and of a higher social class with better family support. The empirical research that showed these differential outcomes was reported in the British Journal of Inebriety. In the implementation of reformatories such as Girgenti, the Society for the Study of Inebriety and other campaigning voices from within the medical

profession had seen their views on treatment put into practice, but many forces later conspired to sweep aside this early system for treatment and reformation. In relation to Girgenti, the reformatory closed as neither local or central government wished to pay for its continuation, particularly in the face of the perception of poor outcomes at high cost.

The inebriate reformatories existed at the end of a period in time when medical theory arrived at a disease model for addiction under such terms as oinomania, dipsomania, narcomania, inebriety, habitual drunkenness and alcoholism (*alcoholismus chronicus*) –conditions eventually viewed as being something a person was predisposed to because of variations of the nervous system, most likely through hereditary influence. (Sournia, 1990). (Inebriety is main term used at Girgenti.) This conception was to become part of the broader theory of degeneracy, which also encompassed mental illness and intellectual disability and became enmeshed with both the eugenics movement and campaigns for separate institutional provision for these broad diagnostic categories. In parallel to, and to a degree in competition with, these developing medical theories ran the temperance movement which saw the problem as lying more with the alcohol or drug rather than the drinker or drug-taker. There are threads that link these two major nineteenth century developments to our current concepts of the dependence syndrome, to Twelve-Step Fellowships and to arguments around the relative merits of targeted and population-based approaches to the treatment of problem alcohol and drug use. It seems worth tracing the threads through the relatively quiescent mid-twentieth century period of Prohibition and restriction of alcohol and drugs that followed the Inebriate Reformatory era into the renewed epidemics of the last fifty years.

It is difficult to see an inebriate reformatory such as Girgenti as a precursor of the future residential rehabilitation units (“Rehabs”) as has been argued in the American context. The idea of mutual self-help and peer support seems not to exist at least in the eyes of those providing the treatment.

The various diagnostic concepts also call out for philosophical analysis, since they raise issues of freewill and the boundaries of legitimate medical concern and the concept of disease. Despite outlining successful challenges to classical disease models of alcoholism/inebriety Reznick (1991) defends the disease status of alcohol dependence/alcoholism, arguing that in everyday circumstances there is evidence of impairment of control over alcohol in most cases. He also sees the modern alternative behavioural and social models of addiction as disease theories in disguise. How one deals with these conceptual issues has historically had implications in both the fields of treatment and in jurisprudence. Reznick argues that disease status does not necessarily imply impaired responsibility for one’s actions or the need to bring these disorders within mental health or special criminal justice legislation. For the Girgenti women, standard imprisonment would have been brief and preferable compared to the three years of compulsory treatment given their repeated minor offending. The inebriate reformatories were, however, an attempt to reduce revolving door imprisonment, which was much discussed prior to the enactment of the inebriate legislation.

Also, as is well illustrated in Valverde's masterly "Diseases of the Will" (1998), the application of a disease model has often led to the denial of the individual's agency and a restriction of their liberty under the auspices of "treatment" or "reformation". A central concern of philosophers looking at addiction is to try to explain how rational agents make choices that they seem to know are detrimental to their own wellbeing. During the nineteenth century in this first wave of attempted medicalisation "akrasia" was the technical term sometimes used by clinicians to explain the disordered will that underpinned addiction. The Aristotelian principle that we choose and shape our own character was also sometimes seen to apply, with the added twist that this might be passed on to the next generation through the erroneously perceived mechanism of Lamarckian inheritance.

The inebriate reformatory movement originated in the United States, occurring earlier than in other western countries such as Scotland. It represented a first attempt to establish a medical specialism around addiction in the form of alcoholism and also less commonly presenting forms of inebriety such as narcomania (Tracy, 2004). The American Association for the Cure of Inebriety (A.A.C.I.) (founded 1870) pre-dates the Society for the Study of Inebriety in Britain (founded 1884) by over a decade. The interplay of medicine with the temperance reformers in the United States as in Britain is of particular interest to Tracy, who documents how doctors capitalise on growing public concern over the alcohol question for their own benefit and in a symbiosis with the popular campaign against drink.

However, there is undoubtedly tension between the idea that the alcoholic or inebriate is constitutionally different in their response to alcohol and the idea that everyone is potentially at risk from the drug alcohol. (The idea of a constitutional difference became central to the later A.A. philosophy of the 1930s onwards and the idea of universal risk to the modern public health approach to alcohol problems.) These are not fully irreconcilable ideas but theoretical sophistication is often absent in nineteenth century approaches to the alcohol problem as Tracy shows in her account. (Tracy's interest in this whole area seems to stem from her fascination with the interplay of the competing explanatory models of alcoholism.)

Certainly, Tracy's account well demonstrates the idea that treatment for these problems is "historically-contingent" given the rise and fall of the inebriate reformatories. The initial enthusiasm for treatment in the United States by a state legislature often falters in the face of increasing expense and perceived poor results. She gives examples of this story from a number of States. She also illustrates how the "medical" treatment was most often moral and social in nature, with exceptions such as the extremely popular and expensive Keeley cure – injections of bichloride of gold – representing quackery on a grand scale. Additionally, the longer American experiment in this area seems to have had more voluntarism than European and colonial equivalents and less of

an emphasis on the incarceration of drunken women – although the idea that female inebriates had deeper pathology than males was certainly in evidence. All of this has close parallels with the story of Girgenti and the Scottish inebriate reformatories, albeit happening twenty years later than in the United States.

The U.S. inebriate reformatory story ends with Prohibition, when the problem with alcohol lessens markedly and inebriate reformatories close. (The illegal market in alcohol was negligible compared to the previous legal and relatively uncontrolled availability of the drug.) Tracy points out in her conclusion that after 1933 when Prohibition was repealed, institutional provision for alcoholics had to be re-established in new guises. Tracy's study, along with White (1998) and Crowley and White (2004), maps out the inebriate reformatory movement within a single country – the USA. These studies give a point of comparison for similarities and difference in the Scottish system. Certainly, the unprecedented taxation of alcohol, combined with the popular movement for prohibition and restriction in Scotland and the UK that reached its height in the aftermath of World War One, took away the need for such institutions. See the steep decline in alcohol consumption levels between 1900 and 1930 as shown in Figure 7, a graph that arguably supports the ideas of Skog, 1986.

