THE "MORAL TREATMENT" OF INSANITY:

A STUDY IN THE SOCIAL CONSTRUCTION OF HUMAN NATURE

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I declare that this thesis was composed by me and embodies the result of my own work.

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ABBREVIATIONS

Description: Tuke, Samuel (1964). Description of the Retreat. London: Dawsons of Pall Mall. (Facsimile copy of 1813 edition with an introduction by R. Hunter and I. Macalpine.)

HMA: Hunter, Robert A. and Ida Macalpine (1963). Three Hundred Years of Psychiatry 1535-1860. London: Oxford University Press.

MECW: Marx, Karl and F. Engels (1975-). Collected Works. London: Lawrence and Wishart.

RA: Retreat Archives, at the Borthwick Institute for Historical Research, York.

SC: Parliamentary Papers: Select Committee Reports

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* * *

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* * *

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* * *

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* * *

SUMMARY

This thesis uses an historical example—the "moral treatment" of the insane in Britain at the end of the eighteenth century and the beginning of the nineteenth—to defend a particular theoretical understanding of the social construction of human nature.

In the Introduction, comparable work in the history of psychiatry and in the sociology of medical knowledge is discussed, as well as the theoretical structure which holds the substantive part of the thesis together. This latter feature, described as "the theory of praxis in historical materialism", is an interpretation of the Marxist theory of history which attempts, within the necessary constraints of that theory, to indicate the subjective element of man's activity in creating his own history. The substantive part of the thesis utilises this theory in order to portray some of the rich detail by which moral treatment appeared as a meaningful and progressive way of treating the insane.

Chapter One examines the prehistory of moral treatment: the social, institutional, medical and intellectual contexts of the mid-eighteenth century, as they affected the treatment of both the insane and the deviant population generally. In Chapter Two, the creation of the concept of moral treatment itself is dealt with through an examination of the work of Philippe Pinel in Paris and the Tuke family in York.

Chapter Three focusses on the various manifestations of moral treatment once it was taken up as a progressive practice in a variety of institutional contexts. Its relation to contemporary concerns such as the idea of moral community, penal reform, the necessity to work, are all discussed in detail; as is the significance of its practice to the ideologists of capitalist social relations.

In Chapter Four the internal history of moral treatment is examined,

and its status as knowledge evaluated. Chapter Five deals with the transformation of moral treatment after the 1830s and the reasons for its gradual demise. There is no separate conclusion, but a short Coda discusses some of the theoretical issues raised from a slightly different perspective.

INTRODUCTION

A review of the theoretical and substantive contexts within which this work is written.

One element in the fundamental cause of the failure of socialism--only an element, but an important one, no longer to be ignored, no longer to be regarded as secondary--is the absence of an effective Marxist doctrine of political psychology.

--Wilhelm Reich

Solely because of the increasing disorder
In our cities of class struggle
Some of us have now decided
To speak no more of cities by the sea, snow on roofs, women
The smell of ripe apples in cellars, the senses of the flesh, all
That makes a man round and human
But to speak in future only about the disorder
And so become one-sided, reduced, enmeshed in the business
Of politics and the dry, indecorous vocabulary
Of dialectical economics
So that this awful cramped coexistence
Of snowfalls (they're not merely cold, we know)
Exploitation, the lured flesh, class justice, should not engender
Approval of a world so many-sided; delight in
The contradictions of so bloodstained a life
You understand.

--Bertolt Brecht

The central point of the following pages is to provide an interpretation of the changes in the treatment of the insane in Britain[1] that occurred around the end of the eighteenth and the beginning of the nineteenth centuries. This will be done mainly by looking in detail at what was recognised to be one of the central means by which these changes were able to take place. This was "moral treatment", a phenomenon which dominated all that was considered to be progressive in the period from the 1790s until the mid-nineteenth century. Moral treatment will be examined here as history, as theory, and as practice.

This thesis was written whilst its author was a member of an interdisciplinary university department, and the approach used here is itself consciously interdisciplinary. It is therefore important that before the substantive part of the thesis can be presented, it must be established precisely what academic areas of interest are to be invoked.

The thesis is written in the form of an historical account because I felt that that format provides the most coherent vehicle for laying bare the features of moral treatment. But the reasons underlying this decision were not primarily governed by historiographical considerations. My main interest in working with historical materials is to use an example, such as the changes in the treatment of the insane, in order to

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[1] By "Britain" is meant primarily England and Wales. Where other countries are discussed, and both Scotland and France receive some detailed attention, the purpose is to illustrate the perceived influences of which English practice took notice, and not to provide an exhaustive account of the practices in these other countries. The reason for this apparent ethnocentrism is purely strategic. There is more than enough to explain for England, where the variety of approaches was itself substantial, without trying to take account of different local conditions in other countries. A more general picture would be more valuable, but it would need to be drawn from a number of detailed studies of local changes. This study of England is meant as a contribution to that project.

support an explicit theoretical and ideological argument. This distinction is vitally important, but may be difficult for the reader whose interests lie mainly in the history of science of medicine to understand. Unless this is appreciated, however, much of this introduction, and all of the Coda, will appear rather superfluous to what might seem to be fairly straightforward historiographic intentions. But more fundamentally, to read the substantive part of this thesis without recognising this intention would be to misread its essential purpose.

At the same time it is recognised that much of the historical material being examined here is of interest to more than those working within the same theoretical and ideological milieux as the author. I draw on work from many disciplines, and I hope that some of my comments will find their way back to those disciplines. In order to clarify this, the remainder of this introduction will be devoted to a review of the different intellectual contexts within which this work is written, or on which it is dependent, or which it can be seen as a contribution towards. These areas of interest are not discrete and indeed the present work is written partly to indicate some <u>necessary</u> connections between them. But for the purposes of exposition, and especially for the reader who may only be familiar with one of them, these interests may be summarised as 1) the history of psychiatry; 2) the sociology of medical knowledge; and 3) the theory of praxis in historical materialism.

1. The History of Psychiatry

The history of psychiatry is an area in which a great deal of research has been done in the last 20 years. Unlike some historical subject areas, the history of psychiatry has not remained the province of one academic speciality, but has been repeatedly examined from different perspectives. Practising psychiatrists, historians of medicine,

sociologists, literary critics, and social administrators are some of the groups who have studied eighteenth- and nineteenth-century attitudes to the insane and the changes in their treatment.

The following review of the literature is not meant to be exhaustive, but it is intended to include most of the work done in the last two decades which could be said to add in any way at all to our understanding of changes in the treatment of the insane in the period from roughly 1750 to 1850, and specifically to an understanding of moral treatment.

No attempt will be made at this stage to define "moral treatment": it is, after all, one of the aims of this thesis to demonstrate the complexity of the concept. For the present it is enough to note that the phrase was first used in the 1790s and was popularised by two people. One of these was Samuel Tuke, the treasurer to a small Quaker asylum known as "The Retreat" near York, who brought the phrase "moral treatment" into common use with the publication of his Description of the Retreat in 1813.[1] The other was Philippe Pinel, a Parisian doctor who made public his new method of "traitement moral" in 1801.[2] "Moral treatment" rapidly became taken up as the essence of all that was progressive in the treatment of the insane, and attempts were made to incorporate it as a mode of therapeutic practice into the numerous asylums that were being constructed at this time. As a result of this it was

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1 Reprinted as S. Tuke, 1964. Henceforth referred to as Description.

2 This was in his Traité Médico-Philosophique sur L'Aliénation Mentale ou La Manie, published in France in 1801, and in translation in Britain as A Treatise on Insanity in 1806 (reprinted as Pinel, 1962). This Treatise made Pinel's work widely known in Britain although, as will be shown, he had been writing about moral treatment since the 1780s.

transformed from its original specific meanings into a diffused and general approach to therapy. The term continued to be used throughout the nineteenth century, but by mid-century its demise was already becoming apparent. The "active" period of moral treatment, in which it was developed as a growing and creative force, covers the time from its prehistory in the mid-eighteenth century until the provision of public asylums for the insane became compulsory in 1845. It is this period that will be the main focus of interest here.

A number of practising psychiatrists today have expressed an interest in this period of their own professional history. The most impressive body of work is that which has been done by the team of Richard Hunter and Ida Macalpine. Their anthology of readings, Three Hundred Years of Psychiatry 1535-1860,[1] which is now 15 years old, still remains the best introduction to the history of psychiatry. A full list of Hunter and Macalpine's work appears in the bibliography to this thesis, although in addition to the works listed under their own names they have provided substantial biographical introductions to reprints of monographs by Samuel Tuke and John Conolly,[2] two of the most influential moral therapists. Writing biographies of outstanding predecessors has been popular among

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[1] Hunter and Macalpine, 1963. Henceforth referred to as HMA.

[2] On Tuke see the introduction to the Description, and on Conolly see Conolly, 1964, 1968, and 1973. It is interesting that Hunter and Macalpine have made hardly any comments on what they considered moral treatment to be. Nearly every time they have referred to it, the phrase has been placed in inverted commas as though it did not really exist. This attitude ties up with their general approach to the value of psychiatric history--to point out precursors of today's more advanced practice and knowledge. From this point of view, moral treatment becomes a ragbag of attitudes in which we can recognise parts of today's practice by the more scientific terms of, for example, psychotherapy, milieu therapy, and occupational therapy. (For Hunter and Macalpine on moral treatment see especially their 1965 and HMA, pp. 602-6, 684-7.)

other practising psychiatrists. Denis Leigh, for instance, has written biographical essays on Conolly as well as on John Haslam, another mad-doctor of this period.[1]

Moral treatment itself has been examined from a number of perspectives: through the biographies of individual practitioners such as Conolly and Tuke; through the institutional history of the madhouses and asylums;[2] as an aspect of the administrative history of the insane;[3] in its relation to the growth of the psychiatric profession;[4] as it was affected by the medical theories of the time;[5] through a straightforward examination of what the moral therapists appeared to be doing;[6] and through a "Whiggish" attempt to locate moral treatment in terms of similar motivations and ideologies to those held in psychiatry today.[7] Whatever the different interests and perspectives of these authors, all of them have unearthed interesting material: taken together they provide a comprehensive basis from which to begin any further research into this period of the history of psychiatry.

Similar valuable research has been done under the auspices of university literature departments, where historians interested in analysing fictional representations of the world have helped to clarify our under-

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1 Leigh, 1955, 1961.

2 Walk, 1964; Rothman, 1971; Parry-Jones, 1972.

3 K. Jones, 1972.

4 Walk and Walker, 1961; Scull, 1974, 1975a, 1976.

5 Bynum, 1974; Cooter, 1976.

6 Walk, 1954, 1970.

7 Bockoven, 1956, 1957.

standing of that world. This applies particularly to a brilliant Study of Conventions of Madness in Middle English Literature[1] and, to a lesser extent, to three examinations of madness in imaginative literature of the eighteenth century.[2] All this work has proved valuable in the preliminary research leading to the present study.

One aspect of most of the historical accounts mentioned up to now is that they take little interest in such concepts as "moral treatment" in their own right. Few historians have bothered to ask why the term "moral", for instance, was used in a way that we no longer use today. There are just a few writers who have concerned themselves with this question: names which may be mentioned in this regard are Dain,[3] Grange,[4] Skultans,[5] Scull, and Foucault.

Of all these names the two which have provided the most substantial contributions to the literature are undoubtedly those of Andrew Scull and Michel Foucault. Scull's doctoral thesis on Museums of Madness: The social organisation of insanity in nineteenth century England[6] is a

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1 The title of a PhD thesis by Doob (1970). See also her 1974.

2 Deporte, 1974; Byrd, 1974; Reed, 1952.

3 Dain, 1974. Dain makes some pertinent comments on the intellectual resources used in moral treatment, but ignores the vast intellectual chasm separating Pinel's and the Tukes' use of the word "moral". At the beginning of his major study of moral treatment and related concepts he writes, for instance, "Hereafter the terms 'psychological medicine', 'moral treatment', 'moral management', and 'moral therapy' are used interchangeably to mean the new system introduced by Pinel, Tuke, and others" (ibid., p. 5).

4 Grange, 1961, 1963. These two papers include some of the most original material on moral treatment to have been written, but they have been largely ignored by later writers in this area.

5 Skultans, 1975.

6 Scull, 1974. His 1975a and 1976 are papers based on material extracted from that thesis.

major document of which all subsequent work must take account. There are many similarities between Scull's approach and mine which cannot be discussed at this stage but which will become apparent as my own account unfolds. The major difference in subject matter between Scull's work and my own is that his primary interest is in the institutional history of the insane, and in the growth of the psychiatric profession which was to govern those institutions. My own primary interest is in moral treatment, a phenomenon which sometimes expressed itself as a coherent practice in those institutions, but which must also be appreciated as a body of knowledge with its own internal history and significances. There are also a number of theoretical differences between Scull's approach and mine. We make use of different sociological models to explain our historical materials, but we do share a strong belief in locating what we have found in terms of the social construction of society by its members. This method of approach is discussed below in Section 2 of this introduction.

The work of Michel Foucault is less easy to describe. His Madness and Civilization was first published in 1961[1] and it is no exaggeration to say that this one work has almost single-handedly redefined our understanding of psychiatric history. In this book Foucault attempted to expose the origins, discovery almost, of insanity and its treatment as meaningful concepts in the seventeenth and eighteenth centuries. It is thus inevitable that Foucault has covered much of the ground that is to be approached here. But while agreeing with many aspects of his account

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[1] Published in French as Histoire de la Folie à l'Âge Classique, it appeared in a second edition in 1972 (Foucault, 1972a). The English translation (Foucault, 1971) is about half the length of the original.

and even occasionally repeating his conclusions, I think there is ample justification for further enquiry. Foucault's work is not generally accepted in this country: his style and rhetorical flourishes alienate himto many, and while it is true that it is this same aspect of his work that makes him attractive to others, this is not seen by the present writer as grounds for acknowledging value. More to the point is the evidence he uses to support his intricate web of explanation. And it is here that Foucault, especially with the English material, appears to rely on very few sources, some of which were not very scholarly secondary accounts written in the late nineteenth century.[1] But insofar as he provides a stimulating reinterpretation of what has become a rather stale legend, Foucault's work must be recognised as a worthy basis from which to begin a more detailed, and if necessary more pedestrian, account of moral treatment. For those unfamiliar with Foucault's style and general approach, it can be summed up in the following quotation from Madness and Civilization:

> Life in the asylum as Tuke and Pinel constituted it permitted the birth of that delicate structure which would become the essential nucleus of madness--a structure that formed a kind of microcosm in which were symbolized the massive structures of bourgeois society and its values: Family-Child relations, centered on the theme of immediate justice; Madness-Disorder relations, centered on the theme of social and moral order. It is from these that the physician derives his power to cure; and it is to the degree that the patient finds himself, by so many old links, already alienated in the doctor, within the doctor-patient couple, that the doctor has the almost miraculous power to cure him.[2]

One way of introducing the account to be presented here is to say that it will attempt to explain at length precisely what the values and

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1 See the bibliography in Foucault, 1972a.

2 Foucault, 1971, p. 274.

structures were that were reproduced in asylum practice, values and structures which Foucault discusses but which often remain opaque and dense to the reader.

