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“Very Many More Men than Women”:
A Study of the Social Implications of Diagnostics at the South Carolina State Hospital

by

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Abstract

Treatment and understanding of mental illness has vastly changed in the past century and a half, leading many historians and psychiatrists to puzzle over the logic and motivations driving the once-abundant mental institutions known as insane asylums. Though a great deal of literature has emerged in this burgeoning historical field, few have looked at the diagnostics used by psychiatrists of the past to see what they reveal about the former system of mental health. This paper uses the South Carolina State Hospital as a case study to demonstrate how diagnostic trends can be used to understand the gender and racial perceptions that physicians at these institutions applied to their work.

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Chapter 1: Introduction

Treatment and understanding of mental illness has vastly changed in the past century and a half, leading many historians and psychiatrists to puzzle over the logic and motivations driving the once-abundant mental institutions known as insane asylums. Though a great deal of literature has emerged in this burgeoning historical field, few have looked at the diagnostics used by psychiatrists of the past to see what they reveal about the former system of mental health. Psychiatrists made assumptions about their patients' forms of illness based on their gender and race; while this may be overtly frowned upon today, racial and gender assumptions can be traced long after the asylums began to close their doors. In fact, as these assumptions once lay at the heart of turn-of-the-century psychiatry which eventually evolved into the psychiatry of today, they form the origins of current ways of thinking about mental illness. While people with mental illnesses are no longer placed in asylums, psychiatrists and the greater society continue to make assumptions about mental illnesses. An examination of these assumptions can reveal trends that when considered can ultimately be avoided.

The South Carolina Lunatic Asylum, later the South Carolina State Hospital for the Insane and finally simply the South Carolina State Hospital, was a mental institution located in Columbia, South Carolina which ran from its opening in 1821 until its gradual closing from the 1990s into the early 2000s. The only publicly-owned mental facility in

the state, many of its historic buildings still stand on its original campus on Bull Street.¹ Towards the beginning, the institution housed fewer than 200 patients at a time and admitted less than 100 each year. As time progressed, the numbers steadily increased until by 1910, over 600 patients were admitted in a year, and over 1,500 were housed in the asylum at a time. Population increase of this kind was common at mental institutions across the United States.

This asylum left behind a long and detailed paper trail in the form of the institution's annual reports. These reports, currently housed at the South Carolina Department of Archives and History, discussed every facet of the institution's operation, from staff to expenditures to crops gathered from the asylum's patient-staffed farm. They were written by the hospital board, with reports by the superintendent, the head physician, and other authority figures. Though written for city and state officials, the language suggests that they were also intended to be read by professionals at other mental institutions. These booklets generally depict the institution in a positive light, while at the same time expounding upon the needs of repairs and new buildings when necessary.

Of particular interest within these reports are the tables dealing with the "alleged causes of insanity" and "forms of insanity" with which patients were diagnosed (See Figure 1.5). These could be found among a number of statistical tables dividing patients by age, place of residence, marital status, and a number of other factors. Each table divided patients by gender, and following 1882, by race as well. The statistics relating to "causes" and "forms" of insanity can reveal trends in what psychiatrists assumed about

¹ While most of the buildings still stand at the time of this paper's authorship, many have been slated for demolition to make room for a baseball stadium. The ones that will remain standing include the Babcock Building, where white patients were housed during the period examined here, and the Mills Building, where the female African American patients were housed.

patients. When paired with articles from the *American Journal of Insanity* (now the *American Journal of Psychiatry*), the publication of the once well-respected Association of the Medical Superintendents of American Institutions for the Insane, these statistics can be used as a case study to explore the social beliefs that underlay psychiatrists' analyses of mentally ill patients. As the statistics of this kind, exemplified in Figure 1, begin in the annual report for 1874, and diagnostic trends (as well as the annual reports themselves) begin to transform rapidly in the early twentieth century, analysis of these records remain within this time period.²

The following analysis is broken down according to category of cause or diagnosis, after a brief section explaining the differences between causes and diagnoses/forms of illness. The first category explored is “toxic,” or diseases relating to addictive substances; this section examines the link between toxic diseases and white male patients. The second section looks into melancholia, a disease associated with femininity. The third section, on mania, explores the connection of this common diagnosis to African American patients as well as its transition from physicians associating it with female patients to associating it with male patients. The fourth section looks at moral and physical causes, examining the contrast in doctors' associations with African American female and white male patients respectively. This essay concludes by linking these perceptions to those held in the latter half of the twentieth century and beyond.

² The years examined do not include 1875, 1876, 1878, 1880, 1881, 1883 1884, 1887, 1890, 1893, 1899, 1901, and 1904. These years are excluded from this study because the South Carolina Department of Archives and History does not possess copies of these annual reports.

TABLE NO. 12.—ALLEGED CAUSE OF INSANITY OF THOSE ADMITTED DURING THE YEAR.

	Males.		Females.		Total.
	White.	Colored.	White.	Colored.	
Moral:					
Jealousy.....			1		1
Fright.....			1		1
Religion.....	10		0		10
Disappointment in love.....		1			1
Financial embarrassment.....	4		5		9
Family affliction.....	2		4		6
Domestic worry.....	2		8		10
Physical:					
Over-study.....	1		2		3
Paralysis.....			1		1
Ill health.....	14		20		34
Traumatic insanity.....	1		1		2
Malaria.....			1		1
Climacteric.....			1		1
Uterine disease.....			5		5
Fuerperi.....			2		2
Typhoid fever.....	1		1		2
Spirilla.....	1		1		2
Substroke.....			1		1
Heredit.....	13		10		23
Congenital.....	4		4		8
Epilepsy.....	13		8		21
Senility.....	5		2		7
Idiocy.....	1		1		2
Spinal trouble.....	1		1		2
Meningitis.....	1		1		2
Apoplexy.....	1		1		2
Pneumonia.....	1		1		2
Toxic:					
Whiskey.....	13		2		15
Tobacco.....	2				2
Morphine.....	1				1
Unknown.....	52	55	57	72	206
Total.	148	149	141	133	571

TABLE NO. 13.—FORM OF INSANITY OF THOSE ADMITTED DURING THE YEAR.

	Males.		Females.		Total.
	White.	Colored.	White.	Colored.	
Melancholia:					
Acute.....	20	2	45	45	112
Recurrent.....			1		1
Hypochondria.....	1		1		2
Hypochondriac.....			1		1
Chronie.....	2	4	2	5	14
Mania:					
Acute delirious.....			1		1
Acute.....	22	54	22	20	118
Recurrent.....		8	7		15
Chronie.....	1	20	1		22
Hebephrenia.....			1		1
Dementia:					
Terminal.....	12	6	20	11	49
Primary.....	7	5			12
Toxic:					
Whiskey.....	14	1	2		17
Morphine.....	1				1
Tobacco.....	1				1
Circular insanity.....			1		1
Moral insanity.....			1		1
Puerperal insanity.....			3		3
Hysterical insanity.....			3		3
Hysteria.....			2		2
Chorea.....			3		3
Paralytic insanity.....			2		2
Post febrile insanity.....			2		2
Syphilitic insanity.....			2		2
Tenile insanity.....			2		2
Epilepsy.....	22	18	10	9	60
Hyperepilepsy.....			1		1
Paranoid.....	5	5	1	10	21
General paralysis.....	5	5			10
Infantile paralysis.....	1				1
Imbecility.....	1		1		2
Idiocy.....	2		1		3
Senility.....	1		1		2
Myrdem.....	1		1		2
Not insane.....	4		1		5
Total.....	148	149	141	133	571