The relative failure of the largest Certified Inebriate Reformatory at Girgenti was put down to the type of inebriate received and arguments were made to expand civil detention to the non-criminal inebriate. This campaign led to a Private Member's Bill but it was never enacted. Medical treatment was very limited – one experiment with drug use was found in Girgenti – and the overall approach was an example of Moral Treatment. A medical model was applied in the analysis of cases, however.

Some reformatories, such as Girgenti, closed after a decade due to disputes over funding but the main reason for closure of the system was a lack of referrals in the later period due to the alcohol control measures brought in during and after the Great War. The recent proposal from one political party – Scottish Labour – for alcohol treatment and testing orders (A.T.T.O.s) has many similarities to the inebriate reformatory experiment in terms of compulsion and this work sounds a note of caution in relation to the likely success of such a proposal.

The work in this chapter also shows that many of the elements of the current medical model of alcoholism were in place one hundred years ago. However they lacked specific medical treatments to deal with withdrawal or promote abstinence and relied on moral treatment approaches with limited success. Success seemed more likely when the reformatory treatment linked to a suitable work placement and eventually relocation to a new environment.



## **SECTION V**

**Beyond the reformatories:  
postscript, 1926-2017**

## **Chapter 9**

### **9 a) Alcohol medicine in the era of control, 1926-1947**

#### **9.1 Introduction**

Virginia Berridge (1990) in her history of the Society for Study and Cure of Inebriety (later to become the still extant Society for Study of Addiction) describes the period of the interwar years as “a period of decline” in terms of the fortunes of the society. The Society did, in the end, weather and survive this period, as did the journal of the Society (British Journal of Inebriety/British Journal of Addiction/Addiction). The marked decline in the consumption of alcohol correlated with a decline in the prevalence of alcohol inebriety and the need for treatment facilities. Applications to join the society reduced and the balance of academic interest moved more towards narcotic drugs as the importance of alcohol diminished.

All the inebriate reformatories in Scotland had closed by 1925, and although the legislation that allowed their establishment was never formally rescinded it is clear from Scottish Office papers that these institutions were not in retrospect seen as successful and that there was no appetite to return to providing such separate provision. There were sporadic requests from Sheriffs, recorded in the Scottish Office papers, to utilise the Inebriate Acts, which eventually petered out in the absence of designated institutional provision.

There is a widely held lay view that alcoholics and addicts will find a way to obtain their drug of choice come what may but the experience in the era of control over alcohol doesn't seem to support this idea.

#### **9.2 D. K. Henderson's 1936 Society Lecture at the Society for the Study of Inebriety**

As was described earlier in the thesis, eminent Scottish psychiatrists had argued for separate provision for the inebriate. By 1936 this view had changed markedly as evidenced by the Sixteenth Norman Kerr Memorial Lecture on the topic of Alcoholism and Psychiatry given to the Society for the Study of Inebriety in London. It was delivered by the pre-eminent Scottish psychiatrist of the day, Professor David K. Henderson – he was Physician Superintendent and Professor of Psychiatry in Edinburgh and previously Physician Superintendent at Gartnavel Royal Mental Hospital in

Glasgow. In his lecture, Henderson takes a stance of embracing alcoholism as a concern for the modern mental hospital, in contrast to the views of his predecessors Yellowlees and Clouston who were arguing in favour of separation in the years preceding the Inebriates Act of 1898.

Henderson's psychiatric worldview was very different to his nineteenth century forerunners. He had studied under Kraepelin and more importantly under Adolf Meyer in the United States. Henderson adopted the Meyerian approach of psychobiology, which combined elements of psychoanalysis with the earlier biological theories, alongside the idea that each inpatient should be discussed at a case conference (see Morrison, 2014) where the contribution of psychological, social and biological elements could be delineated along with treatment and prognosis. The addition of the neuroses to the diagnostic system allowed Henderson and others to see alcoholism/inebriety as a more definite psychiatric concern with the heavy drinking seen as a manifestation of underlying neurosis.

In the 1936 lecture, Henderson looks back and states, in relation to alcohol control:

"Great strides in the right direction have been taken: the increase in the price of liquor, the restriction of hours of sale, the reduction in the number of licenses, local option, increased facilities for amusement, better housing and better conditions of work, and, most important of all, a higher moral standard in relation to the use of alcohol have all exercised a beneficent influence. The improvement has been reflected in every walk of life, and our mental hospital statistics bear ample testimony to the altered conditions prevailing. Our admission rate for cases of mental disorder due to alcohol has been reduced too, from one-half to one-third, as compared with twenty-five to thirty years ago".

For Henderson, psychiatry "is in a very specialized position in relation to studying the causes of alcoholism and carrying out appropriate care and treatment."

Henderson challenges the view that the alcoholic is a "willful sinner" and castigates "a very famous psychiatrist" who "refused to receive into his mental hospital a patient suffering from alcoholism for the reason that he dealt with mentally ill patients only and had nothing to do with inebriates." For Henderson, the "victim" of alcoholism "requires skilled and considerate treatment" and Henderson believed this was something that psychiatry could provide.

From Hazel Morrison's research at the Glasgow Royal Mental Hospital (Personal Communication), Henderson certainly dealt with a small number of cases of alcoholism there in the 1920s. At least one of these cases had seen service in World War One and had both "shell-shock" and alcoholism. However, unlike the current position where soldiers who have seen recent service

in Iraq and Afghanistan are seen to have increased rates of alcohol dependence in conjunction with PTSD, the observations in the 1920s suggested that this wasn't a common comorbidity.

The 1922 "Report of the War Office Committee of Enquiry into 'Shell-Shock'" presents research that those with "war neurosis" drank much less than those who were wounded but not "nervously effected". In fact forty-eight out of 100 subjects with war neurosis were described as teetotallers and only 6% were said to have drunk excessively at some point in their life – compared to 16% in the wounded but not nervously afflicted group who only had twenty teetotallers out of 100. The shellshock cases were said to have been more likely to have parents who were alcoholics than the non-shell shock group, in keeping with theories at the time that parental alcoholism produced constitutional weakness in offspring. The fact that the mental aftermath of World War One did not produce an increase in alcoholism is a strong indicator of the effectiveness of the alcohol consumption controls of the time.