2. Sociology of Medical Knowledge

The works discussed in the previous section are the main secondary accounts of moral treatment and the history of the treatment of the insane, to which the present work may be seen as an addition. On the other hand, it was stated at the beginning of this introduction that this account should be seen only secondarily as a contribution to our understanding of the history of the insane. It is primarily a sociological work, an attempt to present, through empirical evidence, some support for a particular mode of understanding what may be called the "social reality of human nature". This mode of understanding is one which has been discussed and theorised in a variety of contexts: the aim here will be to contribute to that theoretical work from within the social history of one part of society--the treatment of the insane.

A good starting point for this journey is Foucault's comment to the effect that

> What is constitutive is the action that divides madness, and not the science elaborated once this division is made and calm restored.[1]

This comment applies both to the concept of madness (or insanity) itself and to the significance of the therapeutic interventions to which the appearance of madness has been subject. Foucault has emphasized many times that we live so much within the logic of one mode of thought that it is almost impossible for us to enter another.[2] To do so is not

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[1] Foucault, 1971, p. xi.

[2] See for instance the example he gives of a "certain Chinese encyclopaedia" (mentioned in a story of Borges) "in which it is written that

entirely impossible but it does require an imaginative recreation in our own minds of the "constitutive action" by which any particular meaning is generated.[1]

Before going any further with this approach it might be as well to remind ourselves of the alternative viewpoint, that the "science elaborated" is the more important aspect, both of the history and of the practical use of the concept of human nature today. As far as the practice of contemporary psychiatry is concerned, it is strongly pluralistic, making use of knowledge derived from many aspects of human life. But at the same time, there has always been a strong tendency, in Britain at least, to ground the theoretical legitimation of psychiatry in one particular cognitive mode, that of science. One of the best-known of modern psychiatric textbooks begins with the sentence,

> This book is based on the conviction of the authors that the foundations of psychiatry have to be laid <u>on the ground</u>

'animals are divided into: (a) belonging to the Emperor, (b) embalmed, (c) tame, (d) sucking pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification, (i) frenzied, (j) innumerable, (k) drawn with a very fine camelhair brush, (l) et cetera, (m) having just broken the water pitcher, (n) that from a long way off look like flies.' In the wonderment of this taxonomy, the thing we apprehend in one great leap. . .is the limitation of our own, the stark impossibility of thinking <u>that</u>" (Foucault, 1970, p. xv).

[1] As far as Foucault's own work is concerned, he considers that he wrote <u>Madness and Civilization</u> before he had formulated a clear idea of the implications of writing history. In his words, "An enterprise by which one tries to measure the mutations that operate in general in the field of history; an enterprise in which the methods, limits, and themes proper to the history of ideas are questioned; an enterprise by which one tries to throw off the last anthropological constraints; an enterprise that wishes, in return, to reveal how these constraints could come about. These tasks were outlined in a rather disordered way [in my earlier books], and their general articulation was never clearly defined. It was time that they were given greater coherence—or at least, that an attempt was made to do so. This book [<u>The Archeology of Knowledge</u>] is the result (Foucault, 1972b, p. 15).

of the natural sciences.

The authors continue that it

> seems to us far-fetched to claim that sociology or cultural anthropology occupy as basic a position in relation to psychiatry as do the mental and biological sciences. . .Our knowledge of medicine and physiology is detailed, relatively precise and capable of clear definition. Our knowledge of sociology is scanty, imprecise and not easily capable of confirmation or refutation.[1]

It is perhaps not surprising that this type of argument occurs within the psychiatric profession itself, given the scientific rationale of medicine generally and the less than confident status of psychiatry within the medical hierarchy. However it is also a point of view that pervades much of our thinking today, and it can even be found in the otherwise rigorously sociological work of Andrew Scull. According to Scull,

> whatever one's opinions on the extent of scientifically based knowledge of mental illness today, there would, I think, be a widespread consensus on the lack of any real knowledge base in early nineteenth century medicine which would have given the medical profession a rationally defensible claim to possess expertise vis-a-vis insanity.[2]

But what Scull does not ask, let alone answer, is what it is that would constitute a "rationally defensible claim" to expertise. At what stage does, or could, psychiatry become scientific?

The answer, if we are to follow the logic of Foucault's reasoning, is that such a question is misconceived. Psychiatry, mad-doctoring, or any method of treating the insane, must always be acknowledged as

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1 Slater and Roth, 1969, pp. 1, 3, emphasis in the original. See also the paper in defence of "scientific psychiatry" by the President of the Royal College of Psychiatrists (Roth, 1973).

2 Scull, 1974, p. 238. This is not a totally isolated instance of this kind of argument in Scull's work. Elsewhere he describes one mad-doctor's attack on his colleagues as "gratuitous" because of "the absence of any adequate theoretical understanding or rational therapy" (ibid., p. 78).

possessing a "rationally defensible claim" to its practice. Not because it had some claim to ultimate truth but because, as practice, it had meaning in the societies and in the "constitutive actions" which created it. This understanding of the determinant bases of meaning is also one which, as a general basis for enquiry, may be seen as providing the substantive basis for two important areas of sociological investigation.

The first of these, known as the "sociology of knowledge", has concerned itself with the macro-sociological implications of this insight; that is, into the general nature of the social production of knowledge.

> Morality, religion, metaphysics, and all the rest of ideology as well as the forms of consciousness corresponding to these. . .have no history, no development; but men, developing their material production and their material intercourse, alter, along with this their actual world, also their thinking and the products of their thinking. It is not consciousness that determines life, but life that determines consciousness. . . . [Our] manner of approach, which conforms to real life, . . . [concerns itself with] the real living individuals themselves, and consciousness is considered solely as their consciousness.[1]

After Marx, this approach--which remained only a programme for research in his writings--was developed into a distinct branch of sociology, most notably by Karl Mannheim, with whose work the sociology of knowledge is usually associated.[2] For many years this approach concerned itself only with the more cultural aspects of men's thought, such as political ideologies, artistic expression, and religious beliefs. More recently however, sociologists of knowledge have confronted the dominant cognitive mode of Western thought--science itself.[3]

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[1] K. Marx and Engels, The German Ideology, in MECW, vol. 5, pp. 36-7, emphasis in the original.

[2] Mannheim, 1960.

[3] On this see Bloor, 1973 and 1976, and Barnes, 1974. As Barnes points out, "A sociological theory which has to make a special exemption of a particular institution or sub-culture, like, for example, natural science, deserves to be treated with the greatest suspicion" (ibid., p. 164).

One feature of the Mannheimian tradition of the sociology of knowledge is its emphasis on the intellectual aspects of thought. These aspects are, naturally, of concern to the academics who write about them, but are hardly the major concerns of most people most of the time. And yet the knowledge which "the man in the street" uses to make sense of his everyday life--his assumptions, expectancies, common-sense beliefs as to how things naturally are--all this is as much socially constructed as the more intellectual ideas of a society. One comprehensive attempt to express this recognition (on the theoretical plane) is in a book entitled The Social Construction of Reality. In the introduction to that work the authors ask

> How is it possible that subjective meanings become objective facticities? . . .How is it possible that human activity. . .should produce a world of things? . . .In other words, an adequate understanding of the "reality sui generis" of society requires an inquiry into the manner in which this reality is constructed. This inquiry, we maintain, is the task of the sociology of knowledge.[1]

By their general statement of the necessary concerns of a sociology of knowledge, Berger and Luckmann have opened the way to the empirical work that needs to be done to substantiate what is still a relatively novel understanding of human nature.[2] Their programme leads on to the second area of sociological investigation mentioned above.

This latter approach is typified by a concern with the micro-sociological features of social reality, with how men actually produce

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[1] Berger and Luckmann, 1971, p. 30.

[2] It will be noted in this discussion of changes in the sociology of knowledge that I am saying nothing of the theoretical traditions underlying these changes of emphasis in practice. Other writers have suggested that such different theoreticians as Durkheim, Schutz, and Wittgenstein have inspired the changes recorded here. To what extent this is true is an interesting question, but not one that needs to be answered here, given my concern with only the practical effects (for empirical research) of the shift in emphasis.

and reproduce the minute details of their existence. Even when members of a society are producing intellectual or scientific knowledge they are doing so in the same way (precisely as members of the society) as everybody else. Given the substantive concerns of this thesis, I want to discuss one area where this approach has proved particularly fruitful: the sociology of deviance. Deviance, according to this method of viewing the social world, is no longer something that men have, a quality (or defect) over which they have no control. It becomes instead a status conferred on them by other men.[1] This approach has been worked out in some detail by the symbolic interactionist school of sociology, and it is now being given expression by the ethnomethodologists.

It must be stressed, however, that this approach to knowledge--at least as understood here--does not involve a denial of "something there", a material reality of which we have to make sense or confer meaning upon. It is rather that the phenomena of the material world, whether they appear as "mental illness" or as any other name we give to them, are not unproblematically given; they are always negotiated, constructed within a social discourse. A recognition of deviance is a product of this discourse and not of the material world per se. A nice fictional example of this is provided by H.G. Wells in his short story, "The Country of the Blind". In this story, Nunez, a mountaineer, loses himself in a distant valley. All the inhabitants of this isolated land are blind, cut off for generations from the rest of the world. Far from recognising the sighted visitor as a saviour

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1 "Deviance is not a property inherent in any particular kind of behaviour, it is a property conferred upon that behaviour by the people who come into direct or indirect contact with it" (Erikson, 1966, p. 6, emphasis in the original). For a general discussion of this subject see Pearson, 1975, pp. 64-78.

or leader, they consider his faculty of sight as a handicap due to a physical deformity in his eyeballs. During their long sojourn in the valley the blind people had developed their other senses and had established an equilibrium with their environment. They worked at night when the valley was cool and slept in the heat of the day. Nunez stumbled around in the dark and saw all sorts of things that for the blinded were not important. Eventually he was examined by the doctor.

> "His brain is affected," said the blind doctor.
> The elders murmered assent.
> "Now, what affects it? . . .This," said the doctor, answering his own question. "Those queer things that are called the eyes, and which exist to make an agreeable soft depression in the face, are diseased, in the case of [Nunez], in such a way as to affect his brain. They are greatly distended, he has eyelashes, and his eyelids move, and consequently his brain is in a state of constant irritation and destruction. . . .And I think I may say with reasonable certainty that, in order to cure him completely, all that we need do is a simple and easy surgical operation--namely, to remove these irritant bodies."
> "And then he will be sane?"
> "Then he will be perfectly sane, and a quite admirable citizen."
> "Thank heaven for science!" said old Yacob, and went forth at once to tell Nunez of his happy hopes.[1]

There is no disagreement in this story as to whether sight or blindness exists: it is rather that what is usually recognised as normality is here recognised as deviance because the "constitutive action" underlying

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[1] Wells, 1958, pp. 142-3 (first published 1904). In view of what might be called Wells' own breadth of vision in being able to conceptualise the variety of social normalities open to man, it is instructive to turn to the "myopia" of some modern psychologists. One of them (Meehl, 1973) has presented a case for accepting an organic basis for schizophrenia on the grounds that schizophrenia is analogous to a "colour psychosis . . .in a society entirely oriented around the making of fine colour discriminations" (ibid., p. 83). While accepting that the recognition of colour psychosis is dependent on the precise values of this fictional society, Meehl emphasises that the important thing is that the physical basis of the psychosis can be traced to "a mutated gene on the X chromosome" and which the medical profession could treat. In other words, whereas Wells was warning us of the totalitarian dangers of accepting medical definitions as ends in themselves, Meehl is assuring us that his profession (he was President of the American Psychological Association) is ready to do just that.

the recognition is, in the Country of the Blind, based on different social interests.

Ethnomethodology takes very seriously the "constitutive action" by which such phenomena as mental illness are created. By directing its attention at the diagnostic procedures of psychiatrists,[1] the features of the institution in which the "ill" person finds himself,[2] the tolerance level of patients' wives,[3] and other social contingencies unconnected with qualities of the "mentally ill person" him or herself,[4] this line of research has done much to unsettle our conventional appreciation of what mental illness is.[5] In the work of ethnomethodologists, mental illness (or madness, or insanity) becomes a chimera, something fluctuating endlessly between the negotiations of everyday life. It loses all the substance that 200 years of organised psychiatry have given it and becomes, like the equally taken-for-granted concepts of suicide and sex,[6] something profoundly problematic.

In the last few years there has been much empirical research in the sociology of medicine, using theoretical insights derived from

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1 Daniels, 1970.

2 Goffman's work on Asylums (Goffman, 1968) is the seminal work here, but see also the study by Rosenhan (1973) in which he shows how he and his colleagues, posing as patients, had their normal behaviour redefined as insane inside a mental hospital.

3 Yarrow et.al., 1967.

4 Scheff, 1966.

5 For a general theoretical exposition of this approach see Blum, 1970, or Coulter, 1973; and for an excellent, but so far unpublished, account of how raw data of "what actually happened" are "worked up" into a defined state of mental illness, see D. Smith, no date.

6 Ethnomethodological examinations of both these concepts appear in Garfinkel, 1967. The study of suicide from this perspective is becoming increasingly popular. See for instance J.N. Atkinson, 1971.

ethnomethodology to enable the researcher to unpack the presentation in which medical knowledge appears. Stimulating work has been done on epilepsy,[1] diabetes, and medical knowledge as a product of the bedside manner of hospital practice,[2] to name three recent studies. The fruitfulness of this approach is becoming increasingly evident. What does need to be said, however, is that because they concern themselves entirely with the minutiae of everyday life, these micro-sociological approaches to the demystification of deviance (or of any other social phenomenon) tend to give a distorted view of the overall picture of how social order is constructed. Phenomenological and ethnomethodological sociology stresses quite rightly that "All social reality is precarious. All societies are constructions in the face of chaos".[3] But in the majority of empirical studies undertaken within this epistemological frame of reference, there is an overwhelming emphasis on the mechanism of constructions, and very little attention is paid to their rationale. Or, to put it another way, micro-sociology asks how society is constructed in a certain way, and not why it is so constructed.[4]

This leads on to another related issue: the absence within the

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1 West, 1976.

2 See the papers by P. Atkinson and T. Posner in Dingwall et.al., 1977. That this anthology on the social construction of medical knowledge contains a paper based on Chapter Two of this thesis (Fears, 1977) is, if nothing else, an indication of the interest of current medical sociology in the theoretical issues raised here.

3 Berger and Luckmann, 1971, p. 121.

4 In terms of types of research undertaken, this has led to work which "criticises the welfare state, but only the low-level officials who manage caretaking institutions; it does not challenge high-level officialdom which shapes the policy and character of these institutions, welfare budgets and research funding" (Pearson, 1975, p. 73).

ethnomethodological paradigm of any concern for the phenomenon of social change. Why do people lose preference for one social order or version of human nature and begin to believe in another, and why at certain periods in history is an intense effort made to change existing conceptions of legitimacy?

To return to Foucault's original comment, we need not only a method to uncover the mystifications by which the concept of "insanity" becomes something apparently beyond human authorship; we also need an explanatory framework within which to understand why this particular "constitutive action" should have taken place at all. Why was insanity "discovered" in the eighteenth century and the asylum movement "born" in the nineteenth? We need to know how individual men and women gave life to new concepts, but we also need to know why they should have bothered to do so--why those people in those ways. We need, in short, a profoundly historical sociology, one that can deal with man's construction of himself within both its diachronic and synchronic dimensions. The next section is devoted to an exposition of just such an historical sociology, one that will be used as the theoretical core of this thesis.