Figure 1.1: Pages from the Sixty-Fourth Annual Report of the South Carolina Lunatic Asylum for the Year 1887

Overall, the literature on the history of mental illness focuses primarily on the evolution of mental institutions and treatments of mental illness rather than on diagnoses. Michel Foucault's *Madness and Civilization* deals primarily with how madness was understood, contained, and constrained. He examines some illnesses such as mania and melancholia in depth, but focuses more on their origins in the seventeenth and eighteenth centuries; he only describes the historic understandings of how these diseases are physically caused.³ *The Age of Madness*, an anthology of important works in the study of the history of mental illness edited by Thomas Szasz, contains only one work that discusses diagnoses of mental illness in any detail. This is an article from the *American Journal of Insanity* published in 1840, highlighting the fact that more free African Americans are diagnosed with mental illness than are whites and slaves.⁴ *Moonlight, Magnolias, and Madness* by Peter McCandless looks into wider trends of mental illness in South Carolina both within the institution and the larger Columbia community. McCandless tracks the evolution of treatment with a strong emphasis on racial disparities, but he does not delve into the changes in the diagnoses themselves.⁵ *Man Above Humanity* by Walter Bromberg also focuses primarily on treatment rather than diagnostics, though he does include a small discussion on causes of mental illness.⁶ These works sometimes touch upon social conceptions of madness, but the changes in the

³ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (New York: Random House, Inc., 1965), 117-135.

⁴ Thomas Szasz, ed., *The Age of Madness: The History of Involuntary Mental Hospitalization Presented in Selected Texts* (Garden City, N.Y.: Anchor Press, 1973), 43-46.

⁵ Peter McCandless, *Moonlight, Magnolias, and Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era* (Chapel Hill: The University of North Carolina Press, 1996).

⁶ Walter Bromberg, *Man Above Humanity: A History of Psychotherapy* (Philadelphia: J.B. Lippincott Company, 1954), 110-111.

diagnoses themselves are not explored in depth; nor does the literature frequently look into the social implications of these diagnoses. The following case study explores diagnostic trends at the South Carolina State Hospital, examining how preconceptions about gender and race affected what physicians saw to be the causes and forms of illnesses in patients.

Chapter 2: Causes and Forms

The analysis below includes both causes and forms of mental illness. As shown above, these are two separate categorizations within the annual reports, though they are both technically diagnoses given to each patient. As Bromberg explains, “the nature of insanity [was thought of] as the response of human nature to life’s injuries.”⁷ For this reason, physicians believed that each patient’s illness could be traced back to a specific cause, whether physical or mental (both discussed in greater detail below). The form of mental illness was the disease itself that doctors considered a patient to have. For the sake of clarity, the term “diagnosis” will only be used in this essay to refer to forms of mental illness.

⁷ Bromberg, *Man Above Humanity*, 111.

Chapter 3: Toxic

In the eyes of the asylum staff, male and white patients were far more susceptible to “toxic” diseases than their female or African American counterparts. Diseases classified as toxic were those linked to the use of alcohol (particularly whiskey), tobacco, morphine, cocaine, opium, and other drugs. Later, pellagra and goitre were included as well. Pellagra and goitre are not discussed in detail below despite their institutional classification as “toxic” beginning in 1909 because they do not relate to addictive substances, as do the other diagnoses.⁸

The most notable toxic disease stemmed from the consumption of alcohol. It was listed first as “intemperance” or “alcohol habit”; then lumped into the overarching titles of “toxic” and “toxic insanity”; later separated and briefly labeled “inebriety”; and finally labeled solely as “whiskey.” Intemperance was in fact the only toxic cause or form of disease listed before 1877, when “opium eating” was first reported as a cause of mental illness (for a single female patient). Even after this, intemperance was the most consistently listed cause of insanity in the “toxic” category.⁹

⁸ While it is unclear why these diseases were classified as “toxic,” there is the possibility that they exhibited similar symptoms to diseases relating to addictive substances.

⁹ *Annual Report of the South Carolina Lunatic Asylum, 1874-1908* (various printers), Mental Health Commission Annual Reports of the South Carolina Department of Mental Health, Boxes 1 and 2, South Carolina Department of Archives and History, Columbia, South Carolina.

The majority of the patients that physicians assigned with intemperance were male, as demonstrated in Figures 3.1 and 3.2. As many as 11.9 percent of male patients had intemperance listed as their cause of illness, and doctors diagnosed as many as 8.0 percent of males with intemperance. On the other hand, doctors diagnosed female patients with this disease rarely if at all; physicians only listed 0.9 percent of female patients as having intemperance as their cause of illness at one time, and never diagnosed more than 0.4 percent of female patients with intemperance as their form of insanity.¹⁰