Returning to the Henderson Norman Kerr Memorial Lecture of 1936, Henderson expands on the case for psychiatric involvement with individual heavy drinkers:

"Let me attempt to state the position quite clearly. In many instances alcohol is responsible (1) for producing certain specific types of mental disorder-e.g. delirium tremens, Korsakow's psychosis, and chronic alcoholism; (2) it is a complicating factor in many other types of nervous and mental illness e.g., general paralysis, manic-depressive states, mental deficiency and anxiety states; and (3) most of all, is a symptom or index of an underlying nervous constitution and instability which may be determined at various levels of development, hereditary, congenital, environmental."

This statement is very reminiscent of that of Yellowlees in his 1874 paper quoted above.

Henderson also considers the question of aetiology and, while indicating he believes there is some truth in the Freudian psychoanalytic theories of causation, he is dismissive of some of the more fanciful explanations offered by British psychoanalysts such as Glover. Compared to the previous generation of psychiatrists he sees the addition of depth psychology to the previous biological understanding – combined with consideration of social milieu – as a key to all psychiatric practice, especially to the understanding of the alcoholic.

Henderson then goes on within his published lecture to give a rich series of case vignettes from his own practice, illustrating the association of "alcoholism" with a number of criminal behaviours and medical conditions. The headings he considers are:

(a) Alcohol and homicide

- (b) Alcohol and assault
- (c) Alcohol and head injury
- (d) Alcohol and sex crimes
- (e) Alcohol and suicide
- (f) Parental alcoholism and children
- (g) Alcoholism and mental illness

Most of his vignettes are drawn from his role as an expert witness for the courts (e.g. his eleven cases of homicide) and a few are drawn from his mental hospital practice. He is particularly interested in the life history of the individuals – in each of the criminal cases Henderson finds evidence of longstanding constitutional predisposition to react adversely to the effects of alcohol. His testimony is effective as a plea in mitigation in the majority of cases, leading in one case to the death penalty being commuted to life imprisonment.

He draws on all the cases presented to make recommendations for current and future practice in a section entitled, “Suggestions Regarding Treatment And Reform”. In this conclusion to his lecture he states that:

“The case histories which have been recorded are examples of alcoholic states which are common, which are difficult to treat, but which need not necessarily lead to any further stage of mental disintegration. Drink in each case produced a state of vainglory, of all-powerfulness and, finally, of temporary oblivion as an attempt to blot out reality and to effect a transitory over-compensation for feelings of inferiority. While I emphasize the psychological aspects, I am not forgetting the importance of the biochemical and physiological reactions, and while the treatment of the individual is in the forefront yet the influence on society is also kept in mind. Under treatment there is usually little or no difficulty in prevailing upon the patient to give up the use of liquor, and investigation invariably shows that the real point of attack must be the remodelling of the man’s disposition. Practically every case demonstrates that from a comparatively early age disorders of conduct were exhibited which had been determined by a variety of factors, personal or environmental, which were susceptible of considerable modification. That point is still lost sight of – far too great an emphasis is placed on the alcoholism and far too little attention is devoted to the type of individual in whom the alcoholism is occurring. It is not the alcoholism we require to treat, it is the man himself.”

This then is his main argument expressed succinctly – for psychiatric involvement with alcoholism – and as mentioned above he is dismissive of colleagues who do not see this as part of the function of the modern mental hospital.

He goes on to state that he is a realist regarding the extent to which treatment can make a difference, and adds the caveat:

“There is no panacea, no cure-all, no specific approach, but psychiatry with its patient unfolding of all the circumstances, physical, biochemical, psychological, and its weighing up of all the constitutional reactive tendencies has a greater chance of producing better results than any other method of treatment”.

For Henderson, alcoholism is one of many behavioural conditions that should be the remit of psychiatry, under the broad heading of constitutional impairment and in some cases “unsoundness of mind”. (The latter designation allowing for involuntary treatment when it is deemed to be present.) It is in this context he then states:

“That, I am sure, is where the Inebriate Acts, introduced some years ago, but now ‘a dead letter,’ went far astray. According to these Acts, provision was made for the establishment of Retreats, Certified Inebriate Reformatories and State Inebriate Reformatories, and it is interesting to note that licences to manage Retreats could not be issued ‘to persons licensed to keep a house for the reception of lunatics.’ This, of course, implies a total failure to appreciate the close link between alcoholism and mental disorder, whereas the Reformatories, either certified or State, were much too closely identified with the prison system. These Retreats and Reformatories failed because of the lack of adequate medical treatment”.

It is in this context that Henderson then makes a plea for greater use of involuntary treatment using the existing Mental Health Legislation, based on a judgement of “Unsoundness of Mind” for the alcoholic. He additionally argues for new legislation to make using such powers easier to detain patients beyond a point of recovery from the initial presenting problem (say delirium) – this would allow treatment of the underlying constitutional disposition which in turn will be preventative or reduce the likelihood of future episodes of difficulty through alcohol. Alongside this plea for what we would now call secondary prevention he also makes a plea for primary prevention, mentioning principles of both good eugenics and also mental hygiene. (There is an interesting aside on a debate as to whether alcohol in early pregnancy might be eugenic rather than dysgenic – Henderson states it is clearly dysgenic, a position that is no longer in dispute.)

This lecture gives a fascinating insight into the practice and theory of the interwar era and a sea change in the view of alcoholism within mainstream psychiatry by the only Scottish Professor of Psychiatry of that period. Henderson’s views were, of course, widely disseminated in Great Britain and beyond through the highly successful and predominant textbook of the era (Henderson and Gillespie’s Textbook of Psychiatry).

### **9.3 A shift from alcohol to drugs?**

A question that is often asked in relation to eras of increased control on alcohol – whether the population at risk of alcoholism shift to other forms of alcohol or other intoxicants. During these interwar years, the use of opiates and cocaine seems to have fallen away in Scotland and Britain, based on official statistics and from indicators of admissions to hospital. (This is not surprising given that greater restriction was brought in around narcotic drugs in the wake of the 1926 Rolleston Committee.)

There is some evidence of a shift towards a more dangerous form of alcohol in relation to statistics around secondary intoxication – methylated spirits or the fortification of existing forms of alcohol by the addition of methylated spirits. Such “cocktails” as “Red Biddy” and “King Fergus” were the result of such admixtures. Concern over this would culminate in legislation in the form of The Methylated Spirits (Sale by Retail) (Scotland) Act 1937. The numbers recorded with such a problem certainly rose in the 1930s, with Scotland being recorded as having a worse problem than England – but compared to the previous statistics around ethyl alcohol alone these numbers were small.