3. The Theory of Praxis in Historical Materialism

The following account of what I am calling "the theory of praxis in historical materialism" is not meant to be exhaustive or definitive. It is however the theoretical basis on which the substantive part of this thesis rests. The theory will be described in as much detail as is necessary to show a) why it is a useful tool for understanding the history of psychiatry, and b) why it is valid today as a method of research. While I can obviously make no claim to providing any sort of definitive interpretation of historical materialism, I have attempted to express an interpretation which is true to the intentions of the major practitioners of Marxism-leninism. In other words, I am writing from within

historical materialism, and not using aspects of it because they appear useful to another theory of history or consciousness.[1]

Put at its simplest, what is meant by the theory of praxis in historical materialism is a particular interpretation of the role and meaning of subjective factors as they appear within objective history. It will be argued that while original innovations such as moral treatment were not completely determined by external and objective factors, the consciousness that gave rise to them was itself a creative part of earlier objectivities. The making of history involves the activity of man in the world in which he finds himself, but what is original in this activity must itself be described in terms of the constituents of that world.

In many ways this understanding of the importance of praxis is similar to the recognition, voiced in the last section, of man's authorship in his cognition of the world. Some Marxists have attacked the concepts of praxis for precisely that reason, because it appears to them to be

> an uncritical product of that very system of capitalism which all socialists wish to see radically replaced. Praxis thinking does not reflect capitalism as it really is, but

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[1] For an example of the latter see Gabel's work on false consciousness (Gabel, 1975). For readers of this thesis unfamiliar with historical materialism it may seem that I use a number of concepts--such as "bourgeois", "interests of the working class"--which are opaque to them and not defined here. I have attempted to explain technical terms, such as "praxis", which are relatively new to the Marxist vocabulary. However, for the majority of my terms I must rest my case on what I take to be a consensus within Marxist scholarship that such terms refer to meaningful and relatively unproblematic descriptions of the world. That this consensus exists can be confirmed by comparing some of the main sources used in the research for this section. See for example K. Marx and Engels, The German Ideology (MECW, vol. 5) and Marx's Capital, vol. 1 (K. Marx, 1974), compared with the non-Marxist authors Ollman (1971) or Venable (1946); or with the trilogy by the Maoist George Thomson (1971, 1973, 1974).

> merely the illusions of "spontaneity" and "creativity" which this system has about itself.[1]

There is certainly a tendency in contemporary (non-Marxist) sociological parlance to use the term "praxis" as a fashionable synonym for "practice".[2] That use of "praxis" does not imply the existence of any theoretical context except that which each writer individually chooses to apply to his work. The understanding of praxis which informs this work is one which has been consciously fashioned out of the Marxist theory of history in order to explain man's role in his own history. The justification for a concept of praxis in historical materialism in encapsulated in Marx's comment that

> Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past.[3]

Praxis is to be sought in every creative moment of this activity, constantly constrained and yet irrevocably new. The most explicit modern discussion of praxis in this sense is to be found in the work of Jean-Paul Sartre. According to Sartre,

> If one wants to grant to Marxist thought its full complexity, one would have to say that man in a period of exploitation is at once both the product of his own product and a historical agent who can under no circumstances be taken as a product. This contradiction is not fixed; it must be grasped in the very movement of praxis.[4]

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1 Hoffman, 1975, p. 232, emphasis in the original.

2 See for instance the collection of essays on the current state of the sociological profession entitled Sociological Praxis (Crawford and Rokkan, 1976).

3 K. Marx, Eighteenth Brumaire of Louis Bonaparte, in K. Marx and Engels, 1958, vol. 1, p. 247.

4 Sartre, 1968, p. 87, emphasis in the original. On this subject see also his 1976, passim., a major work in which he attempts to specify the general requirements for writing history sensitive to the existence of praxis. A long and not entirely satisfactory discussion on the Marxist

From the point of view of making sense of any particular historical phenomenon--such as the birth of moral treatment--it is therefore necessary to appreciate what is creative about the action which constitutes it as meaning. But to understand why it is meaningful, it is necessary to appreciate the "circumstances directly encountered, given and transmitted from the past". These circumstances include not only material facilities, such as the existing provision of asylums or whatever, but the whole range of social, psychological, and biological features which are recognised as constituting human nature. Historical materialism works with a very precise formulation of the course that human history has taken, and that course must now be reviewed--although there is no space here to do more than review the basic features of the way in which praxis has manifested itself in our society.

Human history begins, according to the main authors of historical materialism, with the utilisation by man of a distinctive feature of his nature. Unlike other species whose nature is fixed for them, the distinctive feature of human nature is its ability to create its own future. From his earliest beginnings, mankind has provided the basis for his own future development.

> Men can be distinguised from animals by consciousness, by religion or anything else you like. They themselves begin to distinguish themselves from animals as soon as they begin to <u>produce</u> their means of subsistence.[1]

This "means of subsistence" refers not only to external products such as foodstuffs, it refers to human nature itself, a phenomenon which is

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concept of praxis is also provided by Sanchez Vazquez (1977). What Sanchez Vazquez does illustrate very clearly is how Marx's <u>Theses on Feuerbach</u> encapsulate all the essentials of praxis philosophy (pp. 115-27).

[1] K. Marx and Engels, <u>The German Ideology</u>, in <u>MECW</u>, vol. 5, p. 31, emphasis in the original.

not a fixed attribute but a developing process. In Marx's words,

> [man] confronts nature as one of her own forces, setting in motion arms and legs, heads and hands, in order to appropriate nature's productions in a form suitable to his own wants. By thus acting on the external world and changing it, he at the same time changes his own nature. He develops the potentialities that slumber within him, and subjects these inner forces to his own control.[1]

Or, to put it another way, the dawn of human history can be dated to the precise moment that man gave up accepting "what is" and achieved a change in the world:

> the satisfaction of the first need, the action of satisfying and the instrument of satisfaction which has been acquired, leads to new needs; and this creation of new needs is the first historical act.[2]

The word that Marx used to describe man's role in this process of change is "labour". It is labour that is the basis for man's objectification of himself in the world as a specifically human animal, and it is labour that makes human nature something that cannot be defined once and for all.

> In short, the animal merely uses its environment, and brings about changes in it simply by his presence; man by his changes makes it serve his ends, masters it. This is the final, essential distinction between man and other animals, and once again it is labour that brings about this distinction.[3]

This process is a dialectical one because it involves the transformation of the various elements as they interact with, and on, each other. All the aspects of human nature (rationality, physical abilities, consciousness, etc) are not static elements but are constantly being transcended and transformed as man produces human history himself. One

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1 K. Marx, 1974, p. 169.

2 K. Marx and Engels, The German Ideology, in MECW, vol. 5, p. 42.

3 Engels, "The part played by labour in the transition from ape to man", in Engels, 1972, p. 260, emphasis in the original.

example given by Engels was of the earliest man who, in making use of pieces of flint, gradually developed them into tools. In so doing, however, he not only developed the flint as a useful artefact; he also developed his hands. In Engels' words, the human hand became "not only the organ of labour, it is also the product of labour".[1] Produced out of the dialectic interplay between man and the world that confronted him, the hand became an objective basis for future creative manipulation. It is this dialectical process, in which man's nature is transcended through his own productive activity and becomes the objective basis for future change, that is the essence of progress as understood by historical materialism.[2]

As stated, this continuing transcendence of man's nature applies not only to organs such as the hand, but to consciousness itself. Consciousness is a necessary product of man's activity being purposive. Man creates consciousness in becoming aware of his needs just as much as he does in satisfying them.

> The animal is immediately identified with its life activity. It does not distinguish itself from it. It is its life activity. Man makes his life activity itself the object of his will and consciousness. He has conscious life activity.[3]

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[1] Engels, 1972, p. 252, emphasis in the original. On this aspect of human nature see Sedgwick, 1966, p. 183, especially note 37; also the extended discussion in Sanchez Vazquez, 1977, pp. 218-23.

[2] Historical materialism is thus essentially rationalistic and progressivistic. The nature of this rationality will be commented on later. It is now possible, however, to understand the meaning of such phrases as Mao's "The history of mankind is one of continuous development from the realm of necessity to the realm of freedom. This process is never ending" (Mao, 1972, p. 203). What is meant here is not that the constraints on man are gradually loosened, but that as he becomes more in control of the production of his own future, the more he will be free to choose which course to take. The freedom to make this choice will be as much due to the existing development of his consciousness as to the range of material artefacts he can call to his aid.

[3] K. Marx, Economic and Philosophical Manuscripts of 1844, in MECW, vol. 3,

Initially man's consciousness is of a limited form, unable to distinguish the effects of his activity from that of nature. Only as the material basis of society provides the means for man to have a greater degree of control over his activity (this process itself being a product of man's developing consciousness working on the products of his already existing labour), is man able to increase his self-awareness and use his consciousness freely, without having it confronting him in forms (such as religion) over which he appears to have little control. Consciousness is the specifically human attribute through which man's material accomplishments are mediated in order that they can be used as the basis for further control of the nature that confronts him. Consciousness is both an objective factor and the possibility for that objectivity to be changed.[1]

The argument of the substantive part of this thesis is that this role of consciousness is the key to understanding moral treatment.

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p. 276. One well-known example which Marx used to make this point is the comparison between a bee and an architect. As he put it, "We have to consider labour in a form peculiar to the human species. . . .many a human architect is put to shame by the skill with which a bee constructs her cell. But what from the very first distinguishes the most incompetent architect from the best of bees, is that the architect has built a cell in his head before he constructs it in wax. The labour process ends in the creation of something which, when the process began, already existed in the worker's imagination, already existed in an ideal form" (K. Marx, 1974, pp. 169-70).

[1] This active role of consciousness in man's formation of his own nature has also been delineated by the Brazilian educator, Paulo Freire. On this see especially Freire, 1972, part 2; 1976a. There are of course many similarities between the above account and interpretations of history by writers who do not consider themselves to be Marxists. The general principle of the creative basis of human nature has been eloquently expressed in such diverse fields as anthropology (Geertz, 1968), philosophy (Natanson, 1969), and sociology (Bauman, 1973). Historical materialism differs from these phenomenological accounts in insisting that the form of this nature can only be understood in conjunction with the content: that is, the objective course that human nature has in practice had to follow.

Before going on to that, however, there is one further series of questions that needs to be confronted. Why do the forms of consciousness take the particular shape that they do? Why has human history taken a specific course, and what are the features of that history in the period being examined here?[1] Again, only a general outline can be given, but it is one that must stress, on the one side, the contingent features of the (natural and social) world with which man is confronted, and on the other, the active striving by men to produce their means of subsistence, both physical and intellectual.

To do this, men

> not only act on nature but also on one another. They produce only by co-operating in a certain way and mutually exchanging their activities. In order to produce, they enter into definite connections and relations with one another and only within these social connections and relations does their action on nature, does production, take place.[2]

In other words, in order to create the means of production men have to form social relations of production. Labour, like language, can only exist in a social world. When the means of production were primitive, so were the social relations of production simple and direct. Distribution to the community of all that was produced by the community was the operating principle governing social relations. As the means of

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[1] No attempt will be made here to give a detailed exposition of historical change, nor will justification be made for the historical materialist assumption that history is best understood as constituted of epochs which are determined by the ownership of the means of production, and overwhelmingly typified by the struggle between the class which owns the means of production and those which do not. What I am concerned with here are the particular manifestations of this struggle in the period of early industrial capitalism (i.e. in the period when the class, or group of men, which derived its power from its ownership of the manufacturing means of production, was attempting to consolidate its economic strength in the areas of political and ideological influence).

[2] K. Marx, Wage Labour and Capital, in K. Marx and Engels, 1958, vol. 1, p. 89.

production became more powerful, so the relations of production took on certain clearly defineable forms. As a surplus was produced over and above what was needed to maintain a society at a subsistence level of existence, so it began to split into divisions or classes based on the objective relationship of its members to the means of production. In capitalist society the primary objective distinction is between those who own the capital, the capitalist class, and those who have only their labour power, the working class. This "totality of production relations"[1] incorporates in its very structure a contradiction, in that the objective interests of the two major classes are opposed. This contradiction expresses itself in many ways, but the one that concerns us here is in the phenomenon of consciousness, the understandings that men have of themselves, the representations they make in their minds of the world they see in front of them. The key to understanding the dominant mode of consciousness of bourgeois society is in the concept of "commodity", the production of which is the principle aim of the capitalist means of production.[2]

"Commodity" is merely the term used to denote the external objects that men use to satisfy their wants. The existence of commodities is not peculiar to any particular mode of production: what is peculiar to the capitalist mode of production is the particular form which commodities assume. In pre-capitalist societies commodities exist primarily in terms of their use-value; that is, their ability to serve the purpose for which they are made. The use-value of a shoe is to clothe the foot,

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1 K. Marx, Wage Labour and Capital, in K. Marx and Engels, 1958, vol. 1, p. 90.

2 The following discussion of commodity production is based on the first chapter of Capital, vol. 1 (K. Marx, 1974, pp. 3-58).

the use-value of human labour is to satisfy men's needs. Commodities, however, have another function: that in which their value derives not from their active use--that is, what they can be used for--but from their exchange-value. This ability of value to be exchanged rather than to be immediately used in consumption is a feature of all societies except the most primitive. But once value is separated in this way from the labour that created it, it begins to lose its appearance as something created by labour. It assumes a separate nature as a thing, something whose value is only expressed in its facility as exchange-value. Money is the prime example of this. Money is "the general commodity with which all others are exchangeable";[1] money is the product whose use-value is its exchange-value, the visible representation of the exchange abstraction.[2]

In pre-capitalist societies commodity production is not the main feature of the society. A feudal society, for instance, does require to produce some commodities for exchange, but this is merely in order to maintain the status quo as an unchanged series of obligations and duties. A feudal ruling class might require its peasantry to produce excess rice in order to trade for salt it does not have but needs in order to maintain this same peasantry as a healthy workforce; or it might exchange home-produced woollen goods for precious metals in order to endow its representatives in the Church with symbols of authority and prestige.[3] The obligation of the worker to produce is invested in the authority

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1 Engels, 1972, p. 175.

2 Sohn-Rethel, 1965, p. 120. See also Hoffman's comment that it is the "social role of money to ensure that social relations do in fact assume the fetishistic appearance of things" (Hoffman, 1975, p. 91).

3 See also the discussion in Ash, 1977, pp. 54-5.

of the representatives of the ruling class who, in effect, order him to produce the required surplus value. The growth of capitalism involves the production of commodities over and above any formal obligations established by the feudal ruling class. As the production of these commodities increases--that is, as commodities to be exchanged and not as use-values--so a society emerges in which the dominant value is that of exchange and no longer that of use. Labour, or any other commodity, comes only to be valued according to the surplus value it can create through the medium of exchange. This conception of surplus value as though it were created through the exchange of commodities and not through the labour which had created the commodities: this is the dominant feature of bourgeois consciousness, and it is this that Marx has described as the "fetishism of commodities". To demonstrate what he meant, Marx drew an analogy from "the nebulous world of religion":

> In that world, the products of the human mind become independent shapes, endowed with lives of their own, and able to enter into relations with men and women. The products of the human hand do the same thing in the world of commodities.[1]

In other words, he argued,

> We are concerned only with a definite social relation between human beings, which, in their eyes, has here assumed the semblance of a relation between things.[2]

Instead of recognising that it is a human decision (made over many years by many people) to reproduce one form of society and not another one, the "fetishism of commodities" obscures the praxis by which man creates his world. It is a general concealment, in which all manifestations of this praxis are to some extent affected, from understandings of human

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1 K. Marx, 1974, p. 45.