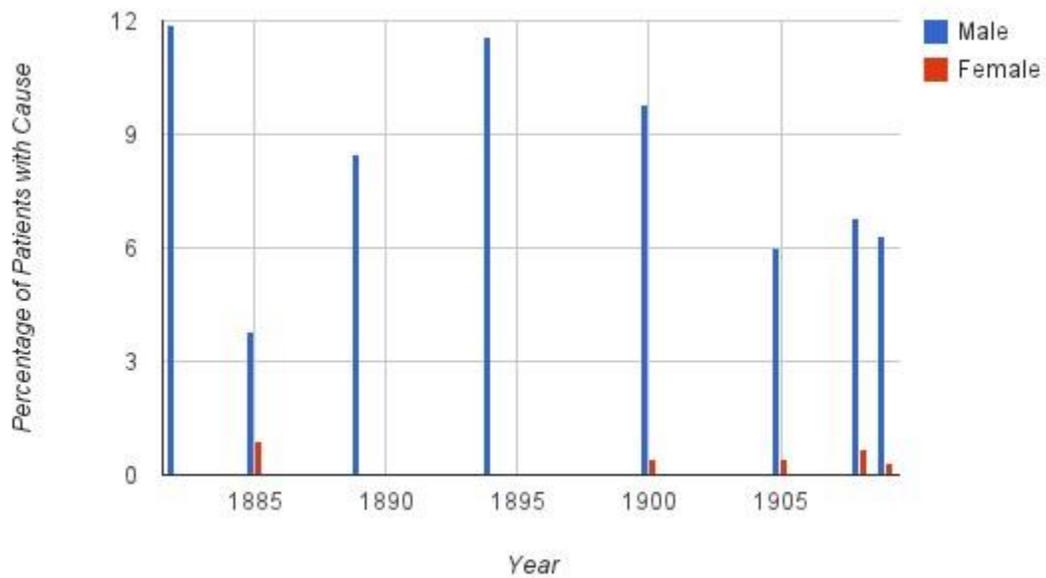


Figure 3.1: Intemperance by Gender, Cause

¹⁰ Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

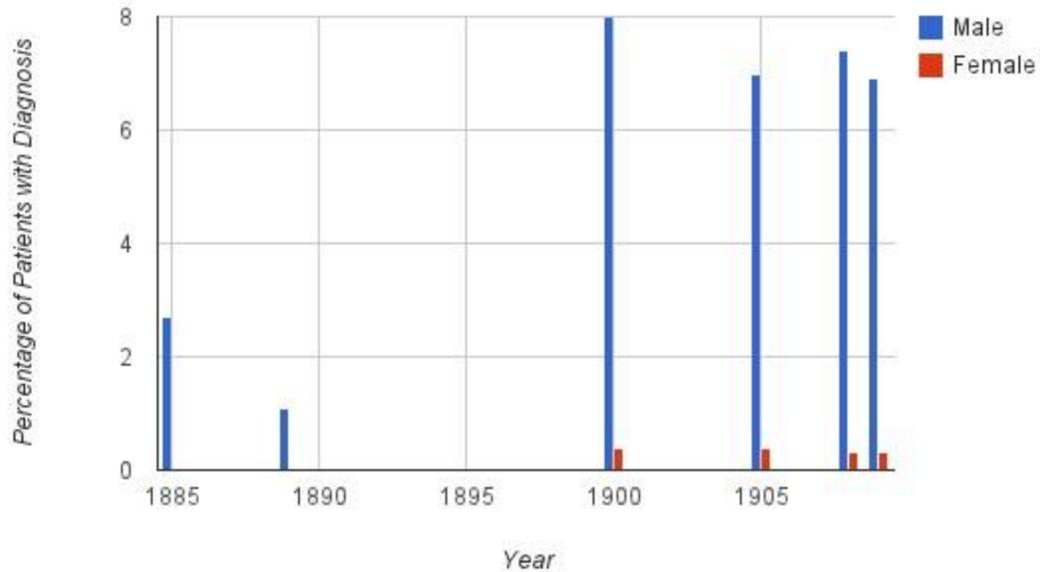


Figure 3.2: Intemperance by Gender, Form

An explanation for this trend can be found in an article in the *American Journal of Insanity* written by Edward Jarvis, an American physician and Harvard graduate who practiced in Concord, Massachusetts; Louisville, Kentucky; and Dorchester, Massachusetts.¹¹ Jarvis describes certain causes and diagnoses as more aligned with males and others as more aligned with females; he also outlines the reasons for this being so. According to Jarvis, “men [had] stronger passions and more powerful appetites and propensities...[which were] more powerful and uncontrollable.”¹² Because mentally ill men had less self-control than women, Jarvis claims, they were more susceptible to substance abuse. He also attributes the greater number of alcoholic men to a greater

¹¹ “Edward Jarvis Papers, 1796-1886 (Bulk 1822-1844).” Finding aid at The Concord Free Public Library, Concord, MA. http://www.concordlibrary.org/scollect/fin_aids/Jarvis_E.htm.

¹² Edward Jarvis, “On the Comparative Liability of Males and Females to Insanity, and their Comparative Curability and Morality When Insane,” *American Journal of Insanity* 7, no. 2 (1850): 150.

exposure of men to alcohol.¹³ According to his logic, it then follows “that very many more men than women [were] addicted to [intemperance], and by a necessary consequence, it produce[d] more lunacy among males than females.”¹⁴ Jarvis’ observations, while not in line with the beliefs of psychologists today, would have been accepted by his contemporaries, or even seen as innovative.

In addition, physicians diagnosed a larger proportion of white than African American patients with intemperance as their cause or form of insanity (shown in Figures 3.3 and 3.4). Doctors deemed as many as 9.4 percent of white patients intemperate as their cause of illness. While the proportion of white patients with this cause reached as low as 0.1 percent (in 1889), in most years it did not drop below 3.9 percent. Similarly, white patients diagnosed with intemperance comprised as many as 7.7 percent of the total white patient population, and only fell to as low as 1.4 percent (also in 1889). On the other hand, the largest proportion of African American patients that physicians deemed to have an intemperate cause of mental illness was 3.4 percent (in 1894 and 1900), and in some years, doctors enumerated no African American patients as having this cause. Doctors diagnosed at most 3.4 percent of African American patients with intemperance as their form of illness, and in several years, they gave no African American patients this diagnosis.¹⁵

¹³ Jarvis, “On the Comparative Liability of Males and Females to Insanity,” 161.

¹⁴ Jarvis, “On the Comparative Liability of Males and Females to Insanity,” 156.

¹⁵ Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

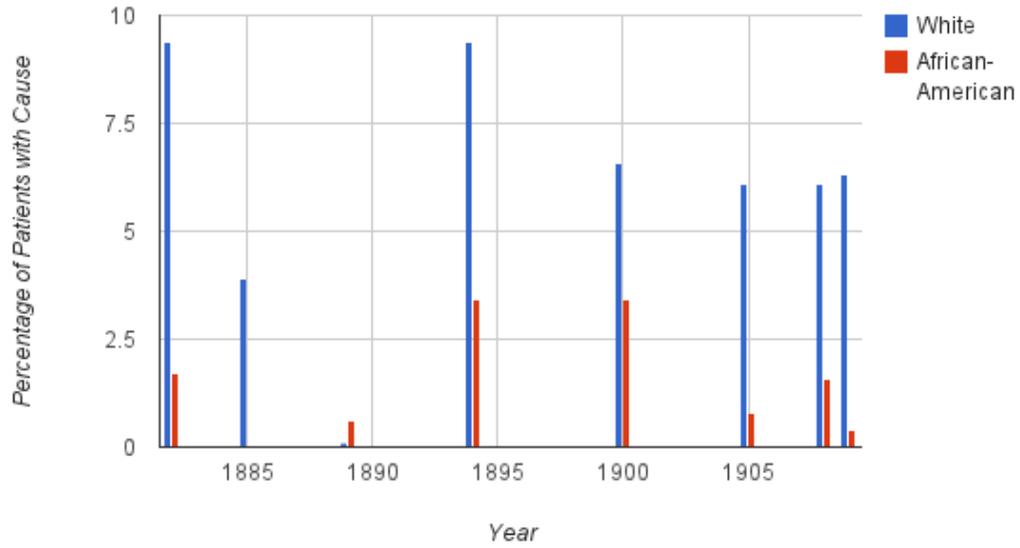


Figure 3.3: Intemperance by Race, Cause

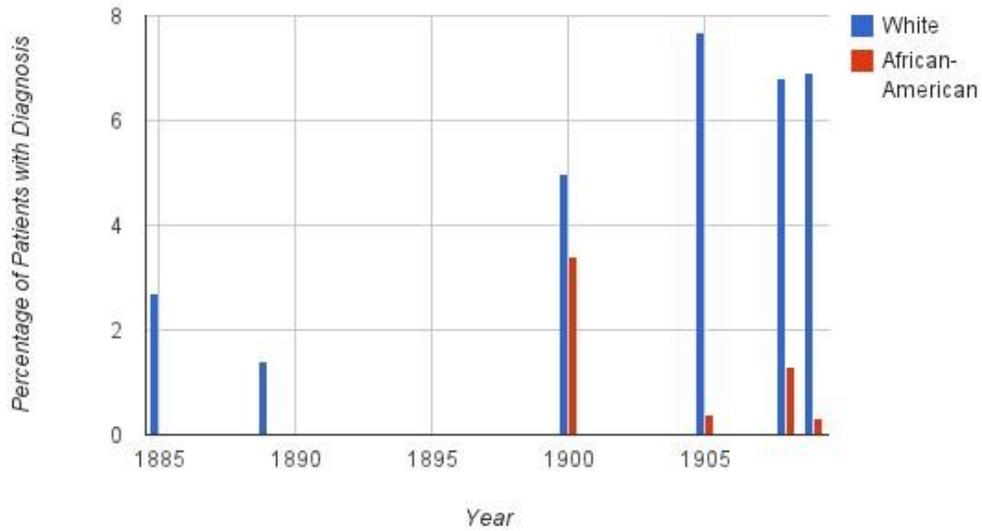


Figure 3.4: Intemperance by Race, Form

As illustrated by the above statistics, physicians considered intemperance to be a white disease. Race is rarely explicitly discussed in the *American Journal of Psychiatry*, but the parallels between the percentages of female and African American patients

associated with intemperance indicate that psychiatrists viewed female patients of either race and African American patients of either gender similarly. Like females, African Americans were considered to be more emotionally fragile, but more capable of resisting vices. Though African American men may have had more exposure to alcohol than did all women (or so doctors assumed), on the whole, doctors did not expect African American patients to so easily succumb to intemperance, expecting these patients instead to fall prey to mental illness in other forms.