### **9.4 Scotland as an exemplar**

The culmination of this dramatic turnaround in Scottish drinking culture was that Scotland was held up as a model for sobriety to be emulated by England in an enquiry into licensing laws in the early 1930s. The history of licensing legislation in Scotland is well set out in a paper on this topic by James Nicholls (Nicholls, 2013).

### **9.5 Conclusions**

In an era where the problem with alcohol was seen to be diminishing, it is worth noting that Scottish psychiatry seemed more willing to embrace alcoholism as a condition worthy of mental hospital treatment. From his practice in this era, D.K. Henderson and others were arguing that all alcoholic patients had underlying psychiatric problems in relation to “nervous disposition” that were worthy of psychiatric intervention – this might in turn lead to a constitutional change that made the individual more able to withstand the temptation of alcohol and, if they were to drink, better endure the adverse effects of alcohol.

## **9 b) The problem returns, 1947-2017**

### **9.6 Introduction**

The year 1947 was one of radical change, with the birth of the National Health Service. It is a convenient cut-off for my more detailed research into the question of the alcoholic's position in Scotland and the treatment systems that existed prior to the NHS. The psychiatric hospitals – all the Royal Asylums and of the district asylums – moved in their totality into the NHS.

Sir David Henderson was the guest of honour at the ceremony held at Gartnavel Royal Hospital to mark this transition. He was later to provide us with an interesting historiographical source in a few short pages in his “The Evolution of Psychiatry in Scotland” (Henderson, 1964; pp236–238), which summarise his views on the long-term trends in the treatment of alcoholism and the treatment of its psychiatric consequences up until the early 1960s. As in his 1936 Norman Kerr Memorial Lecture discussed above, he very much continues to see alcoholic psychoses and chronic alcoholism as being a core remit for psychiatrists. He notes the long-term decline in the incidence of alcoholic psychoses. He quotes figures from England and Wales saying that “the percentage of admissions to mental hospitals on account of alcoholism decreased from 15.99 in 1902 to 1.66 in 1956”. From the Scottish perspective, “these figures correspond to (his) experience both as a consultant psychiatrist and as a physician-superintendent of a mental hospital”.

However, he notes what is perhaps the beginning of a reversal of this long-term trend in the revealing passage that follows:

“While the number of patients suffering from alcoholic psychoses has decreased there is reason to suppose that since the introduction of the National and Mental Health Service Acts the number of alcoholics seeking admission to nursing homes and mental hospitals has increased. There may be a tendency to exploit the accommodation provided because they (alcoholics) know that they will be looked after and treated in comfortable quarters either free of charge or at very economic rates until they feel fit to return to their ordinary way of life”. This sentiment is later reaffirmed in the 1971 paper “Alcoholism And Its Treatment in Scotland: A critical Review” by Warder and Ross. They record how, in the late 1950s and the early 1960s, increasing numbers of patients with alcoholism were being admitted to general psychiatric units. Like Henderson, they are sceptical that these patients are genuinely motivated towards a “cure” and believe that most of these alcoholic patients “use a hospital as a port of call during a storm rather than as a convenient site for major repairs”.



Henderson also tells us that:

“Alcoholism is a disease, not a sin, but only those who are genuinely anxious to be cured should be admitted informally to mental hospitals”.

He admits that even with those who are motivated:

“The answer and cure is not easy to find”.

In the “Evolution” Henderson reflects again that the inebriate reformatories were ineffective, that prohibition (presumably thinking of North America) had been a “disaster” and that “cures” (presumably thinking of the patented drug remedies such as Keeley’s Cure) were “a makeshift that only touched the fringe of the problem”. For Henderson, a “new orientation is required” which involves education targeted at those who are psychologically vulnerable. He agrees with Fergusson Rodger, Henderson’s assistant when he was Physician-Superintendent at Gartnavel Royal, in his assessment of Alcoholics Anonymous

Henderson states:

“The members of The Alcoholics Anonymous Association have helped many sufferers by dedicating themselves to prevent others from suffering the ordeals which they themselves have experienced”.

At the point of the “Evolution’ being published, Alcoholics Anonymous had been active in Scotland for seventeen years – it had begun in North America twenty-nine years previously. Henderson links the methods of A.A. to the fact that it is “essential to help the patient to understand himself, to become more philosophical, to appreciate that his ideas of reference, and his sense-of-inferiority, can be compensated in other healthier ways than by boosting his ego with alcohol to gain temporary satisfaction and a sense of superiority”.

Henderson’s assistant was another psychiatrist who later looked back on developments in relation to alcoholism over his career from the perspective of the 1950s– he later became the first Professor of Psychological Medicine in Glasgow, Professor T. Fergusson Rodger. Glasgow University Archive holds transcripts of a talk he gave to Alcoholics Anonymous in Glasgow in the early 1950s and a lecture to medical students in 1969 on alcoholism – in both he gives a retrospective view on alcoholism in relation to his “twenty-five” and “forty years” in psychiatry, respectively. He hails

Alcoholics Anonymous, which arrived in Scotland in 1947, as a great step forward. He talks of A.A. getting off to a “shaky start” in Glasgow – obviously not aware of the potential humour in that expression – before it settles down to become a rapidly expanding organisation. In relation to the practice of the interwar years there had been “no great advance in the treatment of alcoholism although one or two methods have been produced which are very helpful”. For Fergusson Rodger “A.A. is one of the greatest health agencies that has ever been created”, as although medicine could help the individual through the immediate physical effects of alcohol in these years it had no effective way to then help the individual stay well, i.e. abstinent, and hence A.A. was filling a void that previously existed in offering help to the alcoholic.

In his lecture to medical students, Fergusson chimes with Henderson’s ideas of thirty years earlier on how psychiatry and medicine had expanded and continued to expand – not just to deal with the mental and physical complications of alcoholism, but the underlying problem itself. He presents an analysis relating to primary, secondary and tertiary prevention of alcoholism, with an historical perspective that takes in the years under consideration here. From the viewpoint of Scottish medicine, he also mentions the idea that people of Scots and Irish descent are more likely to be alcoholic when living elsewhere in the UK – an analysis of names showed people with names beginning with M (particularly Mc and Mac) have a higher proportion of alcoholics among them compared to names beginning with any other letter.