2 Ibid.

nature[1] to the laws protecting the rights of private property.

Commodity production may thus be said to "mystify" reality: it reproduces reality yet it does so in a way which conceals what it is that makes it real. What makes it real is, according to historical materialism, the labour power of the vast majority of the population. And it is the recognition of this fact which provides the key to the demystification of social life. It may at this stage quite legitimately be asked, if this "false consciousness" of the world is so pervasive, how are we to break out of it? How can this present account, for instance, proclaim a "better" understanding of the treatment of the insane than those produced within the logic of the fetishism of commodities? Two answers may be given, both stemming from Marx, and both relying on an interpretation of the concept of ideology.

One fairly common understanding of "ideology" is that it is merely a wrong way of seeing the world. There is support for this view in the pages of The German Ideology, in which Marx and Engels first developed their historical materialist account of consciousness. Ideology appears there as an essentially passive reflection in men's minds of their material relationships:

> If in all ideology men and their relations appear upside-down as in a camera obscura, this phenomenon arises just as much from their historical life-process as the inversion of objects on the retina does from their physical life-process. . . .
>
> [Our method] is a matter of. . .setting out from real, active men, and on the basis of their real life-process

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1 MECW, vol. 5, p. 7. Or as Mao puts it in a more obviously Marxist form, "Is there such a thing as human nature? Of course there is. But there is only human nature in the concrete, no human nature in the abstract. In class society there is only human nature of a class character; there is no human nature above classes. We uphold the human nature of the proletariat and of the masses of the people, while the landlord and bourgeois classes uphold the human nature of their own classes, only they do not say so but make it out to be the only human nature in existence" ("Talks at the Yenan Forum on Literature and Art, 1942", in Mao, 1967, p. 31).

> demonstrating the development of the ideological reflexes and echoes of this life-process. The phantoms formed in the brains of men are also, necessarily, sublimates of their material life-process, which is empirically verifiable and bound to material premises.[1]

On the one side lies this confused, false, and passive view that men have of themselves, and on the other, Marxism, based on a recognition of the material world.

> [Our] manner of approach is not devoid of premises. It starts out from the real premises and does not abandon them for a moment. Its premises are men, not in any fantastic isolation and fixity, but in their actual, empirically perceptible process of development under definite conditions. . . .Where speculation ends, where real life starts, there consequently begins real, positive science, the expounding of the practical activity, of the practical process of development of man. Empty phrases about consciousness end, and real knowledge has to take their place.[2]

Marxism is thus a science, a means by which the social (and of course, to many, the natural) world may be understood.

Whatever Marx and Engels meant in 1845 and 1846 when they were writing The German Ideology, this assertion of positivist surety has done little to encourage research into the precise ways that ideology exerts the power it seems to hold. According to the passage just quoted, ideology can have no history of its own: it is merely the pale and empty reflection of real history. Works such as this thesis would take about ten pages to write--that is, just space enough to describe the material changes in the social relations of production and to align moral treatment to them.[3] The critique of ideology degenerates into a simple unmasking of illusions,[4] an activity for which many Marxists have assumed that

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1 K. Marx and Engels, The German Ideology, in MECW, vol. 5, p. 36.

2 Ibid., p. 37.

3 For an example of this sort of approach see Haigh, 1974.

4 On this see Lichtheim, 1965, pp. 183ff.

they are automatically the holders of the scientific tool with which to analyse social reality. This conception of ideology proves not only useless as a means of untangling the activity of praxis in history, it also ignores the historical source of its own epistemology. It implicitly rejects the continual process of history and attempts to capture change in a philosophy which, in so doing, it changes from a materialist one to a branch of metaphysics.

That is one conception of "ideology". An alternative one, which is not explicitly defined by Marx, can nevertheless be found to permeate all that is creative in Marxism-Leninism. It is encapsulated in Sartre's aphorism that "Marxism is History itself becoming concious of itself".[1] As already stated, human nature is not, according to historical materialism, fixed once and for all. It develops dialectically as man appropriates the world and objectifies himself in this appropriation. Consciousness is an aspect of this process: consciousness is not a passive mode of experiencing the world but a means in the creation of human nature, produced out of labour and itself a resource in the production of what is distinctively human in man. Ideological forms of consciousness, such as animism and political economy, are merely examples of that limited consciousness as, it must be stressed, is Marxism itself. These forms of consciousness are inherently limited because they are attempts to define man's purpose in the world (or some aspect of it) when that purpose is constantly being changed, and that precisely by the material existence of these forms of consciousness themselves.

According to this mode of thought, consciousness cannot be neatly separated into ideological and scientific aspects.[2] It is rather that

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[1] Sartre, 1976, p. 40.

[2] According to this definition, then, "science" cannot be opposed to "ideology", or even "scientific knowledge" to "ideological knowledge".

knowledge becomes less ideological to the extent that it allows man to exert greater conscious control over his own future. Each form of consciousness may be assessed insofar as it recognises the material reality of a particular time.

The material reality of our time is the fetishism of commodities. If this mode of consciousness is spelt out in all its manifestations--from the laws of private property to the practice of psychiatry--we will gradually be able to develop a consciousness which can be used to defend new interests not committed to the maintenance of capitalism. This new way of thinking will still require a change in the material conditions to be, as moral treatment was before it, both meaningful and progressive. My own feeling is that these material changes are taking place and that this present contribution in the sphere of ideas is in some way complementary to these far more significant changes in the economic and political world.[1]

We exist within history as much as did those to whom we direct our attention. Our reason is formed out of the dialectical interplay of the forces and relations of production as much as are our factories, churches, and universities. As much as those we study, we "make [our]

All knowledge this side of perfect communism (which we can barely conceptualise at this stage) is to some extent ideological, based as it is on an imperfect consciousness of what could be possible. Equally, much knowledge is scientific to the extent that it contributes to our attaining that state. On this see Sedgwick's comments on Gramsci's conception of science (Sedgwick, 1966, pp. 185-6).

[1] In the words of Santiago Carrillo, "In present conditions, the only way towards changing the ideological-political apparatus which upholds the capitalist regime is the creation of a new correlation of forces by means of political, social and cultural struggle. . . .Certainly one of the great historical tasks of the present time for the conquest of state power by the socialist forces is the determined, resolute, intelligent struggle to turn the weapon of ideology, the ideological state apparatusses, against the classes which are in power" (Carillo, 1977, pp. 41, 45).

own history. . .under circumstances directly encountered, given and transmitted from the past". Within that logic we can attempt to expose "laws of human nature" as so much petrified praxis. The point of doing this is not to produce a general theory of ideology, but to aid in the transformation of that petrified praxis. Or, as Sartre has put it,

> The dialectic reveals itself only to an observer situated in interiority, that is to say, to an investigator who lives his investigation both as a possible contribution to the ideology of an entire epoch and as the particular praxis of an individual defined by his historical and personal career in the wider history which conditions it.[1]

To accept this dictum is not to imply that one has an automatic guarantee of top quality research data. That will only come from rigorous work by the researcher, whatever his ideological commitments. All that is claimed here is that the "theory of praxis in historical materialism" provides a theoretical basis which is intellectually adequate to explain changes in the treatment of the insane, as well as being sociologically reflexive in that it is able to account for its own meaning.[2]

* * *

The air is now cleared and the precise intellectual debates within

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[1] Sartre, 1976, p. 38.

[2] There is a similar recognition of the materialist implications of the sociology of knowledge from a bourgeois academic viewpoint in Barnes, 1974, pp. 154-7. Where this present account differs from that of Barnes is in its conception of the nature of rationality. Barnes maintains that the "sociologist will be unable to advance his understanding of belief and action by categorizing it in terms of his own criteria of rationality, efficacy or truth" (ibid., p. 43), and that "belief systems cannot be objectively ranked in terms of their proximity to reality or their rationality" (ibid., p. 154). My argument is that any description of the world must do precisely that to be meaningful at all, which is indeed what Barnes does by locating the meaning of his work within contemporary debates in bourgeois universities on the nature of science (ibid., p. 155). In contrast, I try to locate the rationality of my work in the consciousness produced by those who have identified themselves with the interest of the working class.

which the following account is written have been revealed. The relationship of the following account to existing work in the history of psychiatry, the sociology of medical knowledge, and historial materialism has been discussed. The disadvantage of such a broad approach is that it may appear to involve a cavalier attitude to many of the usual concerns of medical and psychiatric history. There is nothing here, for instance, on the "real" causes or incidence of insanity, nor on the social history of the insane.[1] These might appear to be a legitimate concern of any social historian of the treatment of the insane; but from the viewpoint adopted here, to include a discussion of them would be merely to confuse the argument. On the other hand, the advantages, indeed necessity, of working simultaneously within different intellectual contexts should by now be obvious. An additional advantage of this type of approach is that it provides not only an account of the specific production of theories and practices in the treatment of the insane, but that it illuminates the general production of cultural forms in capitalist society.

There will be few references in the substantive part of this thesis to the theoretical issues raised in this introduction. We do not need to understand an architect's knowledge of mathematics and physics when we are walking through a building constructed from his plans, and yet without those theoretical components the building could never have been

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[1] It will also be noted that there is far less time spent on the "post-history" of moral treatment than there is on its "pre-history". This is because the main interest here is in understanding the praxis that established moral treatment as a meaningful activity, not in providing a full description of a historical phenomenon. The praxis that led to the "decline" of moral treatment was informed by different values, different material interests; and although these values and interests are not entirely ignored here, it is not felt that to examine them in any detail would add to an understanding of moral treatment itself.

erected. In the same way the theoretical structure of this thesis has been laid bare for those with a technical interest in its rationale. But the value of the thesis must lie in its practical use to us as historians or sociologists or whatever, and not because of its theoretical pedigree.

In many ways, what is presented here is very similar to work in the history of art, especially that of T.J. Clark or Max Raphael. Clark has emphasized the need to elucidate the relationship between a work of art and the society in which it appears, what he calls the verb of which the work of art is the noun.

> If the history of art has a specific study, it is exactly this--the process of conversion and relation, which so much art history takes for granted. I want to discover what concrete transactions are hidden behind the mechanical image of "reflection", to know how "background" becomes "foreground"; instead of analogy between form and content, to discover the network of real, complex relations between the two.[1]

Similarly, Raphael has provided a number of "monographies" in which the individuality of the work of art and the generality of the conditions out of which it was produced are completely integrated in his study of them.[2] However, while recognising that my own research has much in common with some art history, no claim is being made of following the precise methods of particular art historians.[3] It is rather that a

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[1] T.J. Clark, 1973, p. 12, emphasis in the original. See also Clark's appeal for a dialectical art history in the Times Literary Supplement (T.J. Clark, 1974). Clark's methodology is discussed by Tagg (1977, especially pp. 188-90).

[2] Raphael, 1968. One of the case studies that Raphael provides is of Picasso's painting of Guernica (op.cit., chap. 5). Raphael situates this work of art both within the objective history of which it is a part and within Picasso's own ideological place within the history of his time. On Raphael's approach see Tagg, 1975.

[3] My understanding of the social determination of cultural forms also owes much to the art history of Arnold Hauser (1962).

number of researchers in related fields have discovered that they are doing similar work. In very different ways the essays by Sartre on Jean Genet's creation of his own image,[1] and by Rodinson on Mohammed's creation of a new religion,[2] are also examples of research which the present account has taken as an inspiration.

What the best of this type of work has in common is that it does not rely on complex theoretical concepts to make its point. Although the issues involved and the approaches taken are indeed complex, the writers accept that a text must stand or fall on its own merit: it must convince as practice as well as theory. Finally then, a work of history, once written, is no more than a pliable resource to be used by the reader in accordance with his ends. Its quality lies less in its existence as a convincing account than in the extent to which the reader is able to repeat the whole process of rethinking history.

The last word in this introduction may be left to Sartre, whose work has remained a constant encouragement throughout my writing of this thesis:

> What is honourable about reading is this: the reader freely allows himself to be influenced. . . .The reader invents us: he uses our words to set his own traps for himself. He is active, he transcends us--that is why we write.[3]

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1 Sartre, 1964.

2 Rodinson, 1973.

3 "The purposes of writing", in Sartre, 1974, p. 22.

PART ONE

CRYSTALLIZATION

In the following account of changes in the treatment of the insane the central focus will be, as already announced, on the phenomenon of moral treatment. Moral treatment will be examined as a means of changing the treatment of the insane both as a theory of what was known and as a practice of what was done. The substantive content of the thesis is divided into two main parts. In Part One the crystallization of the concept of moral treatment is followed, a crystallization that made use of numerous and disparate fragments of existing ideologies and practices. The metaphor of "crystallization" is used because it captures the imagery of formation, of using existing resources to make a new and indivisible whole. It will be shown that moral treatment was such a construct, with the difference that, unlike natural crystals, the significance of moral treatment derived only from the men in whose hands and minds it was fashioned.

Part One is divided into two chapters. Chapter One concerns itself with the prehistory of the announcement of moral treatment--the social and intellectual context that made it possible for moral treatment to appear as both meaningful and progressive. Chapter Two is devoted to an examination of the creation of moral treatment in the work of the Tuke family at York and of Philippe Pinel in Paris. Chapter Two also assesses the significance of the phenomenon at this stage of its career.

At this time (that is, until about 1815) moral treatment was merely an experiment, one method among many contemporary therapies. It was with the publication of various accounts of moral treatment as a successful practice that it emerged into the world, to be used as a

ready-made resource in the treatment of the insane. Part Two follows the fortunes of moral treatment after this emergence. Because it was now an established "fact", one which had a concrete praxis to appeal to for its validation, this phase of moral treatment is most appropriately described as one of Petrification. Chapters Three and Four deal with the petrified forms of moral treatment as they appeared both as social practice and as natural knowledge.

The heyday of moral treatment was short-lived. By 1845 it was both proclaimed everywhere and indistinguishable as a method of treatment from many others. The concept of moral treatment had been transformed from a distinct ideology into a general term, and what had been distinctive about the early practice of moral treatment began to appear under a new banner. These transformations of the petrified fragments and their re-crystallization into new forms will be dealt with in Chapter Five.

CHAPTER ONE

The Prehistory of Moral Treatment:
A survey of the social and intellectual world into which moral treatment was to appear.

We must cease once and for all to describe the effects of power in negative terms: it "excludes", it "represses", it "censors", it "abstracts", it "masks", it "conceals". In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production.

--Michel Foucault

Let us start with the basic datum of any social investigation: the people who were involved.

Those recognised as insane[1] in the 1790s were kept in a number of large and small institutions. Table 1 gives a rough idea of the numbers involved. The first national attempt to find out what the figures were was not made until 1806, but this was far from being an exhaustive survey. The number of insane listed as being in private custody and in the workhouses is probably underestimated, but this does not seriously alter the general picture. For most of the institutions private records were kept which allow at least an outline of provision to be drawn. From the lunatics' point of view we can divide the facilities into the predominantly custodial-only and the therapeutic. From the point of view of the institutions this is not so easy to do. Some are obviously purely custodial and others overwhelmingly tied to a rehabilitative programme, but in many the decision to emphasize one or other aspect rested with the head keeper, or superintendant, or physician, and often policy changed as personnel changed. However the distinction is worth making because although the 1790s were a time when the concepts of both custody and therapy were being questioned, this occurred within an intellectual and institutional context when they had had very precise meanings. To understand the significance of this change it is necessary to uncover something of these meanings as they appeared to the physicians and reformers

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[1] The terms "insanity", "madness", "asylum" etc. are used here because they were the terms used in the period being researched. There was a change in the concepts being used at this time, and this itself requires comment. As far as possible this comment will be made consciously and not hidden within an evaluational rewriting of the past as "psychiatric history" or its antithesis, "The Manufacture of Madness" (Szasz, 1973).