Other toxic causes and diagnoses fingered narcotics, cocaine, tobacco, morphine, and other drugs. Physicians assigned these less frequently than intemperance, but they still held a majority of white male patients, with the exception of two years in which physicians blamed cocaine for insanity in female patients only.¹⁶

The similarities in the statistics relating to toxic causes and diagnoses imply that the assumptions made by Jarvis about intemperance can be applied to other toxic causes and diseases as well. According to the thinking of the time, men's strong and uncontrollable urges led them not only to consume alcohol, but to use morphine, tobacco, cocaine, and opium as well; unlike mentally ill women, who were "less given to sensual indulgence," mentally ill men were less capable of resisting addictive substances.¹⁷ In addition, women were not exposed to illicit substances with the frequency that men were, or so doctors thought, making women by necessity less likely to fall prey to toxic illnesses. African American patients, whom doctors saw on the whole as equally

¹⁶ *Annual Report*, 1874-1908 (various printers).

¹⁷ Jarvis, "On the Comparative Liability of Males and Females to Insanity," 150.

emotionally fragile as women, were more emotional but less susceptible to mental illnesses relating to the consumption of toxic substances.

Chapter 4: Melancholia

Melancholia, a commonly-diagnosed disease throughout the early twentieth century, was regarded by psychiatrists of the time as a feminine disease. This disease, though originally a single diagnosis, later became an entire category split into many separate diagnoses, including acute, sub-acute, recurrent, hypochondriacal (relating to concern over health), chronic, senile, and puerperal (following childbirth).¹⁸ Over the period covered in this paper, the use of the term “melancholia” changed greatly, and some believed by the late nineteenth century that it was altogether inaccurate and outdated, preferring the term “lypemia.”¹⁹ However, as “melancholia” is the term used in the annual reports until 1909, and the term “lypemia” is never mentioned, melancholia will be used here to refer to this common diagnosis.²⁰ An article in the January 1855 issue of the *American Journal of Insanity* describes a “melancholic” as “feeble, timid, and irresolute; his life is passed in inaction and silence, and his conceptions are slow and embarrassed.”²¹ Although these traits align most closely with what is defined as depression today, it would be an oversimplification to assimilate

¹⁸ *Annual Report, 1874-1908* (various printers).

¹⁹ “Billod on the Classification and Semiology of Various Forms of Lypemia,” *American Journal of Insanity* 13, no. 2 (1856): 185-86.

²⁰ *Annual Report, 1874-1908* (various printers).

²¹ Baillarger, “Baillarger and Falret on a New Species of Insanity,” *American Journal of Insanity* 11, no. 3 (1855): 230.

melancholia under this twenty-first century term; rather, the above-mentioned characteristics will serve as a definition of melancholia for the purposes of this paper.

Physicians diagnosed a far greater number of female patients as melancholic than male patients, as illustrated in Figure 4.1. Each year, doctors diagnosed more than 12 percent of female patients with melancholia. The percentage of male patients, on the other hand, went as low as 2.9 percent, one-seventh of the percentage of female patients diagnosed as melancholic in that same year. The percentage of male patients diagnosed with melancholia exceeded the percentage of female patients only once, in 1889, and then by only 1.8 percent. Doctors diagnosed as many as 39.7 percent of female patients with melancholia in one year (1905), while the largest proportion of male patients diagnosed with this disease in one year was 24.8 percent (in 1902).²²

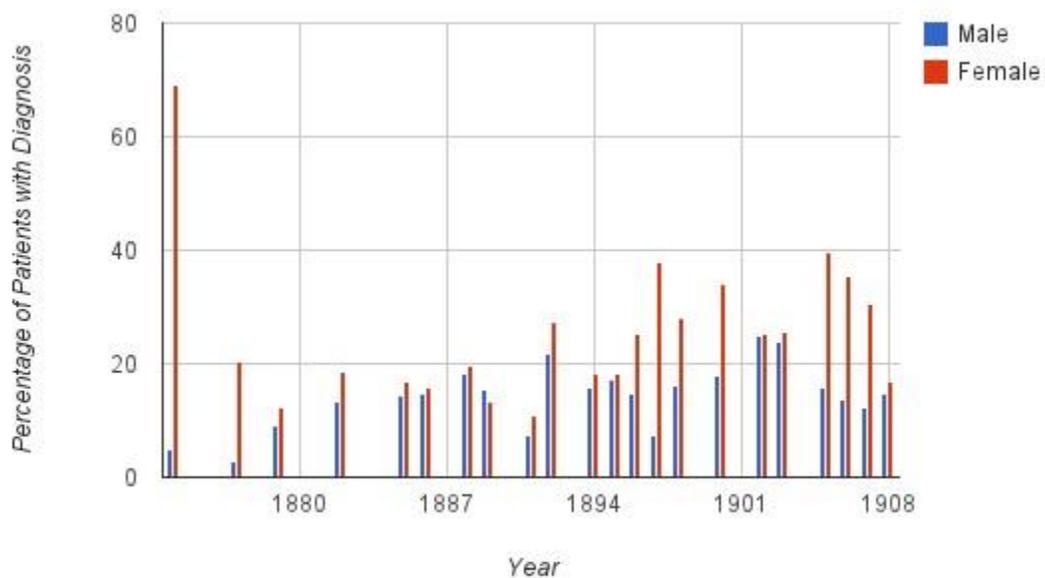


Figure 4.1: Melancholia by Gender

²² Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

The fact that physicians diagnosed a larger proportion of female patients with melancholia than male patients, as well as the association of some forms of melancholia with childbirth, indicate that this disease was viewed as a feminine disease. Because certain forms of melancholia (namely puerperal melancholia and the later involution melancholia) were considered to be directly linked to childbirth, there was a clear connection between those forms of melancholia and womanhood. Although doctors frequently diagnosed men with melancholia as well, the connection to the womb indicates a psychiatric association with femininity; men diagnosed with this disease may have been considered effeminate for the symptoms they displayed. The fact that the term melancholia came to be assigned only to a birth-related disease further demonstrates this disease's association with femininity.

Statistical analysis relating to the diagnosis of melancholia does not stretch beyond 1908 because the diagnosis of melancholia was not listed after 1908, with the exception of involution melancholia.²³ Doctors only assigned this new diagnosis to females, as it related to the shrinkage of the uterus after childbirth.²⁴ It is unclear if physicians developed a male or gender-neutral equivalent at the time, as the year 1909 saw a great change in the terms used for diagnoses. For instance, the term “psychosis” began to be used as a replacement for “insanity” (as in “senile psychosis” and “epileptic psychosis”), and new forms of disease such as “infective exhaustive” and “manic depressive” were additionally listed.²⁵ As an “indefinite symptom-complex” made up of

²³ *Annual Report, 1909-1910* (various printers).