## **9.7 Alcohol consumption rises, and rises**

As can be seen from the consumption graph reproduced above the amount of alcohol being consumed per capita has more than doubled since the end of World War Two. There is good evidence that this UK average is accentuated for Scotland – recent data from alcohol actually sold suggests the average Scot to be drinking 11.5 litres of absolute alcohol per annum, compared to the English average of 10.2 litres of absolute alcohol per annum. We have only seen a slight downturn in consumption since 2012, in a period of austerity. The drivers for this change are undoubtedly the lower relative price and increased availability of alcohol and increased disposable income. The harm caused by alcohol is more marked in socially deprived areas due to the polarisation of drinking behaviour seen in such communities. Recent research shows that Scottish clinic attenders with an alcohol problem are buying their alcohol as cheaply as 21p per unit, in the form of white cider and unbranded vodka.

## **9.8 Alcohol treatment reemerges from within general psychiatry**

In parallel with this rise in consumption, alcohol specialisation has again emerged from within the field of psychiatry, more distinctively than it did in the nineteenth century. In the post-war period,

the re-emergence of such a defined group of practitioners dealing with the alcoholic means that by 1975 there are twenty-one regional units on psychiatric sites, with 434 beds in the United Kingdom as a whole – but still only one-third of alcoholics are said to receive treatment in psychiatric care. A Dependence/Addiction Group was formed in the College of Psychiatrists in 1978, which expanded through time in numbers and importance to its current faculty status in 1997.

Since the 1980s, important trends in service provision within Scotland and the United Kingdom have included a move from hospital to community-based treatment – paralleling a similar move in psychiatry as a whole. Alongside this, voluntary sector treatment has expanded and continues to be extended particularly in England. In Scotland, Day Hospitals have proven particularly useful settings for treatment provision. Along the way there have been threats to intensive treatment provision which have had more of an impact in England compared to Scotland

A notable recent Scottish initiative has been the delivery of Alcohol Brief interventions through G.P.s and the increased involvement of general practice in this area of work over the last decade. In this time there has also been investment in specialist nurses working in Acute Hospitals to deliver advice and treatment around alcohol misuse and dependence.

## **9.9 Scottish distinctiveness, again**

Scotland has today returned to a situation where the alcohol problem is worse than with its neighbours both in the British Isles and in Western Europe. The recent facts are stark:

- Rates of alcohol use and dependence are higher in Scotland than in the rest of the UK.
- More alcohol is sold in Scotland per head of the population than in England and Wales.
- In 2007, an average of 12.2 litres of pure alcohol was sold per person aged 18 and over in Scotland, compared to 10.3 litres in England and Wales.
- Estimated prevalence of 8% alcohol dependence in the adult population of Scotland.
- Levels of alcohol dependence are a third higher in Scotland than in England.
- Scotland has the highest alcohol-related death rate in the UK. The rates in Scottish men are double that of the rest of the UK.
- Alcohol-related problems place an enormous burden on NHS Scotland.
- In 2011/12, there were 38,737 alcohol-related hospital discharges in Scotland.
- Alcohol was the underlying cause of 2.4% of deaths registered in Scotland in 2009.
- The total cost to Scottish society of alcohol misuse is estimated to be around £3.56 billion, with healthcare costs alone accounting for £231 million (2007 prices).
- Up to 79% of NHS Scotland costs attributed to alcohol-related problems were hospital costs (2007 prices).

In the light of this, the Scottish Government has acted with several measures either already implemented or proposed. The lowering of the alcohol limit for driving has had a definite effect, as has action to end irresponsible promotion and below-cost selling of alcoholic drinks in licensed premises.

At the time of writing, the UK Supreme Court has just agreed the introduction of minimum unit pricing (MUP) for alcohol after the Scottish Whisky Association had challenged it over the last five years in a lengthy court case. It will go ahead now with a likely price of 50p per unit of alcohol in 2018. This remains needed as after a slight fall in alcohol-related deaths and alcohol-related hospital admissions between 2010 and 2014 the statistics have again worsened with rises in 2015 and 2016. The figure of 1265 deaths in 2016 representing a 10 percent increase on 2015.

## **9.10 Conclusions**

Given that past attempts to hivel off patients with addiction issues have previously failed – Yellowlees’ “respectable lunatics” vs. “demoralised drunkards” – it does seem that Henderson’s thinking on this issue won out when the need to address the problem again arose in the 1960s and 1970s. Certainly today, with alcohol again available and abundant, dealing with its mental and physical consequences is a big part of both general psychiatry and general medicine. As such this should be “everybody’s business” and historical experience shows that in Scotland it needs to be supported by a system of more specialised services grounded within psychiatry. As with Henderson, prevention of the problem is certainly the aim with the most effective measures to be found through political action – just as was the case a century ago.

## **SECTION VI**

### **The relevance of 1855-1925: conclusions and discussion**

## Chapter 10

### Summary and discussion of the research findings

#### 10.1 Introduction

The years 1855 to 1925 provide a fertile period for study, allowing for a detailed analysis of how marked fluctuation in population levels of alcohol consumption correlated with medical involvement with the consequences of heavy drinking in Scotland. It is also a period during which medicine and psychiatry staked a claim to expertise in dealing with the underlying condition of heavy drinking itself. New terminology and diagnostic systems are implemented with the idea that inebriety represents a disease, a disease of the will. This disease concept is based on presumed differences in the make-up of the affected individual's nervous system, either inborn or acquired. Medical theories of the time also raise the possibility of the inebriate adversely affecting the next generation through tainted reproduction.

Of particular interest to this thesis is the suggestion that alcohol consumption and associated problems rise and fall in "long waves" throughout history (Skog, 1986). This theory argues that when alcohol-related problems in a society pass a certain threshold, government intervention becomes unavoidable. Subsequently if the extent of the problem declines sufficiently laws and taxation are relaxed – leading to the start of a further rise in alcohol use. The period under study here is one in which there is a steep decline from an alcohol consumption peak to an alcohol consumption trough. In fact it captures the steepest sustained decline in alcohol consumption we have on record in the British Isles– from 25g pure alcohol per person per day around 1895, down to 10g pure alcohol per person per day around 1925. Additionally, from the midpoint of the nineteenth century to the last quarter of the century is also a period of marked rise in overall consumption in the British Isles brought about by an increase in beer drinking – after the liberalisation allowed by the 1840 Beer Act – and to a lesser extent a rise in the consumption of spirits. Thus, the last quarter of the nineteenth century has a conjunction of some of the highest levels of alcohol use in the course of the century alongside the expansion and consolidation of the asylum movement that was to continue well into the twentieth century.