Table 1

Provision for the Insane in England and Wales circa 1800

Custodial Institutions		Therapeutic Institutions	
Private custody (1807)	483[b]	St Peter's Workhouse, Bristol (1819)	30[c]
Gaols (1807)	27[b]	Bethlem (1800)	266[a]
Houses of Correction (1807)	115[b]	Subscription hospitals	732
Workhouses (1807)	1765[b]	St Luke's, London (1800)	300[b]
Private madhouses (all in London)	1341	Newcastle (1819)	69[c]
Hoxton House (1819)	348[c]	York (1800)	112[g]
Holly House (1819)	118[c]	Liverpool (1790)	64[h]
Whitmore House (1819)	78[c]	Guy's, London (1800)	20[i]
Red and White Houses (1819)	797[c]	Manchester (1800)	100[j]
		Bethel, Norwich (1771)	55[k]
		Leicester (1819)	12[c]
(Plus another ten to twenty private madhouses of less than 20 patients and an unknown number in private custody)[m]		Private madhouses	481
		Droitwich (1816)	85[d]
		Greatford, Lincs (1796)	25[e]
		Retreat, York (1800)	36[f]
		Brooke House, Surrey (1814)	40[a]
		Fishponds, Bristol (1816)	57[l]
		Brislington, Bristol (1819)	73[c]
		Ticehurst, Sussex (1819)	40[c]
		Spring Vale, Staffs (1815)	25[a]
		Laverstock, Wilts (1819)	100[c]
		(Plus another ten to twenty smaller private madhouses of less than 30 patients)[m]	

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[a] 1815 SC, Report and Appendices. [b] 1807 SC, Report. Even at the time these figures were published they were held to be gross underestimates. Halliday in an appendix to this Report gives detailed, and much higher, figures for two counties.

[c] Burrows, 1820, Appendix. [d] 1816 SC, Report. [e] Anon, 1796. The physician in charge of this house is stated to have had about 200 patients he was treating for insanity, many of whom he boarded out in peoples' homes.

[f] Retreat, State of the Institution, 1800. [g] Gray, 1815. [h] J. Currie, 1805, vol. 2, Appendix 2. [i] Cameron, 1954. [j] Brockbank, 1934.

[k] Bateman and Rye, 1906. [l] H.T. Phillips, 1973. [m] Hunter, Macalpine and Payne, 1956.

of the 1790s.

1. The theory and practice of confinement

Of the "single" lunatics (that is, those confined alone) in private custody we have little information. No public records were kept of their numbers and, although we have the usual anecdotal stories about isolated cases, it is more likely that these have been remembered more because of their exceptionality than because they were typical of the mass. In any case, no theory of care was developed around the single lunatic. Where they were treated at all, and many of the wealthy ones obviously were, it would have been by a mad-doctor or apothecary[1] with an interest in insanity who for various reasons did not admit the patient to a private madhouse. Those who could not afford the expenses of a doctor were left to their own resources, or if a nuisance, held in confinement.

There were a number of small custodial madhouses which functioned on a nursing-home principle: that is, they provided a place of confinement for those lunatics who were judged to be dangerous and who could pay for more than the very minimum. Examples of unnecessary restraint and coercion are frequently used to portray the eighteenth-century private madhouse trade, but as with all institutions existing in a free market, you got what you paid for. It is possible to point to examples of rich patients who were put away by relatives who wanted to get their hands on the family fortune, but it is equally possible to find examples of kindness and concern.[2]

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1 The term "mad-doctor" is a contemporary one referring to a medical specialist in insanity. It could be used to refer to a physician, an apothecary, or a surgeon, the three strata of the medical profession at the time. All three had representatives in the "Trade in Lunacy" (another contemporary term), the only difference being the status or wealth of their clients. On the structure of the eighteenth century medical profession see Hamilton, 1951; N. and J. Parry, 1976, pp. 104-17.

2 On the former see almost any of the evidence given to the 1816 SC.

The important point is not the existence of individual examples but the underlying factor which led them to develop as solutions. This factor was of course that the insane constituted a social problem. They could not support themselves, they were sometimes violent, and at the very least they appeared as a nuisance. There was nothing new about this: the itinerant lunatic had been recognised as a problem at least since Shakespeare's time, but so too had the existence of the Parish responsibility for its dependents who could not care for themselves.[1] This was the deciding factor for most of those classified as insane: what it was that their parish decided to do with them. A variety of means had been tried in the seventeenth century to cope with the problem of order that the insane presented, but by the late

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Examples of "good" custodial care are harder to point to, if only for the reason that good news is not newsworthy. If Faulkner's advertising tract for his madhouse (Faulkner, 1789) is to be believed, "every indulgence, as far as is consistent with physical and mental operation, is allowed. . ." (p. 23). A more reliable source of evidence is perhaps that of patients' relatives. Charles Lamb wrote to Coleridge about the madhouse at which his (Lamb's) sister was confined after killing their mother: "The good lady of the madhouse, and her daughter, an elegant, sweet behaved young lady, love her, and are taken with her amazingly; and I know from her own mouth she loves them, and longs to be with them as much" (letter of 3rd October 1796, in Lamb, 1907, vol. 1, p. 37). The poet William Cowper was at Dr Cotton's madhouse in St Albans from 1763 to 1765 and had no words of criticism for his custodian at all; indeed he summed up the madhouse proprietor's attitude as "ever watchful and apprehensive for my welfare" (Cowper, 1816, p. 69). But as Cotton was charging between three and five guineas per week to patients at his house at this time, the concern is perhaps not surprising. (See HMA, p. 425.)

[1] That is, since the Poor Law Act of 1601.

eighteenth century the solutions were becoming institutionalised.[1] One answer was to treat the insane offender purely as an offender and to sentence him to one of the penal institutions. John Howard has left a description of what it was like for the lunatic in prison:

> . . .in some few gaols are confined idiots and lunatics. These serve for sport to idle visitants at assizes, and other times of general resort. Many of the bridewells are crowded and offensive, because the rooms which were designed for prisoners are occupied by the insane. When these are not kept separate, they disturb and terrify other prisoners.[2]

But, as Howard points out, the numbers involved were very small. A disruptive lunatic dependent on his parish for support was far more likely to be boarded out in a private madhouse or workhouse.

By the late eighteenth century the workhouse was undoubtedly the major institution for the social control of deviance. The importance of the insane in these workhouses, at least as far as the workhouse ethos was concerned, was minor. But the aims of the workhouses were so closely tied to many of the ideological concerns that were popular in the eighteenth century that all the institutional innovations, for the insane or for any other deviant group, were to some extent dependent on the example the workhouses had set. The specialist facilities for the insane that were to appear later developed a specialised rhetoric, but this rhetoric can hardly be assessed without understanding the basis in social practice from which innovations were to emerge.

One of the first workhouses to be built in England was at Bristol.[3] This particular workhouse is of interest here because not only was the

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1 In the seventeenth century the most usual course of action was for a relative of an insane person to petition a Justice of the Peace, and for the latter to authorise the parish to provide financial assistance or safe keeping or to send the lunatic to a House of Correction. For examples, see D.H. Tuke, 1882, pp. 41-2; HMA, pp. 137-9; Fessler, 1956. Fessler points out that the custodial madhouses were merely an extension of the earlier ad hoc arrangements whereby the parish authorised payment to an individual to look after the "village lunatic".

2 J. Howard, 1973, vol. 1, p. 8.

3 The most comprehensive survey of the early workhouse movement is

rhetoric surrounding its establishment quite explicit in its claims of what the point of the new institution was to be, but also because this workhouse had a large number of insane inmates. The first proposal for a Bristol workhouse appeared in a book published by a Bristol merchant in 1695, John Cary's An Essay on the State of England, in Relation to its Trade.[1] Cary noticed that as each parish within a city like Bristol was responsible for its own poor, some parishes were likely to have a much heavier burden than others. These were likely to be the parishes in the suburbs of the town. They received little income from commerce, but they attracted the poor, both because they were cheaper places to live in than the commercial areas, and because once the poor started to move in, others were attracted to the area. Cary saw the solution of providing for these poor in a general poor rate for the whole city being used to create a general provision for all in the workhouse.[2] This idea was given legislative voice by the Bristol Poor Act of 1696 which allowed parishes to combine their responsibilities for more efficient administration of the Poor Law. As a direct consequence of this Act one building was opened in Bristol in 1698 to accommodate the poor of eighteen parishes, and one uniform rate was levied in each parish.

The workhouse was a building conceived as a containment of idleness, both physically and metaphorically: life in the workhouse was

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still to be found in the Webbs' history of English local government. See especially S. & B. Webb, 1927, chap. 4.

1 Cary, 1695

2 ". . .if Cities and Towns were made but one Poor's Rate, or equally divided into more, these Inconveniences might be removed, and the Poor maintained by a more impartial Contribution" (ibid., p. 168).

constructed to symbolise the values of society--the competitive, dynamic of commercial capitalism that had made Bristol such a prosperous place. There was the physical contribution that the inmates could make: assistance in simple manufacturing processes such as beating hemp, dressing flax, carding and spinning wool, stripping and rolling tobacco, and picking oakum. Although the aim was to get real work done, just as important was the instillation of the right attitude:

> . . .if a reward were given to that Person who should spin the finest Thread of either [wool or flax], to be adjudged yearly, and paid by the County, 'twould very much promote Industry and Ingenuity, whilst every one being prickt on by Ambition and Hopes of Profit, would endeavour to exceed the rest, by which means we should grow more excellent in our Manufactures.[1]

The confined space was the new society writ small; a moral universe with no escape except that which could be obtained by following the rules. Foucault, in describing the similar institution of the Hôpital Général in France, has written,

> The prisoner who could and who would work would be released, not so much because he was again useful to society, but because he had again subscribed to the great ethical pact of human existence.[2]

Foucault has captured exactly the idea of the workhouse as a moral fable, in whose confined space the seeds of entrepreneurial competition were to be sown and nurtured.

In practice, the whole idea of turning the workhouses into centres where the poor could be profitably employed was repeatedly shown to be

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1 Cary, 1695, p. 158.

2 Foucault, 1971, pp. 59-60. This is not to say that there were no major differences between the Hôpitaux Généraux and the workhouses. The former were much more inclusive, the one in Paris, for instance, holding 6000 inmates by the 1660s. But insofar as the Hôpitaux Généraux and the workhouses accepted the thesis that "mendicancy and idleness [were] the source of all disorders" (Edict of 1656 authorising the establishment of the Hôpital Général in Paris, quoted in Foucault, op.cit., p. 47), it is legitimate to compare them.

invalid. For a number of reasons, relating both to the difficulties of getting the paupers to work and of selling the goods and services they produced, the practical expression of the workhouse as a House of Industry was a failure.[1] A number of workhouse overseers did believe however that, although the workhouse regimes themselves did very little to keep the poor rate down or to encourage their inmates to work, the very existence of a workhouse in a small community often had a startling effect. As the master at Maidstone workhouse put it in 1724,

> very great Numbers of lazy People, rather than submit to the Confinement and Labour of the Workhouse, are content to throw off the Mask, and maintain themselves by their own Industry.[2]

This idea of the workhouse as deterrent remained one of its most popular images throughout the eighteenth century.[3]

It was however as an expression of ideology that the workhouse really inspired such men as John Cary. Whatever an individual workhouse's failure as a means for producing profit, the principle of the institution remained an attractive one to many. Part of this attraction derived from the obvious element of social control expressed in the whole notion of a workhouse: the idea that only by taking the aims of their society seriously can people be made to abstain from civil disobediance--and this was a real problem that Bristol faced on a number of occasions. But Cary's ideas are more complex than that. As an ideologist at a time when his class was breaking down barriers imposed by a less democratic authority, Cary expresses the positive, liberating

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1 Numerous reasons are given in S. and B. Webb, 1927, pp. 227-40.

2 in Anon, 1732, p. 128. This work consists entirely of letters and documents from workhouses and provides a revealing picture of the everyday workhouse practices of that time.

3 S. and B. Webb, op.cit., pp. 243-5.

element of bourgeois thought as well.[1] The passage in which he does this is worth quoting at length because it contains many of the themes that sections of the English middle class have continued to repeat up to the present day:

> Idleness is the Foundation of all those Vices which prevail amongst us, People aiming to be maintained any way rather than by Labour betake themselves to all sorts of Villanies, the ill Consequences whereof cannot be prevented but by encouraging Youth in an early Delight of Living by Industry, which would keep up a true English Spirit in them, and create a Desire to secure a Property in what they have; whereas a sloathful Dependance on another's Bounty makes Men slavishly give up all at the Will of their Benefactors, and having no Properties of their own to secure, are easily perswaded to part with their Liberties; this a former Reign knew well, when the Ministers of that Court found an Inclination in the People to sell their Privileges for Luxury and Ease.[2]

Instead of the moral ties bonding men to their patrons, man was to be made free. The material benefits of this freedom were obvious to a prosperous merchant like Cary for whom the unfettered exploitation of labour and capital was also the source of his enrichment.[3]

That servitude and not enrichment was the likely outcome of any person's stay in a workhouse hardly needs comment, but it is not enough

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1 Cary was not just a merchant who happened to write about the subject he knew best; he was an active propagandist for the trading section of the community for most of his life. He took an active part in local Bristol politics and was chosen by the committee of trade of that city as their representative in London. Cary wrote a number of works on all aspects of commercial capitalism, from international markets to the concept of "industry" (that is, work) itself. His best-known book, the Essay on Trade (Cary, 1695) was described by that other bourgeois ideologist, John Locke, as "the best discourse I have ever read on the subject" (DNB).

2 Cary, 1695, p. 165.

3 Vide The Communist Manifesto: ". . .the feudal relations of property became no longer compatible with the already developed productive forces; they became so many fetters. They had to be burst asunder; they were burst asunder. Into their place stepped free competition, accompanied by a social and political constitution adapted to it, and by the economical and political sway of the bourgeois class" (MECW, vol. 6, p. 489).

to write off the workhouses merely as attempts at social control of the poor. Their meaning is hidden deep within the logic of bourgeois rationality: it is both an expression of the moral worth of individuals in a society committed to commodity production as well as a means to conceal that morality within the objective needs of that society. This is a theme that was to be repeated endlessly in the eighteenth- and nineteenth-century institutions for the control of deviance, as well as in the theoretical constructions that were created to justify their existence.