²⁴ *Oxford Dictionaries*, online ed., s.v. “Involution.”

²⁵ *Annual Report, 1909-1910* (various printers).

symptoms of both mania and melancholia, manic depressive cannot be interpreted as a new gender-neutral term for melancholia, since patients with this disorder also exhibited symptoms of mania.²⁶

Psychiatrists of the day considered melancholia and mania to be opposite diseases. Whereas melancholics were characterized by weakness, slowness, and hopelessness, maniacs were seen to be full of energy, confidence, and dauntlessness.²⁷ As Foucault notes, psychiatrists of the day believed “melancholia...is always accompanied by sadness and fear; on the contrary, in the maniac [they found] audacity and fury.”²⁸ Despite their opposition, psychiatrists found links between the two. An article from the *American Journal of Insanity* describes that “in many, indeed in most cases melancholia follows mania, and *vice versa*, as if there were a secret union between these two diseases.”²⁹ The term mania was not used in any diagnosis after 1908. It would follow, then, that “manic depressive” was created as a new category of disease to account for this “secret union” in which symptoms of both mania and melancholia were most often exhibited together.

It is likely that the term “insanity” was phased out in favor of “psychosis” because of a shift in the field of psychology away from old conceptions of mental illness to a more scientific approach.

²⁶ Stewart Paton, “Studies in the Manic-Depressive Insanity, with Report of Autopsies in Two Cases,” *American Journal of Insanity* 58, no. 4 (1902): 679.

²⁷ Baillarger, “Baillarger and Falret on a New Species of Insanity,” 230.

²⁸ Foucault, *Madness and Civilization*, 125.

²⁹ Baillarger, “Baillarger and Falret on a New Species of Insanity,” 230.

Chapter 5: Mania

Doctors primarily associated mania with African American patients; in the beginning, they also associated it with female patients, but later associated mania instead with male patients. Like melancholia, mania was until 1909 split into a number of categories: acute, acute delirious, recurrent, chronic, hebephrenia, simple, puerperal, epileptic, hysterical, parietic, syphilitic, and suicidal.³⁰ Patients were diagnosed with acute, recurrent, and chronic mania nearly every year before 1909.³¹ Doctors diagnosed epileptic mania for six years, and hysterical mania for seven.³² The year in which hysterical mania disappeared was the same year in which hysteria appeared as a disease outside of the category of mania.³³ Doctors diagnosed epileptic insanity both in the years preceding and following the diagnosis of epileptic mania, but not during these years.³⁴ As these two diseases formed their own separate categories that could easily be analyzed distinct from mania, they will not be counted in the statistics below. Syphilitic mania also

³⁰ *Annual Report*, 1874-1908 (various printers).

³¹ *Ibid.*

³² *Annual Report*, 1882-1892 (various printers).

³³ *Seventieth Annual Report of the South Carolina Lunatic Asylum for the Fiscal Year 1892-93* (Columbia, SC: Charles A. Calvo, Jr., State Printer, 1893).

³⁴ *Annual Report*, 1874-1908 (various printers).

will not be counted in these statistics as it was only diagnosed in two years, and is similarly listed in other years as “syphilitic insanity.”³⁵

Physicians diagnosed proportionately more African American patients with mania than white patients each year, as demonstrated in Figure 5.1. Starting in 1882, when the statistics were first divided by race as well as gender, the proportion of African American manic patients exceeded the white proportion by at least 2.7 percent. Doctors diagnosed as many as 55.8 percent of African American patients with mania (in 1891), whereas the highest percentage of white patients diagnosed was 42.3 percent (in 1886 and 1888). The proportion of white patients that physicians diagnosed with mania gradually decreased over time, while that of African American patients stayed the same. After 1896, the percentage of manic white patients never rose above 20 percent, whereas in African American patients, it never fell below 26.3 percent.³⁶

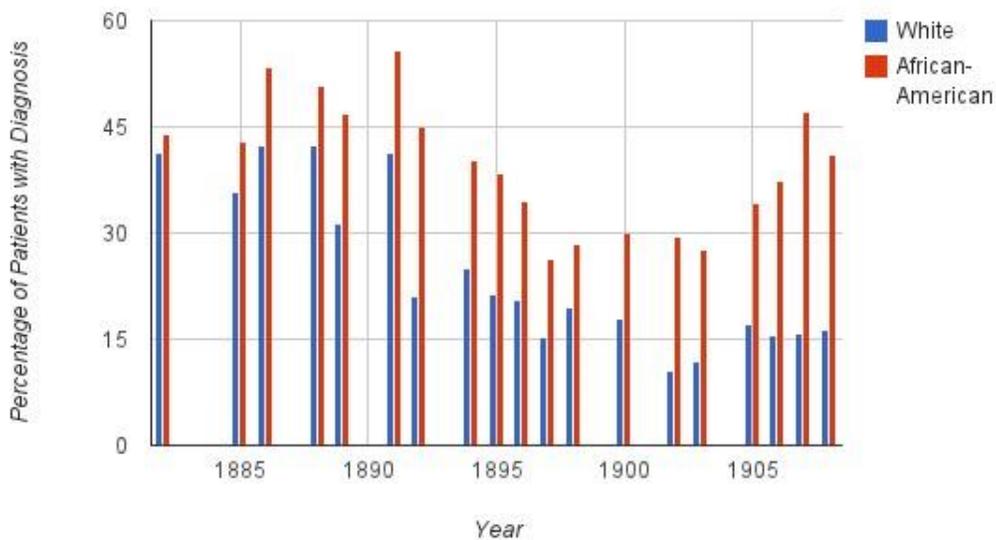


Figure 5.1: Mania by Race

³⁵ *Annual Report*, 1879, 1882, 1895-1908 (various printers).

³⁶ Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

While as previously mentioned, race is rarely discussed in the *American Journal of Insanity*, an article from 1914 does discuss mania in African American patients in regards to manic depression. The author, Senior Assistant Physician at the Government Hospital for the Insane in Washington, D.C., refers to past discussions of mania, saying that “writers...have asserted that ‘mania’ is the most common form of mental disease observed in the colored people.”³⁷ She goes on to explain that this diagnosis is logical because “the colored race is of a highly emotional nature, with little capacity for selfcontrol.”³⁸ In other words, African American patients were particularly susceptible to mania because of the volatile, reactive, and at times obsessive behaviors associated with the disease.

Because of the “secret union” between the diseases, if doctors originally diagnosed more female patients than male patients with mania as well as melancholia, it should follow that more African American patients than white patients would be diagnosed with melancholia as well as mania. However, physicians did not diagnose either white or African American patients remarkably more frequently with melancholia. The question remains why doctors diagnosed female patients frequently with both mania and melancholia while African American patients were only frequently diagnosed with mania. The answer lies in the timidity of melancholic patients. As mentioned above, African American patients were believed to be overly emotional by nature, making them less susceptible to a disease associated with quietness and timidity. In addition, African American patients later diagnosed with manic depression, what seems to have been the

³⁷ Mary O’Malley, “Psychoses in the Colored Race: A Study in Comparative Psychiatry,” *American Journal of Insanity* 71, no. 2 (1914): 323.