Unfortunately for the time period under consideration we don't have accurate data differentiating Scottish alcohol consumption from that of the rest of the British Isles though we do have statistics that strongly indicate that the consequences of heavy drinking were more prevalent in Scotland compared to England and that within Scotland the city of Glasgow had worse problems than the city of Edinburgh. The other fact that seems undisputed for the period is that whisky or Scotch was

the drink of choice in Scotland, for those who hadn't joined an abstainers' union, whereas in England the majority of alcohol was consumed as beer. This was seen as an explanation for the worrying statistics in Scotland around public drunkenness. The contrast made one hundred and fifty years earlier by Hogarth between Gin Lane and Beer Street still held with ardent spirits such as whisky seen as the worst way to consume alcohol. The idea of today that it is the amount of alcohol overall rather than the form of alcohol that causes the damage either in the short term or long term had not yet become orthodoxy.

One hypothesis that follows from the ideas of Skog, for my thesis, is the idea that medical concern with the issue of alcohol will rise and fall with the extent of intrusion of the alcohol problem into the clinical domain. This idea is based on the idea that the extent of such presentations to clinics and hospitals is likely to rise and fall with consumption levels, which for our current era seems to largely hold true. In turn when the problem is at a peak the doctors concerned may then become more inclined to join in with calls for action at a societal level with the opposite being the case at times of relative trough consumption.

It also seems likely that there is a level of average per capita consumption from our knowledge today, leaving aside fluctuations and peaks and troughs in population level consumption, above which increased harm will be seen in both the individual and by implication the population. This is the basis for the Chief Medical Officers' Guidance on Safe Levels of drinking with the advice recently adjusted to no more than fourteen UK units of alcohol in a week with at least two or three days in the week without alcohol to allow for recovery.

## **10.2 Alcohol on the clinical frontline**

One question I wished to explore in this thesis was that of whether alcohol was being recognised in relation to physical and mental ill health in the day-to-day practice of physicians and psychiatrists, particularly at a time when both hospital provision and population were expanding in Scotland. This increase in numbers of hospital beds and population growth ran alongside the increasing rates of alcohol consumption that were to be found in the second half of the nineteenth century. An additional trend in this period, relevant to some of our debates around alcohol today in Scotland, is a polarization of drinking behaviour with a differentiation between 'refined' and 'rough' culture, between rich and poor, respectively. Certainly the fears of racial degeneration linked the issues of intemperance, insanity and idiocy and mainly focused on the indigenous population.

Unsurprisingly my research shows that the role of alcohol was being recognised in relation to presentations to both the infirmary and to the asylum, but often with a different, and arguably mistaken, understanding of causality from the vantage point of today. However, there was far from

uniformity among the views of the medical men involved as shown by the contrasting views of physicians on the causes of delirium tremens or of some of the Medical Superintendents of the Glasgow Asylums in the late nineteenth and early twentieth century on whether alcohol was a cause of insanity.

I have in the course of this thesis looked at three detailed examples, which allowed me to look at practice through the case notes of patients. These three case studies were of patients under the care of three particular medical men. I was then able to supplement and contextualise this practice by looking at the statements made by these same doctors on the subject of alcohol and alcohol-related illness. All of these examples span a number of years, in each instance, and the three examples are at differing time points in the seventy-year period under consideration. The three settings I have focused down on in the thesis are the infirmary, the asylum and the inebriate reformatory. The three medical men at the centre of the study are Thomas Laycock, David Yellowlees and John Cunningham, respectively. In the same sequence they represent a physician with an interest in delirium tremens, a psychiatrist with an interest in alcoholic insanity and a general practitioner who develops a special interest in inebriety.

In the infirmary, the main diagnosis of interest is that of delirium tremens or “D.T.s”. It is a diagnosis that has a 100% association with alcoholic beverages, and therefore changes in its apparent incidence and presentation are a good barometer for extreme alcohol consumption in the general population. The Royal Infirmary of Edinburgh proves an excellent source to study this issue through the case notes of the Delirium Ward. These notes can be viewed alongside the writings of Thomas Laycock, which utilise the same case material. Laycock’s views can be contrasted and supplemented by the views of other physicians of the time on the topic of delirium tremens.

In the context of a large Scottish nineteenth century teaching hospital where patients can present for help on a voluntary basis, we see a remarkable number of people so presenting with what we would now call alcohol dependence, seeking help for D.T.s or for the possibility that D.T.s may be about to commence. They are not turned away and the physicians who care for them once they are admitted have a particular interest in their condition. There is no real concept of a withdrawal syndrome at this time and the aetiology is believed, by Laycock, to be a toxic reaction to alcoholic beverages, and as a result in the 1850s and 1860s treatment is conservative or in Laycock’s term “anticipatory” and where possible without the use of alcohol or opium. Remarkably, this treatment results in a greatly reduced death rate compared to the preceding decades and the percentage is certainly well below the figure given in modern textbooks of a supposedly up to 35% death rate in the era before effective sedation and the use of intravenous fluids.



The vast majority of patients with the D.T.s are discharged “cured”. However, they aren’t, of course, cured of their underlying habituation to alcohol and some return with further recurrence of D.T.s after a relapse into heavy drinking. There is no sense from these case notes of any medical advice or intervention in respect of the underlying habit. Presumably this remains the domain of individual choice and responsibility in the view of the treating physician. Also, if D.T.s represents an extreme of intoxication, with unknown factors in alcoholic beverages other than alcohol possibly responsible (as in Laycock’s view), then moderation of drinking habits rather than abstinence is the logical advice.

Additionally the delirium ward casebooks of the Royal Infirmary of Edinburgh give an indication of other forms of substance-induced poisoning presenting to the infirmary at that time along with Delirium Tremens. D.T.s was seen as the most prevalent form of alcohol poisoning but other possibilities existed. There was an understandable concern at this time that alcohol may be contaminated or adulterated in some way and such a perspective may have informed Laycock’s view that alcohol may not necessarily be the cause, or sole cause, of delirium tremens as chemicals other than alcohol were present in alcoholic beverages, with toxic potential, and perhaps one or more of these compounds may be to blame.