As already stated, the Bristol workhouse is of particular interest because it took on a special function of caring for the insane. The building had always been known as St Peter's Hospital, and although its first inmates were a hundred boys, these were soon joined by the aged, the infirm, and lunatics, the latter eventually becoming the sole inhabitants.[1] The first mention in the Bristol Corporation of the Poor Court records of a lunatic at St Peter's is in 1707. By 1825 the transformation was complete and the building was recognised as the Bristol lunatic asylum.[2]

It is sometimes asserted that because Bristol was ahead of its time in recognizing the insane as a separate category, this meant that their treatment was in some way "better" than that of the insane in the mixed workhouses.[3] What evidence we have suggests that St Peter's was run with the same overriding concern for economy that typified all workhouses at the time. The insane inmates appear to have had little medical attention. Not until 1768 do the Court books announce ". . .that the Physicians and Surgeons of this House should be desired to visit (once a Week at least) the Frenzy Objects and report the State of

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1 H.T. Phillips, 1973

2 Butcher, 1932, p. 10

3 See for instance K. Jones, 1972, pp. 20-1.

their Health to the Committee."[1] The following year a cold bath for the lunatics was installed on the physician's advice. Two years later it fell into the adjacent river following the collapse of a wall due to disrepair. Overcrowding was another perennial problem. There were complaints in 1767 of children having to sleep eight to a bed; and in 1785 by getting rid of some "workshy" inmates the total number of inmates was reduced to 325. But within thirty years the figure was up by half as much again.

One thing is certain: whatever the treatment of the insane at St Peter's, as far as establishing the principle of workhouses went, Bristol was ahead of its time. National legislation authorising parishes to erect workhouses was not passed until 1722,[2] and legislation allowing them to combine into Unions, as Bristol had done, did not appear before 1782.[3]

A thorough survey that was made of workhouses in 1732 suggests that at that time few recognised lunatics were being placed in them. For instance, Rule 14 of the Regulations of St Andrew's workhouse in Holborn stated

> That no pension be allowed to any Pensioner out of the House, unless in Cases of Lunacy, Plague, Small-Pox, Four-disease, or Idiotism. . .[4]

A similar sentiment was expressed at Bedford workhouse. This must be seen in the context of the reasoning governing the establishment of these workhouses: if the poor were made to enter an unpleasant institution before being offered any assistance they would try harder to be

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1 Quoted in Butcher, 1932, p. 114

2 9 Geo. I, chap. 7

3 22 Geo III, chap. 83

4 Anon, 1732, p. 19. The first edition published in 1725 does not mention lunatics at all.

self-supporting. It has already been pointed out that the principle of deterrence was an important one for the advocates of the workhouse; that is, the belief that it was not so much the actual reformation that was achieved with those who became inmates, as the example that was set to those who did not. A typical comment was this from Brentwood workhouse:

> In the Work-House at this Place, there are only at present 4 or 5 ancient People, past their Labour, one incurable, and half a dozen small Children, under the Government of a Mistress: And tho', the poor People being helpless, there is little or no Work done in it, yet the setting of it up has had this good Effect, that the Poor's Rates are lessened above one half, by exciting the Industry of the poorer Sort, who are willing to exert their utmost Endeavours to maintain themselves at Home, rather than to be put into the Work-House.[1]

With this philosophy underlying the foundation of the workhouse movement the existence of lunatics within a workhouse would be at best irrelevant, and at worst a nuisance.

Some counties never took much interest in the lunatics in their workhouses. Perhaps some areas received less than their share, or perhaps the local administrators took a more relaxed attitude to their dependents. Or perhaps the existence of a local asylum introduced an element of choice, encouraging workhouse overseers to get rid of some of their more disruptive inmates. A comparison of two counties for which we have detailed information supports this latter thesis. Suffolk in 1807 had at least 47 pauper lunatics, all of them held in workhouse cells except for 13 who were in a privately-endowed lunatic asylum in Norwich and 2 at St Luke's in London. Norfolk at the same time had 112 pauper lunatics, of whom 51 were in the Norwich asylum, 20 in another asylum, three in gaol, four in Houses of

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1 Letter from Brentwood workhouse, in Anon, 1725, p. 57

Correction, 14 not confined at all, and only 20 in workhouses.[1] These figures, whatever their inadequacy in providing a complete and reliable account, do at least indicate the differing use made of the facilities available for the insane at that time.

We do have a number of descriptions of what life was like for the pauper lunatic in a mixed workhouse. William Perfect, a physician with an interest in insanity, described how in 1776 he visited a maniac in the Rochester workhouse. The lunatic was attached to the basement floor by fetters and iron staples, in a room visible to the passing public who apparently gave him gin to encourage his mad behaviour.[2] A more extreme example of this simple mechanical restraint is found in the records of a Yorkshire public asylum.

> No. 240. Admitted February 18th, 1819, Aged 75 years. Insane 36 years. When aged 39 [i.e. in 1783] she drowned her infant child and from that period had been chained in a cell in the workhouse of Barnsley, until the time of her removal to this place.[3]

This simple policy of segregation or confinement may have been effective in terms of reducing the lunatics' nuisance potential; but it could only be tried if the lunatic was recognised as being separate, without the potential for reform that the rest of the deviant population was held to possess.

Certainly there was a recognition that the insane created special problems of order for the workhouse. But it was a problem that was not solved by the methods that were recognised as being appropriate to the institution of the workhouse. Even St Peter's in Bristol, adapted for use as a workhouse-hospital, never really developed a policy whereby

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1 See the letters from Halliday in the appendix to the 1807 SC Report, p. 13.

2 Perfect, 1787, pp. 131-4.

3 Quoted in Bolton, 1928, p. 617.

the reformative ideals of the workhouse could be adapted to the specialised case of the insane. It was this failure of the workhouses to generalise the bourgeois solution to deviance across the whole spectrum of the deviant population that provided one of the major planks in the attempt to build a hospital movement. Insanity was recognised as a distinctive social problem precisely because it remained intractable to the generalised solution to deviance of the workhouse.

Not everyone drew the conclusion that a hospital was the best solution for the problem of the pauper lunatics. The private madhouses have already been mentioned and in terms of size of provision they remained important until the mid-nineteenth century.[1] As the overcrowding in the workhouses grew so did the number of entrepreneurs who agreed to board out parish paupers at a minimum charge. For a small regular payment the parish could fulfill its responsibility to its deviants without involving itself in any capital expenditure or overcrowding its reformative institutions with the apparently unreformable.

This was especially true in the home counties, served by the very large houses in the East End of London of Thomas Warburton and Sir Jonathan Miles, houses which were to become infamous with the disclosures of the 1816 and 1827 Select Committee reports.[2]

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[1] See Parry-Jones, 1973. Not until 1845 was it made mandatory for all county authorities to provide a place in a medically-supervised asylum for all their lunatics.

[2] Miles owned Hoxton House from 1790 (although the house had been run as a madhouse by his family since 1695). In 1819 it held 348 patients. Warburton, who started his career as a butcher's boy, became a porter at Whitmore House and subsequently servant, keeper, and owner (Mitford, 1825a). In 1819 it held 78 patients. Warburton also owned the Red and White Houses in Bethnal Green which he set up to cope with the less affluent overspill of Whitmore House. In 1819 the Red and White held 797 patients. A large number of Warburton's charges came to him from Thomas Dunston, head-keeper at St Luke's Hospital, who

Given that most of these paupers were only being confined at all because they were believed to be dangerous by the parishes who were paying to have them boarded out, the main problem confronting the administrators of these madhouses was one of restraint. Mechanical restraint, such as the use of chains and strapping the patient into his bed, was cheap and effective. In the Red and White madhouses,

> They were in the habit of treating those men by chaining them down of an evening about an hour previous to dusk, in things called cribs, which are boxes containing straw, and leaving them there till the following morning, locked in, without any attendance being paid to them in the course of the night, let whatever would occur; and on the Saturday evenings, they were locked down in the same state, and kept until Monday morning, without being unchained or allowed to get up to relieve themselves in any way whatever.[1]

And this was in 1827 when continuing reports of cruelty had led to yet another official enquiry into the madhouses. In another asylum

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frequently had between six and seven hundred names on the waiting list for St Luke's (Dunston's evidence to the 1807 SC, Report, pp. 9-13). Dunston received a retaining fee of £500 per annum from Warburton for recommending patients to him and is said to have "amassed a fortune of £30,000" (Morris, 1958, n.p.) from this source. The relationship was strengthened when Warburton's daughter married Dunston's son, an apothecary who was later to become visiting doctor to Warburton's houses. One vivid example of Warburton's mis-use of public funds was given by the publisher Charles Knight, then Overseer in the parish of Windsor. In 1818 the parish was in debt and one of the largest outstanding debts was to Warburton. This was for £400 in respect of a pauper who had been confined in one of Warburton's houses for ten years for causing a public nuisance. Knight went to enquire and at the madhouse was received at the door "by a civil man-servant" who turned out to be the cured lunatic. He was subsequently discharged. (C. Knight, 1864-1865, vol. 1, pp. 195-7).

[1] Evidence of William Solomon, ex-patient at one of Warburton's madhouses, 1827 SC, Report, p. 32.

> when the keepers were asked the reason for putting them [the patients] in irons, [the keepers replied] that it would require a larger expense than they could afford to keep servants to take care of them if they were not ironed.[1]

As an institution to deal with the insane, the private madhouse was not necessarily custodial or coercive any more than the workhouse was necessarily reformative. But whereas the workhouse was a public institution and was based on the ideology of those who controlled the public purse, the private madhouses were by definition dependent only on the private concerns of their proprietors. Many of the proprietors saw their madhouses as a financial investment with monetary profit the only aim of their "Trade in Lunacy". Others, as will be shown later, saw their enterprise not so much a financial as an ideological investment in which they could demonstrate the superiority of the values they had elected to live by. In some of these madhouses and private asylums significant innovations in the treatment of the insane were to be made.

This concludes the review of predominantly custodial facilities. Before turning to the radical innovations in therapy that were to be made it is necessary to sketch in the background of the provision that was made for the insane that could be said in any way at all to be based on a commitment to therapy rather than to confinement.

2. The beginnings of therapy for the insane

In the eighteenth century the major institutional embodiment of therapeutic principles was the public hospital. These hospitals were committed to the cure of their patients as well as to their care, and in numerical terms these constituted the most important of all the institutions in which the insane were likely to find themselves.

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[1] Evidence of Dr R. Fowler, visiting physician to Fonthill madhouse, in the 1815 SC, First Report, p. 46.

Table 2 gives details of the size and source of finance of the public hospitals that existed in the 1790s. At that time not all of these

Table 2

Public Lunatic Hospitals in England circa 1790

Hospital	Date of Founding	Number of Beds	Original Source of Finance
Bethlem	1377	266 (1800)	Endowment
Bethel, Norwich	1713	55 (1771)	Endowment
Guy's, London (lunatic beds)	1727	20 (1797)	Endowment
St Luke's, London	1751	228 (1793)	Public subscription
Newcastle	1764	30 (1767)	Public subscription
Manchester	1766	80 (1787)	Public subscription
York	1777	72 (1792)	Public subscription
Liverpool	1790	64 (1790)	Public subscription
Leicester	1790	12 (1819)	Public subscription

hospitals took what could be called a progressive approach to the treatment of the insane. In fact some of them provided little more than a rough confinement. The reasons for this can to some extent be located in the motivations that led to their foundation in the first place: the rhetoric surrounding this usually relied more on an appeal to philanthropic benevolence than on any belief that the hospital could provide a sure cure for insanity.

It is well known that throughout the eighteenth century extremely large amounts of money were being made in trade and commerce, far more than could easily be spent by men who had neither the opportunity nor the desire to repeat the extravagances of the gentry.[1] The founding

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[1] Some indication of the very large amounts involved is provided by D. Owen, 1965, pp. 79-80. Richard Reynolds, manager of Darby's furnaces at Ketley and Coalbrookdale, retired from business in 1789 and devoted the rest of his live to philanthropy. Much of his money was given anonymously, but estimates have been made that he was regularly distributing £8000 per annum. Amongst other institutions, he gave to Bristol Infirmary, almshouses, and orphan asylums.

and endowment of hospitals appeared to provide a very suitable investment for the surplus wealth; Guy's Hospital, for instance, was established almost entirely with money made by its founder out of the "South Sea Bubble" speculation.

The usual course with the founding of a public lunatic hospital was for a number of interested persons[1] to circulate a letter asking for subscriptions.[2] Two themes can be discerned in the motivations that people had for giving so generously. On the one hand was the felt desire to do something about the social problem of deviance, to control the disorders of an increasingly complex society. But more immediately important for many philanthropists was the self-satisfaction they got from the act of giving itself. Philanthropy established its donor as a member of a certain stratum in society. By getting on the subscription list of a hospital, the smallest subscriber was able to attend the same social functions as the largest. For many of the nouveau riche middle class at this time, to identify with the aristocracy was one of their greatest hopes; the subscription hospital provided an opportunity for paternalist largesse of the most impeccable kind. Such passages as the following express this blend of sentiment based on philanthropy and self-interest that many subscribers felt:

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1 In the case of St Luke's, this meant one physician, two merchants, one apothecary, one druggist, and one other "gentleman" (French, 1951, p. 5).

2 In York, the suggestion that a lunatic asylum should be built there was met by an enthusiastic response of three hundred names, with many subscribers contributing £100 and some as much as £500 (D. Owen, 1965, p. 71). Bethel Hospital in Norwich, although originally the result of an endowment, "promptly became a favourite philanthropy for charitably inclined Norwich testators" (ibid., p. 76). During the eighteenth century it received 35 legacies totalling nearly £8000, and from 1751 to 1791 St Luke's received more than £80,000 in legacies.

> Hospitals improve the disposition of mankind, by cultivating charity. A degree of dependence upon public opinion, and munificence, is therefore useful.[1]

> If affluence and independence could universally prevail, the benevolent would not experience the inexpressible pleasure of relieving the distressed; neither could there exist that grateful satisfaction, which modest indigence ever feels from well-timed succour.[2]

The rhetoric being expressed here is, at least with hindsight, fairly obvious in its implication, but even this is surpassed in the transparency of its intent by a suggested prayer for the patients at Guy's Hospital:

> Bless all the worthy Governors of this hospital; excite in our hearts a grateful sense of their charitable care for our welfare, and grant that they may plentifully reap the reward of their labour and love, both in this life, and that which is to come.[3]

This was one strain of ideological support for subscription hospitals that many physicians eagerly emphasized. It located them firmly within a conservative philanthropic tradition which assured them that they were helping to eliminate the social problems around them merely by patronage of worthy causes. By itself, this sort of motivation would only have established hospitals like Bethlem: grand facades concealing benign neglect. Which of course it did, notably at St Luke's and at York Asylum, where the initial public enthusiasm soon died away and the enterprising person in charge was left to run the hospital primarily for profit. Not all hospitals, however, were so simply tied to this sort of paternal benevolence. While this may have been adequate for those who were primarily concerned with raising their status within the ruling class, there were others who were more concerned with the vicissitudes of the class on

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1 Blizard, 1796, p. 33.

2 J.C. Lettsom, Of the Improvement of Medicine in London, quoted in Trent, 1948, p. 537.

3 Quoted in Woodward, 1974, p. 20.

whom the whole society was dependent. This motivation was the same as that which led to the workhouse movement: the desire to do something about the large numbers of potential workers who were a drain rather than an asset to the productive economy.

> As the true foundation of riches and power is the number of working poor, every rational proposal for an augmentation of them merits our regard

wrote Jonas Hanway in 1750.[1] Another merchant, John Bellers, estimated in 1714 that 200,000 people died every year in Britain from curable diseases, and of this number three-quarters were poor and could not pay for treatment.