³⁸ O’Malley, “Psychoses in the Colored Race,” 323.

combination of the two diseases, often saw “phases of excitement,” but “if there [was] a depressive phase it [was] not always recognized.”³⁹

While at first, doctors diagnosed female patients with mania more frequently than male patients, by 1905, they diagnosed a greater proportion of male patients with this disease than female patients, as shown in Figure 5.2. From 1874 to 1903, the proportion of manic female patients exceeded that of manic male patients in each year except 1895. The highest proportion of female patients with this diagnosis was 54.0 percent in 1891. In 1894, physicians diagnosed 41.6 percent of female patients with mania; after that, the proportion never exceeded 30.3 percent. While male patients reached their peak of mania diagnosis in 1888 (46.3 percent), the percentage of male patients was at least 6.6 percent larger than the percentage of female patients from 1905 to 1908, the last year doctors used any diagnosis of mania besides “manic depressive.” Before 1905, the proportion of female patients exceeded the proportion of male patients by as little as 0.3 percent.⁴⁰

Before its transition in 1905 to a greater rate of diagnosis of mania in male patients, doctors saw this disease, like melancholia, as feminine. As the opposite of melancholia, it would be logical to assume that physicians diagnosed male patients with mania more frequently than female patients. However, the “secret union” between these two diseases as mentioned above suggests that doctors were more likely to diagnose female patients with mania simply because they were also more likely to diagnose these patients with melancholia.

³⁹ O’Malley, “Psychoses in the Colored Race,” 326.

⁴⁰ Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

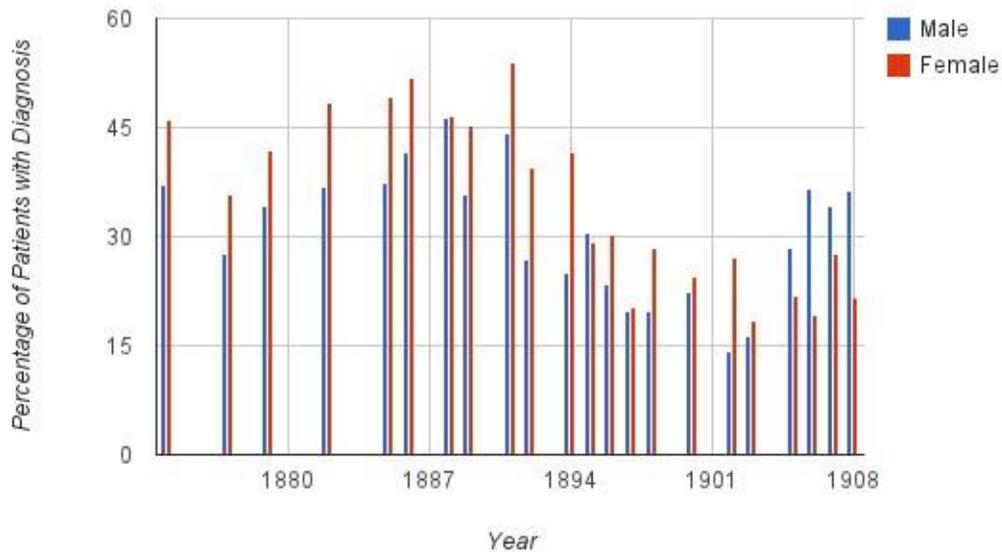


Figure 5.2: Mania by Gender

The shift from physicians diagnosing higher proportions of female patients with mania to diagnosing higher proportions of male patients with this disease indicates a transformation in the understanding of mania. While originally male patients were not diagnosed with mania as frequently because of its association with melancholia, a feminine disease, the larger proportion of male patients with this diagnosis that came later indicates that mania later became a masculine disease. Doctors came to view mania as masculine for the same reasons that melancholia was not: men, like African American patients across the board, were considered to be more passionate and less self-controlled, attitudes more aligned with mania in contrast to the quiet and somber nature of melancholia.⁴¹ While at first, the “secret union” between these diseases caused both to be

⁴¹ Jarvis, “On the Comparative Liability of Males and Females to Insanity,” 150.

viewed as feminine, ultimately, their nature as opposites caused physicians to associate them with opposite genders.

Chapter 6: Moral and Physical

In 1894, two categories of causes of mental illness emerged: “moral” and “physical.”⁴² Moral causes could be best described as emotional disturbances; examples included fright, financial embarrassment, jealousy, domestic affliction, and worry. Physical causes were far more numerous than moral causes, and included such diverse causes as insomnia, malaria, masturbation, and injury by falling from train.⁴³ The statistics below include the years preceding 1894, calculated using totals from causes that follow the categorization themes of the later years.

Though at first doctors included toxic causes within the category of physical, in 1903 they made these causes into a separate category.⁴⁴ Because of this, and because of the discussion of toxic causes and diagnoses above, the statistics below will not include toxic causes such as inebriety and opium habit. Also not included below are “overstudy” and “pellagra.” Overstudy was listed in both moral and physical categories depending on the year, and was omitted for the sake of continuity.⁴⁵ Out of the years examined, pellagra

⁴² *Seventy-First Annual Report of the South Carolina Lunatic Asylum, for the Fiscal Year 1893-94* (Columbia, SC: Charles A. Calvo, Jr., State Printer, 1894).

⁴³ *Annual Report, 1894-1908* (various printers).

⁴⁴ *Eightieth Annual Report of the South Carolina State Hospital for the Insane, for the Year 1903* (Columbia, SC: The State Company, State Printers, 1903).

⁴⁵ *Annual Report, 1874-1908* (various printers).

appeared only in 1908 and 1909; in 1908, it was listed as physical, and in 1909, outside of all categories, leading it to be omitted for the sake of continuity as well.⁴⁶

Doctors heavily linked moral causes to African American patients, as demonstrated in Figure 6.1. Doctors designated causes in this category to as many as 24.8 percent (in 1894) of African American patients, and they deemed no fewer than 11.9 percent of African American patients to have illnesses with moral causes in any year. On the other hand, the percentage of white patients that physicians said were driven insane by moral causes never rose above 18.8 percent, and it went as low as 6.6 percent (in 1900). The proportion of African American patients exceeded that of white patients by as many as 10.3 percent (in 1903). Only in 1898 did the proportion of white patients exceed that of African American patients, and then only by 1.7 percent.⁴⁷

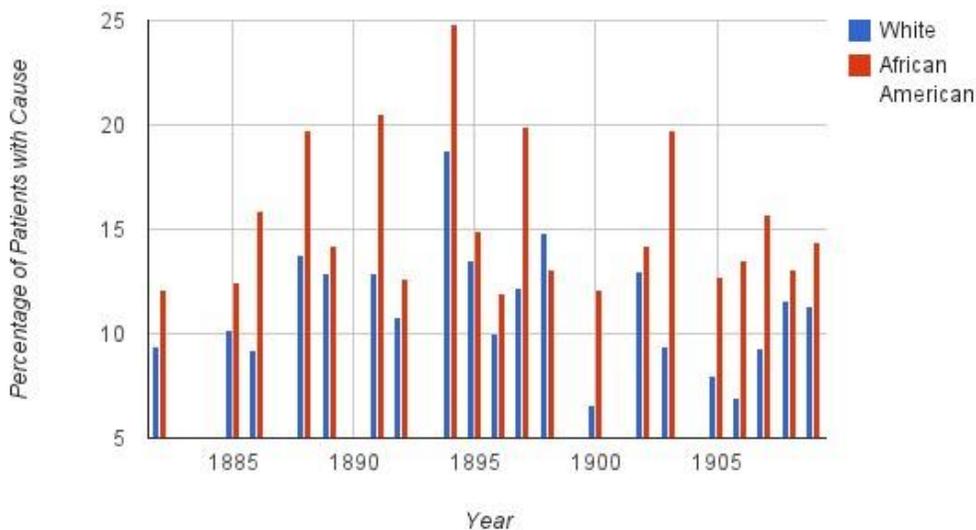


Figure 6.1: Moral by Race

⁴⁶ *Eighty-Fifth Annual Report of the South Carolina State Hospital for the Insane for the Year Nineteen Hundred and Eight* (Columbia, SC: Gonzales and Bryan, State Printers, 1908); *Eighty-Sixth Annual Report of the South Carolina State Hospital for the Insane for the year Nineteen Hundred and Nine* (Columbia, SC: Gonzales and Bryan, State Printers, 1909).