The other arena of major interest is that of the asylum. Here there is a wish to exclude acute alcoholic insanity or delirium tremens as too transient an illness to count as lunacy or insanity proper. These cases are best dealt with in the poorhouse infirmary in the view of most Physician Superintendents and Asylum Officers. Inevitably some cases slip through the net. This is not surprising given the difficulty of differentiating delirium tremens from other forms of acute mental illness if the background history of heavy alcohol use is unknown. However, even with this exclusion alcohol comes to be seen as a major cause of insanity either by itself or in combination with other factors.

The meaning of the term “alcoholic insanity” in every day practice in Scottish asylums is explored therefore through the records of Glasgow Royal Asylum for Lunatics, particularly the Annual Reports, and through the Annual Reports of three other Glasgow Asylums: Woodilee, Gartloch and Leverndale.

The year 1855 was chosen as the year for the beginning of my period of study as this is the year of commencement of an Inquiry that led to the Scottish Lunacy Act of 1857. The Inquiry Report crystallises the growing concern around the impact of alcohol on Scottish asylum practice, a concern that hadn’t been anticipated at the outset. The term used in the report for what we would today call alcohol dependence, that of oinomania, is discussed at length within its pages. By the end of the nineteenth century, figures such as David Yellowlees are talking of “true” alcoholic

insanity as an entity differentiated from the D.T.s and as a major contributor to the caseload of the asylum, particularly in male patients. However, a definite confounder at this time to any understanding of the mental consequences of alcohol was the high prevalence of neurosyphilis and the fact that high alcohol consumption and the presence of what was subsequently to be shown to be a sexually transmitted disease were positively associated.

The forms of mental illness caused by alcohol that are recorded in the asylum tables of medical statistics are varied and tend not to encompass all of the cases admitted within any one year in which alcohol is given as the principal cause. Diagnostic categories found in addition to alcoholic insanity include alcoholic mania, chronic alcoholic dementia and mania a potu. Delirium tremens is also recorded on occasions including, sometimes, and confusingly in the same table as mania a potu. The one condition not given the sub-label alcoholic is melancholia. This is surprising as today we would see alcohol-induced depression as a major concern. Yellowlees' recognition of the "demoralized drunkard" in his 1895 testimony did not seem to extend to allowing such a condition of mind to have a diagnostic category.

Both Yellowlees and Clouston published on the association of intemperance and insanity and both formed a pessimistic view of the treatability of the underlying inebriety. They believed that underlying brain changes – which could be seen at post-mortem under the microscope – were only slowly reversible with abstinence and that therefore an enforced separation from alcohol was the necessary treatment. They did not see this as the role of the asylum and advocated for alternative provision for this problem.

At the end of the nineteenth century there was much concern around a "rising tide of insanity" with increased alcohol consumption being viewed as a major factor in this, an attribution that was seized upon by temperance advocates. However, alcohol consumption declined markedly in the first quarter of the twentieth century but insanity and mental hospital numbers continued to rise. As a result there were a few voices in the medical literature asking the question as to whether a false conclusion of cause and effect had been previously reached on the association of alcohol and insanity. This possibility, of an overemphasis of the role of alcohol in the causality of insanity, had been anticipated by at least one of the Medical Superintendents in Scotland.

The third arena for engagement with the alcohol problem has no strict modern equivalent. (Although institutions do exist today, with medical input, such as the 218 Project in Glasgow for helping criminally-involved women with substance misuse problems and diverting them from prison). The Inebriate Reformatory was a bold experiment built on the basis of a particular medical conception of alcohol addiction and the findings from my research in this arena are addressed in the section to follow.

### 10.3 The inebriate reformatory era

The fact that in the first quarter of the twentieth century Great Britain and Ireland had a form of civil detention for those convicted of four or more minor alcohol-related offences in a year—drunkenness, drunk and incapable, breach of the peace – and deemed such offenders to be inebriates is not widely known. The legislation was based on a medical conception of chronic heavy drinking that came from the idea that “vice has become habit”. This was to such an extent that free will had become impaired and the belief at the time, in this era of the first biological psychiatry, was that this change was etched upon the brain in a way that was difficult to reverse. Hence, logically this led to the draconian measure of three years of detention to allow for medical treatment, which largely in the end was moral treatment. Certainly, in Scotland, there was great scepticism over specific remedies and “secret cures” for drunkenness.

This experiment in compulsion seemed destined to fail from the outset. The potential numbers who might require such treatment were enormous, as would be the financial burden that such an enterprise in mass incarceration would place on the exchequer. The experiment in its British incarnation mainly locked up women though undoubtedly the drink problem mainly affected men. There is some circumstantial evidence from rates of deaths through delirium tremens that female drinking in the “lower classes” may have been differentially increasing at the end of the nineteenth century and therefore the perception of a rising problem with female drinking may have influenced this along with other concerns such as not wishing to send women to jail (Sherwell, 1903; page 22).

Any reading of the case notes of the inebriate women reveals a lack of an answer to the basic question of whether the individual themselves believed they had a problem – some evidence suggests that in most cases they probably did not – and whether they were indeed wanting help for their addiction. As was often the case at this time, the patient’s voice appears to be suppressed, particularly in this context of involuntary treatment. The medical men<sup>95</sup> involved in the enterprise saw their patients as mainly “hopeless cases” and would have pursued the idea of civil detention for more hopeful, non-criminal cases if the problem had not subsided. The City of Glasgow along with others put forward such a civil detention bill but this never came to fruition. Also plans were afoot centrally to build a larger State Inebriate Reformatory in Houston in Renfrewshire, which were dropped as the inebriate reformatories began to close one by one.

One legacy of this period is, perhaps, that future mental health legislation specifically excluded primary alcohol and drug dependence from any compulsory measures, given the poor outcomes for

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<sup>95</sup> Although the legislation called for female doctors to attend female inebriates where possible there were too few female doctors to make this the norm.

those forced into treatment.