> Every Able Industrious Labourer, that is capable to have Children, who so Untimely Dies, may be accounted Two Hundred Pound Loss to the Kingdom.[2]

Insanity was never of course recognised as a major cause of death, but it was a social problem in that it prevented people from working: it tied up resources, and it had proved intractable to the workhouse regime. The future physician to Liverpool Lunatic Asylum, William Currie, argued for the establishment of an asylum there on the grounds that

> When the Poor-house shall be relievd from the Insane. . . the respectable magistrates. . .will then find it easier to extirpate vice, disorder, and guilty idleness, from this great family of the lowest and most ignorant class of society.[3]

But why a hospital and not just a custodial madhouse? One reason is that the subscription hospitals were not just for the paupers; in fact, in

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1 Quoted in D. Owen, 1965, p.15.

2 J. Bellers, Essay towards the Improvement of Physick, 1714, quoted in Bellers, 1935, p. 111.

3 James Currie, Liverpool Advertiser, Oct 15th, 1789, printed in J. Currie, 1805, vol. 2, Appendix 2, p. 29. Similar sentiments were expressed by the Manchester physician, John Aikin: "By placing a number of them in a common receptacle. . .they are removed from the public eye to which they were multiplied objects of alarm, and the mischiefs they are liable to do to themselves and others, are with much greater certainty prevented." (Aikin, 1771, pp. 65-6. For a recent commentary see Scull, 1974, pp. 58-60.)

spite of Currie's impassioned plea it is likely that most of the patients in the subscription hospitals were not paupers at all. A major reason for subscribing to a hospital was that it gave the subscriber the right to nominate patients. This was seen as an insurance policy, giving the subscriber the opportunity to get rid of any of his servants who developed unpleasant diseases, or it might save him a protracted expense if he had to pay for a relative to be cared for privately.[1] This was the sober philosophy of a class to whom money, while available, was a resource by which commodities were to be carefully assessed in terms of their rational value. The subscription hospital, like the other forms of personal insurance then being developed, represented the bourgeois need to protect its own life style.

The other reason Currie, like other reformers of the time, should be enthusiastic about a hospital as a solution to social problems was that the hospital as an institution incorporated many of the cultural ideals that were seen as progressive at the time. Specifically, it appeared to its enthusiasts to embody the norms of scientific activity. This is not to say that science itself is progressive: it will be argued that scientific knowledge, like religious doctrine, can be used to legitimate the status quo as much as it can to justify change, but in the last quarter of the eighteenth century science was the ideology of progressivism. As one of the most optimistic writers of the time

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[1] This was made quite clear in a circulated letter appealing for subscribers to St Luke's: ". . .it appears that the expenses necessarily attending the confinement and other means of cure are such as people born in middling circumstances cannot bear, it generally requiring several months, and often a whole year, before a cure is completed; so that many persons who could easily support themselves for the same length of time under any other Disease, do not apply for and are indeed proper objects to receive benefit of a Charity of this sort, and whose families without such assistance must sink under the expense" (circular appeal by the Governors of St Luke's Hospital, 1750, quoted in French, 1951, p. 8).

put it,

> Who shall say where this species of improvement must stop? . . . . The conclusion of the progress which has here been sketched is something like a final close to the necessity of human labour.[1]

It was in the new manufacturing towns such as Manchester and Liverpool that this philosophy found its strongest expression. In Manchester the physician in charge of the Infirmary and the Lunatic Hospital, John Ferriar, belonged to the group whose members held many positions of social and economic power in the Manchester of the last quarter of the eighteenth century.[2] This was the Manchester Literary and Philosophical Society, a group of men who between them were responsible for the administration, police, health, and welfare of one of the fastest-growing towns in the country.[3] Manchester was not tied like some towns, such as York, to a corporate authority who governed manufacture and trade according to some earlier conception of progress.[4] Its authority, as

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1 William Godwin, quoted in Woodcock, 1963, p. 82.

2 Manchester at this time was physically and politically isolated from central government. Until the 1840s the journey from London to Manchester took 20 hours, and until 1832 Manchester had no Members of Parliament. It was not until 1838 that Manchester even had an elected local government of its own. For a discussion of these points and their effect on the growth of organised administration in Manchester, see Thackray, 1974.

3 Some of the problems involved can be seen merely be reciting the statistics of population and riots. The population increased from 15,000 in 1760 to 118,000 in 1801. There were food riots in 1757, 1762, 1795, and 1818; and political riots in 1792, 1809, 1812, and 1819.

4 On York at this time and on the stranglehold exercised by the Company of Merchant Adventurers see Sellers, 1918; Armstrong, 1974.

expressed in the activites of men like Ferriar, was synonymous with its dynamic. Accordingly, the rhetoric that was popular with the "Lit and Phil" invoked an appeal to talent rather than to authority, and to science rather than to God. Not that these intellectuals were atheists, but their Christianity was an undogmatic one that was easily made subservient to the needs of progress. A number of these men were Unitarians, a Protestant sect which denied the triune nature of the Deity and emphasized instead the humanist aspects of Christianity.[1] Joseph Priestley, one of the most famous of the Unitarians, expressed the general combination of values and beliefs that underlay many of the "Lit and Phils" at this time: "The social millenium will be brought about by the influence of the commercial spirit aided by Christianity and true philosophy."[2] "True philosophy" was of course science, and the hospital appeared to be an appropriate place in which to develop it.

The reason for this can be analysed from a number of perspectives. The aim of the present discussion is to analyse the social and intellectual context from which moral treatment was to emerge. The subscription hospital with all its values and significances was part of that context; but, as already stated, not every hospital remained in the forefront of progressive thought. One of the most famous hospitals in the history of psychiatry was the Lunatic Hospital at Manchester. The example of this hospital provides a useful basis on which to show both the role

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1 Unitarianism originated with the Reformation but it was not until the late eighteenth century that it became at all popular as a vehicle for humanist thinking. A typical Unitarian remark was that made by Thomas Belsham in 1811 that Jesus was "a man constituted in all respects like other men, subject to the same infirmities, the same ignorances, prejudices and frailties" (quoted in Hastings, 1921, vol. 12, p. 524). For a review of the contribution made by Unitarians towards social change see Holt, 1952, passim.

2 Priestley, A letter to. . .Edmund Burke, quoted in Thackray, 1974, p. 688.

of individual thinkers in the development of moral treatment, and the intellectual resources these thinkers made use of to express themselves at that time.

The scientific approach favoured by John Ferriar, physician at Manchester Lunatic Hospital, was one that is probably best described as a "rigorous empiricism".[1] In his Medical Histories and Reflections of 1792-8 he described how he had tried all the standard medical therapies for insanity of his day, from tartar emetic through the "antiphlogistic regimen" of saline purgatives to the old standby of bleeding. He recommended or dismissed each of the therapies in turn depending on the results he had noticed in his own practice. Ferriar discussed Locke's theory of the nature of madness[2]--that it was due to misdirected perception--but he did not let his theoretical discussion interfere with his trial-and-error approach to treatment. This in itself was quite an innovation because all medical therapies of the time were underwritten by a considerable body of taken-for-granted assumptions.

Before looking at Ferriar's specific contribution to the treatment of the insane it is necessary for a while to move the focus of investigation on to these background assumptions, towards the intellectual context from which Ferriar was able to present his own work as a meaningful contribution.

There were two main traditions or types of thinking on which Ferriar could have drawn, which I will call the "commonsense" and

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1 Or, in his own words, "conducted on the strict principles of inductive philosophy" (Ferriar, 1792-8, vol. 2, p. v).

2 On Locke's thinking on madness see the extracts from his Journal for 5th November 1677 and 22nd January 1678, quoted in Lewhurst, 1963, pp. 89, 101-2. Locke's contribution to eighteenth-century theories of insanity is discussed below (pp. 75-6).

the "theoretical". The essence of the commonsense tradition was a reliance on existing beliefs, a conviction that if a certain practice had been made use of for generations, there was something intrinsically correct in its continued use. In the treatment of the insane this approach can be seen both in the strictly medical therapies and in the more general management of the insane as a special category of person.

Bleeding (or phlebotomy) for instance was perhaps the oldest of all the medical therapies a physician could draw on. According to a medieval commonplace book

> Phlebotomy clears the mind, strengthens the memory, cleanses the stomach, dries up the brain, warms the marrow, sharpens the hearing, stops tears, encourages discrimination, develops the senses, promotes digestion, produces a musical voice, dispels torpor, drives away anxiety, feeds the blood, rids it of poisonous matter, and brings long life. It eliminates rheumatic ailments, gets rid of pestilent diseases, cures pains, fevers, and various sicknesses and makes the urine clean and clear.[1]

This quotation received its contemporary, medieval, sense because it drew on the theoretical concepts of the four humours--each with its propensities and roles which any bleeding of a patient had to take into account. Pre-eighteenth century medical theory is discussed below, but at this stage of the discussion the significance of the continued practice of bleeding lies in the fact that many mad-doctors continued to believe in it for purely commonsense reasons. In 1815, for instance, the physician at Bethlem reported that his patients

> . . .are ordered to be bled about the latter end of May, or the beginning of May, according to the weather; and after they have been bled they take vomits once a week for a certain number of weeks, after that we purge the patients; that has been the practice invariably for years, long before my time; it was handed down to me by my

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1 Quoted in Doob, 1970, p. 162.

father, and I do not know any better practice.[1]

This is quite explicitly a justification for a certain practice based on the physician's belief in his own personal authority as an experienced practitioner of the art of medicine. It is perhaps not surprising that it was at Bethlem, the only hospital for the insane founded before the eighteenth century, that this type of belief was most strongly held.[2] All the physicians there came from the same family (Monro) and the strongly defended their right to monopoly in treating the insane and, when that was eroded, their authoritarian approach to mad-doctoring, all through the eighteenth century.[3]

On the subject of the general management of the insane, the physicians at Bethlem were equally dependent on conventional wisdom. In 1758 William Battie, the physician at St Luke's Lunatic Hospital, attempted to develop a theoretical approach to management. This was not possible, argued John Monro at Bethlem. For him, "management was never to be learned, but from observation." The patients, Monro continued,

> should be accustomed to obey, and though talked to kindly, it should still be with authority. . . .Everyone is not to

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1 Thomas Monro, evidence to the 1815 SC, First Report, p. 95.

2 The Bethlem of the eighteenth century was built in 1676 in the Moorfields district of London. Although it did allow the casual visitor to wander around the wards for purposes of entertainment until 1770, Bethlem always had a policy of curing its patients. The first incurable patients were not even admitted until 1728 (O'Donoghue, 1914).

3 There were four generations of Monros at Bethlem. James Monro was physician from 1728-51; John, his son, from 1751-91; Thomas, John's son, from 1791-1816; and Henry, Thomas' son, from 1816-56. It is an indication of the strength of their reputation that even when one of the family was dismissed from Bethlem in 1816 after disclosures of cruelty and incompetence, his son was appointed in his place.

> be accosted in the same manner, some are to be commanded, others are to be soothed into compliance, but we should endeavour in every instance to gain their good opinion.[1]

Little changed in the policy of Bethlem over the following half-century. Management remained a problem of establishing personal authority, as John Haslam, the apothecary, pointed out in 1798:

> . . .by gentleness of manner and kindness of treatment, I have never failed to obtain the confidence, and conciliate the esteem of insane persons, and have succeeded by these means in procuring from them respect and obedience.[2]

Bethlem was certainly not alone in conceiving of management in this way. There was a generally felt need to establish control over the insane through personal influence and the medical literature of the 1790s is full of various suggestions as to the best way to go about it. One popular method was by "catching the eye". There are a number of graphic accounts of how this was done, of which the following is typical:

> I then suddenly unlocked the door--rushed into the room and caught his eye in an instant. The business was then done--he became peaceable in a moment--trembled with fear, and was as governable as it was possible for a furious madman to be.[3]

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[1] Monro, 1962, pp. 36, 38, 40 (first published in 1758).

[2] Haslam, 1798, p. 128. The apothecary's position at Bethlem at this time involved the tasks of daily medical administration. The physician attended only for specific consultations.

[3] Pargeter, 1792, pp. 50-1. This madhouse proprietor's patient has gone unrecorded, but a more famous example of the same technique was that practised by Francis Willis on King George III during his insanity. According to one visitor to Willis' madhouse, "On his first meeting a new patient, his usually friendly and smiling countenance changed its expression. He suddenly became a different figure commanding the respect even of maniacs. His piercing eye seemed to read their hearts and divine their thoughts as they formed and before they were even uttered. In this way he gained control over them which he used as a means of cure." (Anon, 1796, p. 764; translation from Macalpine and Hunter, 1969, pp. 270-2.)

Sensational though this type of management might appear it rested on a very conventional base: that of the physician as personal authority.[1] For many physicians the essence of medical practice was the patron-client relationship. It was a one-to-one relationship in which the individual claims of the patron were answered by the personal attention of their physician. The operative word was "service", fashioned to the needs of the particular patron.[2] Not that the patients at Bethlem employed the Monros in any sort of personal capacity: it was the physicians' ideological perception of themselves as living in a world where personal authority based on ascribed status was important that was expressed in the management of the insane, rather than any "real" relationship between doctors and patients.

For John Monro the antithesis to the proper role of the physician was a medical profession based on education rather than on patronage. In his one venture into print he attacked the idea of "reading lectures" or book learning on the subject of insanity as degrading mad-doctoring to the status of a "trade" that any entrepreneur could practice.[3] He saw medicine being corrupted by the introduction of bourgeois ideas, and its deterioration by becoming a "career open to talent" rather than a profession for those who were fitted to it by virtue of being gentlemen.

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1 Benjamin Rush, the "father" of American psychiatry, acknowledged this aspect of the "eye" therapy by comparing the therapist to a tamer of wild animals. "The first object of a physician, when he enters the cell, or chamber, of his deranged patient, should be, to catch his EYE, and look him out of countenance. The dread of the eye was early imposed upon every beast of the field. The tyger, the mad bull, and the enraged dog, all fly from it: now a man deprived of his reason partakes so much of the nature of those animals, that he is for the most part easily terrified, or composed, by the eye of a man who possesses his reason." (Rush, 1962, p.175; first published in 1812.)

2 On this see Jewson, 1974.

3 Monro, 1962, p. 36.

For the Monros then, and for those who agreed with their conception of medical authority, the commonsense appeal that the management of the insane ought to be a question of personal "governance" was primarily an ideological expression of the social relations of a pre-capitalistic mode of production. The achievement of "normality" was seen in the context of a conformity to a personal untheorised discipline; but one which could be re-enacted in every case because the "insane were like that". That the insane were "like that" was of course precisely because the physicians insisted on treating them within authority relationships over which the patients had little control.

This "commonsense" tradition of management appealed to the more conservative sections of the medical profession, but Ferriar and a growing number of the profession rejected the conception of authority solely because it was authority. For these physicians, the subscription hospital, with its emphasis on the bourgeois values of investment and utilitarian knowledge, was an ideal place to work. But there was still a need to "manage" the patients. Chains and whips were dismissed as crude and barbaric, and "catching the eye" was inappropriate to the conditions of the large public hospitals.

Not surprisingly then, many physicians turned to their theoretical resources for justification of a new approach. Little will be said here about the variety of medical theories based on advances in other sciences using concepts derived from such diverse fields as hydraulics, optics, classical atomism, and electrical theories.[1] These theories were used by mad-doctors to justify their medical therapies, but they were not believed to be of any importance in the management of the insane. For

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[1] For a discussion of these theories see Carlson and Simpson, 1969

the theories legitimising that practice it is necessary to turn to the less esoteric discussions on human nature that took place at the time. Two main approaches to human nature can be distinguished in the eighteenth century, appraoches which may be very broadly described as the "hierarchical" and the "constructivist".