⁴⁷ Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

The above statistical analysis indicates that psychiatrists of the day saw moral causes as linked to African American patients. As mentioned above in the discussion of toxic causes, physicians saw the fragile nature of African American patients as leading them to be more susceptible to diseases with similar causes to those of female patients. While the description above of mania indicates that physicians believed that African American patients exhibited more masculine and higher-energy symptoms in their mental illness, this does not preclude the causes of the illnesses from being linked to emotional fragility; after all, these patients were believed to be “of a highly emotional nature,” as quoted above.⁴⁸

Doctors also more frequently assigned female patients with moral causes than male patients, as illustrated by Figure 6.2. Physicians assigned moral causes to no less than 10.1 percent of female patients within this period, and they deemed as many as 48.4 percent of female patients to have these causes. By contrast, doctors assigned as few as 8.0 percent of male patients with moral causes, and the largest percentage of male patients assigned these causes was 27.9 percent in 1894. This happened to be one of the only two years in which the proportion of male patients with moral causes exceeded that of female patients, the other being 1892. While the percentage of male patients assigned with moral causes exceeded the percentage of female patients by 14 percent in 1894, in the overwhelming majority of years, the percentage of female patients was larger.⁴⁹

⁴⁸ O'Malley, “Psychoses in the Colored Race,” 323.

⁴⁹ Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

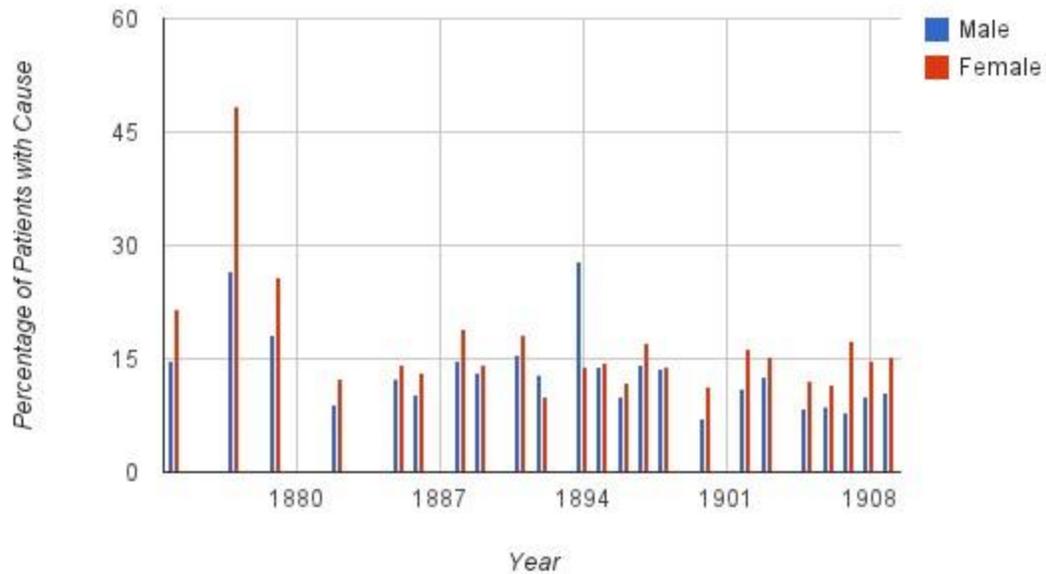


Figure 6.2: Moral by Gender

This majority of female patients assumed to have moral causes of their insanity indicates that physicians considered moral causes of insanity to be feminine. As described in Jarvis’ article, “women [were] more under the influence of the feelings and emotions.”⁵⁰ Like African American patients on the whole, female patients were more affected by their emotions than male patients. Because of this, moral causes, or causes relating to emotional disturbances, would be the most likely to force women into insanity, and thus could be best understood by physicians of the day as feminine. McCandless cites one student from South Carolina College’s description of a visit to the asylum, where he found that “The women were much worse than the men; some dancing, some walking

⁵⁰ Jarvis, “On the Comparative Liability of Males and Females to Insanity,” 150.

about, and others just raving. The men were all very calm.”⁵¹ Even outsiders to the asylum perceived female patients to be more emotional than male patients.

Contrary to moral causes, doctors primarily linked physical causes to white patients, as shown in Figure 6.3. The proportion of male patients assigned with physical causes never dropped below 37.8 percent (in 1902), and rose to as high as 76.6 percent (in 1885). Physicians deemed no more than 64.8 percent and as few as 23.1 percent of African American patients to have mental illnesses with physical causes. The percentage of African American patients with these causes exceeded the percentage of white patients in only two years: 1882 (by 0.3 percent) and 1896 (by 11.3 percent). While the difference in 1896 may seem extraordinarily high, it is important to note that in most years, the percentage of white patients labeled with these causes exceeded the percentage of African American patients by as many as 22.8 percent (in 1908).⁵²

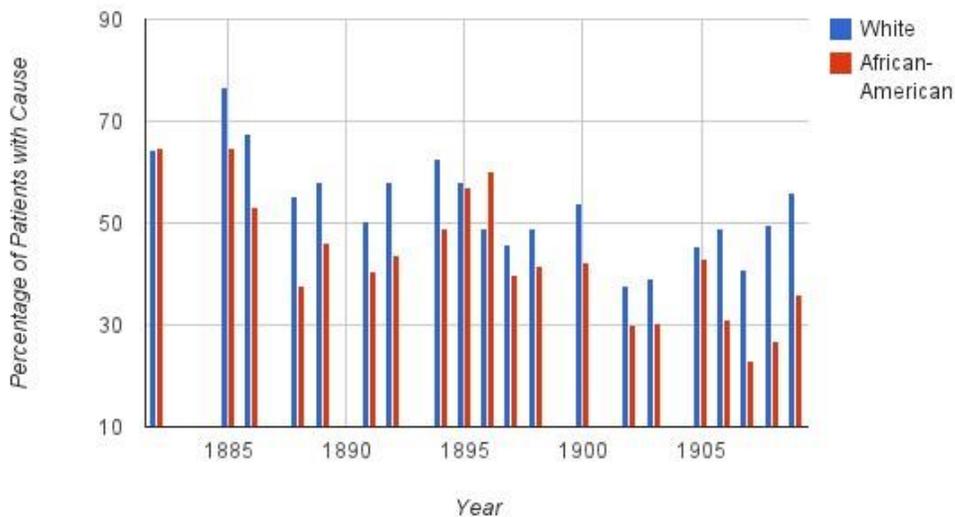


Figure 6.3: Physical by Race

⁵¹ McCandless, *Moonlight, Magnolias, and Madness*, 101.

⁵² Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

Doctors expected white patients to have mental illnesses caused by physical sources more frequently than African American patients because they saw African Americans as less emotionally stable than whites. To physicians of the day, an emotional upset like the ones listed as moral causes were reason enough for an African American patient to contract insanity. White patients, on the other hand, required a more substantial reason such as a physical illness or bodily trauma in order to fall to mental illness.