## **10.4 The effects of changes in consumption**

My contention in this thesis is that it is possible, in the time period chosen, to trace an effect of population levels of alcohol consumption on both the prevalence of certain definable medical consequences – e.g. deaths from delirium tremens in official statistics – and also the degree of medical concern with the problem. The way in which this medical concern manifests itself is variable and at the beginning of my time period the physicians concerned with Delirium Tremens were not joined up with the growing Temperance movement. (This is a different narrative from that seen in the early American republic, for example, where doctors led the way with temperance). As the century moved on this position changes particularly with psychiatry wishing to stem the “rising tide” of alcoholic insanity and psychiatrists advocating strongly for something to be done about inebriety as a way of intervening in this perceived epidemic. Psychiatrists were not at this stage offering treatment for the habit that underlay the cases of alcoholic insanity and believed that this provision should be made elsewhere. In fact they held a very pessimistic view of prognosis and encouraged a dark vision of declining racial health in which inebriety played a major role given the belief that acquired traits could be passed on to the next generation.

However, the willingness of mainstream psychiatry to accept a responsibility for the treatment of the underlying addiction seems to alter from that of defensiveness to a wish to embrace the condition within the space of twenty-five years (1900–1925). The views of Thomas Clouston can be contrasted with those of Sir David Henderson in this regard.

In this same period, the prevalence of the condition, that of intemperance or inebriety, has fallen and the numbers become more manageable for asylums. For the first time in the 1920s the terms alcohol and drug addiction have a legitimate place in the diagnostic table of the Glasgow Royal Mental Hospital with Dr.D.K.Henderson as the Physician Superintendent. Arguably also the smaller numbers of heavy drinkers presenting are likely to be of more interest to the new psychological approach within psychiatry. The psychology and phenomenology of addiction from this point onwards begins to be studied in greater depth.

## **10.5 Doctors as public health advocates**

After an initial reluctance to ally with the temperance movement at the beginning of the nineteenth century, doctors in Scotland were more likely to associate with the cause by the end, in the light of the perceived impact of alcohol on their practice. Thus, figures such as Gairdner, Clouston and Yellowlees were ready expert witnesses on the topic of inebriety in 1895. However this remained

an uneasy alliance in the sense that the medical conception of inebriety placed more of an emphasis on the individual and their constitution whereas the temperance approach placed the emphasis on the availability of the drug alcohol and its ability to undermine all of society. Arguably at the current time the population-based approach of the temperance movement is that which is now embraced by public health medicine, with the danger that the need to treat the severely affected individual is forgotten. Undoubtedly there is an ongoing tension between population-based and targeted approaches to the problem of alcohol misuse, with a constant need in each era for us to ask ourselves whether we are getting the balance right.

Another factor worthy of comment and well illustrated in the historical period under consideration in this thesis is the contrast between doctors' social situation and the social situation of their patients. In the nineteenth century, asylums were designed to keep paupers separate from gentlemen and ladies. While the social divide is less stark today it is still there with a steep gradient of alcohol-related harm found, more so for men, between the more affluent and the poorer in our community. The argument that MUP will mainly affect the less well off has echoes in the debates around the Inebriates Acts in relation to personal liberty.

## **10.6 The centrality of psychiatry?**

From the statement made by Trotter in the late eighteenth and early nineteenth century that the habit of drunkenness is a "disease of the mind", it always seemed likely that mental medicine and psychiatry would stake a claim to have expertise in the understanding of this phenomenon. Certainly, every psychiatric textbook today will have a chapter on alcohol dependence or alcohol use disorders. However, this apparent hegemony is under challenge and perhaps has always been in the modern era. Alongside challenges from within medicine there are also challenges from clinical psychology to the whole edifice of the medical model and the modern idea of the "hijacked brain". The history certainly shows that physicians have always been on the frontline of the problem, as has public health. The psychiatric approach to the problem has also varied widely depending on fads and fashions within the wider discipline. The concepts of the late nineteenth century were in accord with the "first Biological Psychiatry" and those of the mid-twentieth century evolved in relation to the psychoanalytic and psychobiological theories that came into vogue at that time.

Today we see a struggle between biological and psychosocial concepts in relation to addiction with strong cultural determinants where the emphasis is placed in relation to either genetic or biological determinants and psychological and social factors. Our ability to create an integrated model of these various viewpoints continues to struggle, perhaps because of the deep philosophical issues at the centre of the debate around agency and freewill.

## 10.7 Concluding remarks

By exploring the history within Scotland of the medical profession's involvement with the alcohol question, a number of surprising findings are brought to the fore.

Firstly, medicine did not take the lead in the early temperance movement and was slow to join the campaign, only joining in meaningfully when temperance became established as a cause within respectable society. A shift in the drinking habits of the middle and upper classes certainly underpinned this in the British context. Also, doctors continued to use alcohol as a remedy until quite late on in the nineteenth century and didn't necessarily blame the alcohol itself for such major consequences such as delirium tremens.

Secondly, growing concern that increasing alcohol consumption in the late nineteenth century was fuelling a rise in lunacy or insanity seemed to become contradicted by the fact that alcohol consumption fell away markedly in the first quarter of the twentieth century yet the presentations to and numbers in the asylums continued to rise. It may have been that the association between high alcohol consumption and mental illness was coincidental in many cases, reflecting the high general population consumption levels rather than being of direct aetiological significance. The evidence requires to be reinterpreted in the light of our current knowledge of alcohol-induced mental disorder.

Thirdly, the inebriate reformatory experiment provides a warning about the idea that undue compulsion might break through a lack of motivation for change, such that any debates around civil detention and mandatory schemes for alcohol and drug dependence require to be informed by this experiment. Certainly, there has been recent interest in the possibility of Alcohol Treatment and Testing Orders within Scotland. The success of any such scheme will undoubtedly rest on the balance of "hopeful"/motivated and "hopeless"/unmotivated cases, just as it did one hundred years ago.

Lastly, and most importantly, the current medical advocacy for effective public health measures around taxation and availability of alcohol is certainly in accord with the lesson of the temperance movement and the effective legislation that brought control over alcohol in the early twentieth century. The unresolved question for this campaign is this – if a downward trend in alcohol consumption and alcohol-related disease can be achieved, at what point can we say it has been successful and is there a target level of population alcohol consumption we should be aiming for. Scotland, as I finalise this Thesis, has now gained permission from the UK Supreme Court to go ahead and introduce Minimum Unit Pricing for alcohol in 2018. We are the first nation to introduce this and it is predicted this will have a major effect on the health of Scottish people.

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