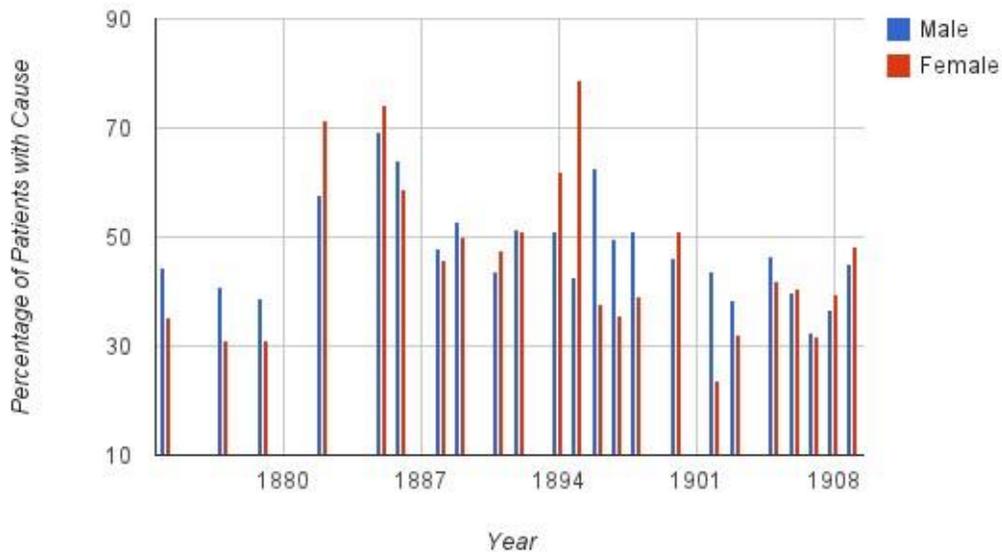


Figure 6.4: Physical by Gender

Physicians deemed a larger proportion of males than females to have been driven insane by physical causes (shown in Figure 6.4). Doctors considered as many as 69.2 percent of male patients to have physical causes in each year; the percentage of male patients with physical causes never fell below 32.6 percent (in 1907). By contrast, the percentage of female patients with physical causes dropped as low as 23.8 percent (in 1902). While in some years, the percentage of male patients exceeded the percentage of

female patients by as little as 0.3 percent (in 1892), in other years, this difference increased to as many as 25.1 percent (in 1896).⁵³

Only in about two-thirds of the years examined did physicians diagnose a larger percentage of male than female patients with physical causes. The reason for this most likely lies in the types of physical causes that psychiatrists assigned to patients. Many physical causes could only be experienced by female patients, due to their relation to female reproductive organs. These included abortion, childbirth, menopause, menstrual suppression, pregnancy, puerperal disease, and uterine disease.⁵⁴ These causes were not omitted from the statistical analysis above because they form an integral part of the physical category; despite them, there is still a majority proportion of male patients with physical diagnoses, though not as overwhelming as it may be without them.

According to this case study, physicians generally viewed physical causes of illness as masculine, contrasting to the femininity of moral causes. Overall, doctors of the time considered men to be more physical, while women were linked more closely with their emotions. According to Jarvis, “the position of women expose[d] them less to many of the causes of insanity, such as...accidents and injuries.”⁵⁵ According to physicians, much in the way that they were less likely to suffer from intemperance, women were less likely to have a mental illness because of a physical trauma simply because they did not find themselves in a position that would lead to physical trauma as often as men did. The year 1910 saw a complete rearrangement of listed causes, much in the way that 1909 saw

⁵³ Percentages synthesized from *Annual Report*, 1874-1908 (various printers).

⁵⁴ *Annual Report*, 1874-1908 (various printers).

⁵⁵ Jarvis, “On the Comparative Liability of Males and Females to Insanity,” 151

a largely new set of diagnoses. The moral category came to have four listings that were broadly categorical in their own right: “adverse conditions”; “mental strain, worry, overwork”; “fright, nervous excitement”; and “religious excitement.” The physical category continued to have more causes listed within it than the moral category, but many of them became more encompassing, such as “disease of skull and brain”; “epidemic diseases”; and “all other bodily disorders, ill health.”⁵⁶ It appears that the period between 1908 and 1910 was a turning point in psychiatric views on cause and diagnosis of illness at the South Carolina State Hospital for the Insane.

⁵⁶ *Eighty-Seventh Annual Report of the South Carolina State Hospital for the Insane for the year 1910* (Columbia, SC: Gonzales and Bryan, State Printers, 1910).

Chapter 7: Conclusion

As demonstrated above, physicians heavily linked causes and diagnoses of mental illness at the South Carolina State Hospital for the Insane to their contemporary perceptions of gender and race. They believed that men had powerful urges to which they often succumbed, and that women were timid and fragile creatures not often exposed to the harsher elements of the world. While white patients were expected to be emotionally stable enough to frequently withstand moral causes of mental illness, doctors saw African American patients as emotionally volatile and overly excited in the symptoms they exhibited. Though a large percentage of patients in each year were listed as having unknown causes of illness, those for which physicians did find a cause inadvertently demonstrated the physicians' own social views. Ultimately, physicians saw patients as belonging to two categories: white male patients, who were more prone to physical causes of mental illness, and who were apt to succumb to addictive substances and thus contract toxic illnesses; and all female and African American patients, whose emotional natures left them more susceptible to mental causes and who were more likely to contract melancholia or mania.

After the State Hospital at Bull Street met its slow demise in the late twentieth century, it seemed that mental illness had become invisible in Columbia. In reality, patients had simply moved from the asylum to the streets. Though no longer locked in unsanitary facilities, many mentally ill people are ultimately left untreated, or at the very

least suffer from various stigmas. These stigmas are not without racial and gendered assumptions. In his book *The Protest Psychosis*, Jonathan Metzl, professor of psychology and sociology at Vanderbilt University, uses the high rate of diagnosis of African American male patients with schizophrenia to explore the implications of race on both white perceptions of mentally ill African Americans and African Americans' own perceptions of the discrimination they face. Metzl acknowledges that "race should be entirely unimportant to psychiatric diagnosis," but uses examples of protest throughout the twentieth century to understand how racial tensions form doctors' and patients' perceptions of mental illness prior to diagnosis.⁵⁷

Before the time of Metzl's study and even before the period of this essay, authors were already pointing out racial disparities in diagnoses. An article in Szasz's anthology published in 1840 which he titles "Madness and Blackness," cites an "amazing prevalence of insanity and idiocy among our free colored population over the whites and the slaves."⁵⁸ The article provides a chart listing the total racial population of each state (white and African American), the population of mentally ill people of each race in the state, and the proportion of mentally ill people among the total racial population. The article's author emphasizes that the proportion of free African Americans was far greater in each state than the proportion of both whites and enslaved African Americans. This data could be used as evidence to apply Metzl's argument of racial disparity affecting perceptions of mental illness even before the abolition of slavery. As Metzl's book and Szasz's anthology demonstrate, the racial perceptions examined above were not confined

⁵⁷ Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston: Beacon Press, 2009), x-xi.

⁵⁸ "Startling Facts from the Census," in *The Age of Madness*, ed. Szasz, 45.

to the late nineteenth and early twentieth centuries, but have carried on through the end of the twentieth century and, more than likely, still continue today.

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