The "hierarchical" theories of human nature all derived essentially from the medieval model shown in Figure 1. This drawing is a representation of a model that was being continually modified in the light of scientific and lay debates as to how man's nature was contructed, but it did have some essential features to which all proponents of the model were committed. The most important feature of this conception of human nature was its reliance on "Reason"--traditionally the means by which man was related to God. However much this Reason had been secularised in the "Age" which has been given its name, it was still held to be the aspect of man's nature by which all else was to be judged.[1] It was the ability to reason which many thinkers presented as the one essential characteristic of humanity. According to Blaise Pascal, writing in the mid-seventeenth century,

> I can easily imagine a man without hands, feet, head. . . but I cannot imagine a man without [rational] thought; he would be a stone or a brute.[2]

A man without reason was a man without sense, and this belief was reflected in the contemporary definition of insanity as "vitiated reason".[3] The main cause of this destruction of reason was held to lie in the passions. These passions, or moral affections, of love, hate, fear, joy, etc., had been given to man by God (it was believed) for him to

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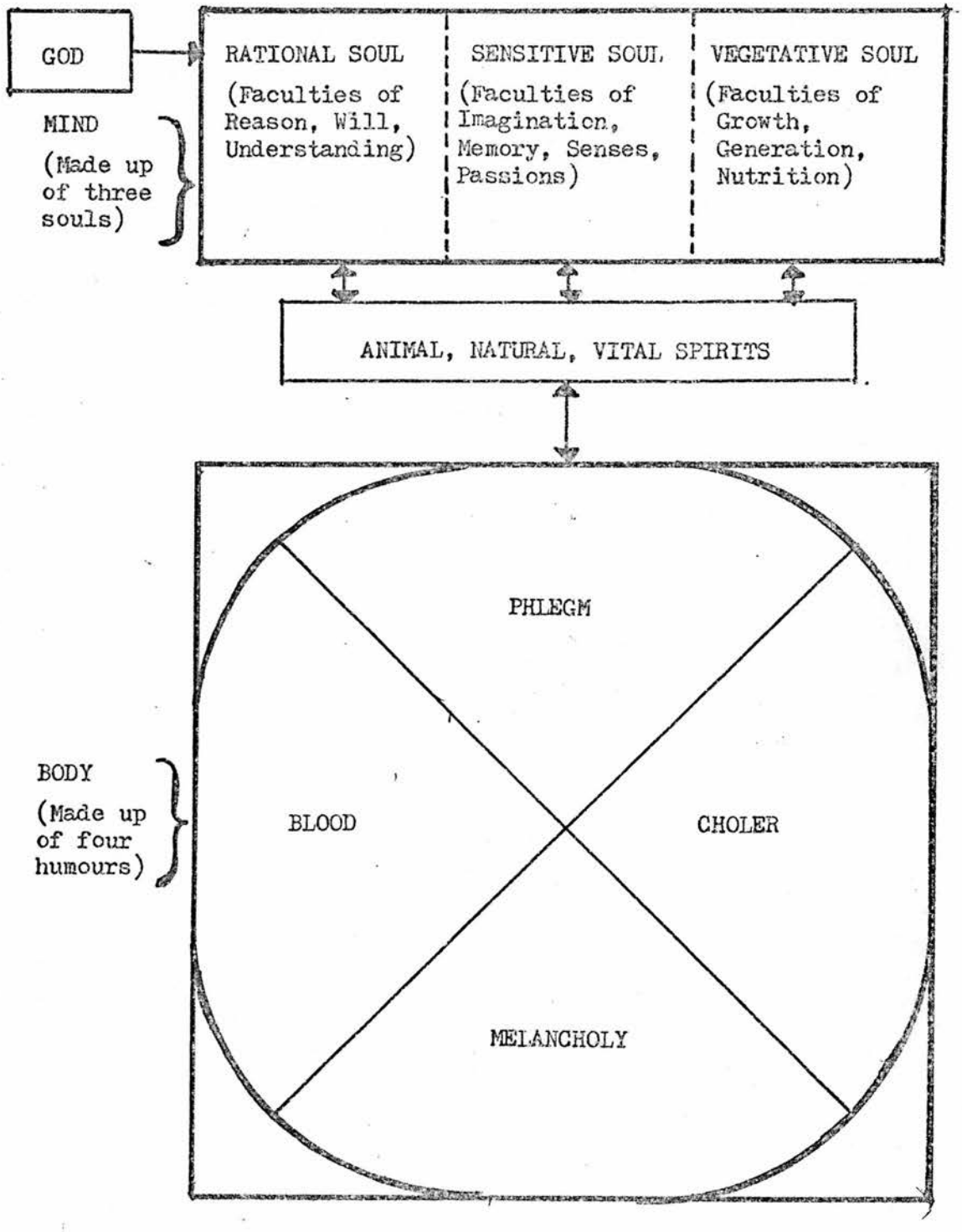
1 For some interesting comments on the Renaissance contribution to this process of secularisation, see B. Clarke, 1975, pp. 227-9; C. Hill, 1974, pp. 87-9, 220.

2 Pascal, 1962, p. 162

3 See for instance Monro, 1962, p. 5. For the source of this belief see Loob, 1970, chap. 1.

Figure 1

Model of human nature in the medieval and Renaissance period



Sources: Doob, 1970, chap. 1; Burton, 1932, vol. 1, pp. 154-69; Bamborough, 1952, passim.; Deporte, 1974, pp. 12-25.

use according to the dictates of reason. Since the time of Aristotle there had been a continuing debate as to how much, if any, good the passions actually created[1] but the general consensus for most thinkers was that the passions were useful, if dangerous. In the words of Richard Mead, society physician and one-time vice-president of the Royal Society,

> The omnipotent Creator has given us these natural commotions for very wise ends; which seem to be, that thereby we may be urged with a kind of impetuosity to shun evil, and embrace good. Wherefore the passions are not bad in themselves; it is their excess that becomes vitious, and when they rise to such an extravagant pitch as not to be governed by the dictates of reason.[2]

This belief was reiterated by other medical writers[3] and by lay moralists, of whom probably the best-known examples are Alexander Pope and Samuel Johnson.[4]

One interesting point that a recent commentator has made is that there was considerable ideological attraction for writers in this imagery, particulary for Pope and Johnson, who wanted as little change as possible in society.[5] These ideologists emphasized the need to keep

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1 On this see Grange, 1962a; Doob, 1970, p. 87, note 115.

2 Mead, 1763-5, vol. 3, p. 129 (first published in 1751). A very similar account was provided by the popular religious writer Isaac Watts in 1729: "Since the passions are certain principles or powers in human nature, which include in them some commotions of flesh and blood, as well as some operations of the mind, we may reasonably suppose, that the design of our Creator in working them into our original constitution, was for the service of our minds and our bodies. Though it must be confessed in our fallen and degenerate state, they often prove our snares and our torments" (Watts, 1810, p. 602).

3 See Vere, 1778, pp. 75-82; Armstrong, 1795, Book 4, lines 469-78 (first published in 1744).

4 See for instance Pope's Essay on Man and Johnson's Rasselas, two essays which deal predominantly with this theme. A recent commentary on Rasselas from this point of view is provided by Grange, 1962b.

5 Foss, 1971, pp. 202-4.

artistic expression under the control of reason--an authority which was repeatedly invoked to legitimate the political, ideological and cultural status quo. "He therefore," wrote Samuel Johnson in 1750, "that would govern his actions by the laws of virtue, must regulate his thoughts by those of reason."[1] It will be shown in the next Chapter that the reason-and-passions imagery was to be put to very different uses later in the century, but for the greater part of the eighteenth century, and especially for many in the medical profession, the hierarchy of "reason and the passions" was used as a core image by which to demonstrate that human nature could not change.

In the treatment of insanity, the implications of this theory appeared to many mad-doctors to be that there was little to be done. The vitiation of reason was held to be too important a factor for any but the strongest passions to have any effect at all on the patient's condition. Fear was about the only passion that most mad-doctors ever mentioned as being strong enough to have an effect on the insane, although its use was as likely to be justified by a commonsense appeal to the madman's cowardice as to any theoretical conception of human nature.[2]

Underlying all the arguments presented by the adherents to this hierarchical conception of human nature was a profound pessimism towards the notion of improvement, whether in society or in the individual. Not everyone who used the "passions" imagery was necessarily conservative,

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1 S. Johnson, 1750, p. 52.

2 Richard Mead stated in 1751 that "Mad-folk. . . are all cowards; and when they are once sensible of being thoroughly conquered, they easily submit for the future, and dare not offer violence to themselves or others" Mead, 1763-5, vol. 3, p. 50). An almost identical statement appeared in John Wesley's popular handbook on self-medication, Primitive Physick (1747, 36 editions by 1791) and in the third edition of Encyclopaedia Britannica, (1797, vol. 11, p. 284).

of course; these concepts were after all a basic intellectual resource of European thought. But it was very easy, for those who so wished, to see in this conception of human nature a clear demonstration of that principle made famous by Pope: "whatever is, is right".[1]

This was one, hierarchical, view of human nature. An alternative view which emerged during the eighteenth century is the one which I will call here the "constructivist" approach.[2] The thinkers who took this latter approach to man's nature did not reject the existence of reason and the passions, but they looked at them in a new way. One of the most influential of these new ways was the philosophy of sensationalism, a theory of man which emphasized the role of the senses in his nature. John Locke was one of the founders of sensationalism; another was the Abbé Étienne de Condillac. Condillac's Treatise on the Sensations of 1754 is an interesting document for the present discussion to consider because it shows quite clearly how the sensationalists made use of both the old and the new imageries of human nature.

In his Treatise, Condillac attempted to demonstrate how the origins of human nature were located in the senses by comparing man to a statue. Give a statue senses, argued Condillac, and he will gradually grow and develop:

> Instructed by experience in the means of relieving or in forestalling its wants, it will reflect on the choice it must make. It will then examine the advantages and disadvantages of objects which until then it has either avoided or sought. . . .It will feel the advantage of being ruled by experience; and accustoming itself to make use of its knowledge will learn to resist its desires and

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1 Essay on Man, Epistle I.

2 I am not suggesting that all eighteenth century thought on human nature can be dichotomised in this way, merely that to pick out these two broad traditions helps to clarify the trends in social thought which have some bearing on the treatment of the insane.

> even overcome them. Interested in avoiding pain it will emancipate itself from the sway of its passions, extend the power of reason over its will, and become free.[1]

"The statue is therefore," continued Condillac, "nothing but the sum of all it has acquired. May not this be the same with man?"[2]

The implications of this approach for a theory of insanity appeared to be considerable. Already in 1678, John Locke was applying sensationalism to his thinking on the etiology of madness:

> . . .those that thinke long & intently upon one thing come at last to have their minds disturbd about it & to be a little crackd as to that Particular. For by repeating often with vehemence of imagination the Ideas that doe belong to or may be brought in about the same thing a great many whereof the phansy is wont to furnish, those at length come to take soe deepe an impression that they all passe for cleare truths & realitys though perhaps the greatest part of them have at several times been supplied only by the phansy & are noething but the pure effects of imagination.[3]

Given the fact that it was the traditional view of madness that was held at Bethlem, the only large public hospital for the insane in the first half of the eighteenth century, it is perhaps not surprising that sensationalism was not quickly taken up by practicing mad-doctors. The first mad-doctor to commit himself unequivocally to sensationalism was William Battie, physician at St Luke's, the rival public hospital for the insane which was built on the other side of the same London square as Bethlem.

Battie voiced his opinion in a Treatise on Insanity of 1758, the first such work to be published in English. Battie stated quite clearly his belief that "madness, or false perception" was nothing else than

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1 Condillac, 1930, p. 200.

2 Ibid., p. 239.

3 Journal entry for 22nd January 1678, quoted in Dewhurst, 1963, p. 101.

"a praeternatural state or disorder of Sensation".[1] Unlike the belief that madness was vitiated reason, an all-or-nothing condition in which the patient was either with reason or without it, sensationalism seemed to offer a more gradable and empirically verifiable conception of madness. The new theory opened up the possibility of determining a precise cause of the ailment, and by extension a precise remedy. Battie gives examples of the etiology of madness which showed how direct he envisaged the relationship to be between impression and faulty sensation. "I lately met," he recounted, "a Sailor, who became raving mad in a moment while the Sun beams darted perpendicularly upon his head."[2] Man's digestive tract was also a frequent cause of madness

> occasioned by the contents of these viscera being stopt in such a manner as to compress the many nervous filaments, which here communicate with one another by the mesenteric ganglia, and which enrich the contents of the abdomen with a more exquisite sensation. Thus the glutton who goes to-bed upon a full stomach is hagridden in his sleep.[3]

So, argued Battie, if wrong sensations were the cause of madness, the aim of therapy must be to create the right ones. This could be done either by physical measures ("shake with violence the head and hypochondria by convulsing the muscular fibres with emetics, rougher purges and errhines"[4]), or by changing the environment. And for a man like Battie, who had already helped in the foundation of the first hospital of its kind in the country, there was still a great deal that could be done in that respect. In his words,

> We have therefore, as Men, the pleasure to find that Madness is, contrary to the opinion of some unthinking persons, as manageable as many other distempers, which

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1 Battie, 1962, p. 6 (this is a facsimile copy of the 1758 edition).

2 Ibid., p. 47.

3 Ibid., p. 49.

4 Ibid., p. 77.

> are equally dreadful and obstinate, and yet are not looked upon as incurable: and that such unhappy objects ought by no means to be abandoned, much less shut up in loathsome prisons as criminals or nuisances to the society.[1]

Here was an optimism concerning the treatment of the insane which Battie grounded in theory rather than common sense.[2] The theory of sensationalism soon developed into one of the most popular and fashionable theories for the discussion of human nature of the later eighteenth century, especially in its more sophisticated form of the "doctrine of the association of ideas."[3] What might appear surprising, in view of Battie's therapeutic optimism, is that although the medical profession continued to incorporate all the new thinking into its theories, it did little to translate them into innovations in practice.

Thomas Arnold, for instance, physician to Leicester Lunatic Hospital and owner of one of the largest madhouses in the country, used an

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1 Battie, 1962, p. 93.

2 Compare with John Monro's profound theoretical pessimism: "Though they [the physicians at Bethlem] did not publish their thoughts on a distemper which was more immediately the object of their care, that was not owing to any design of keeping their manner of practice a secret, but that they thought it disingenuous to perplex mankind, with points that must for ever remain dark, intricate, and uncertain" (Monro, 1962, p. 3).

3 The doctrine of the association of ideas was formulated by David Hartley (in his Observations on Man of 1749) out of a combination of sensationalism and a theory of physiological vibrations which he took from Newton's writings on optics. The doctrine attempted to give some physiological basis to the realisation that impressions on the senses affected the brain. Thus, for Hartley a physical cause of insanity could be over-indulgence in opium or alcohol: "their greatest and most immediate Effect arises from the Impressions made on the Stomach, and the disorderly Vibrations propagated thence into the Brain" (Hartley, 1749, vol. 1, p. 393). Cure for Hartley, as for Battie, consisted in creating the correct sensations; but Hartley, although a physician, preferred to emphasize what he saw as the correct religious sensations based on man's moral purpose. (For a modern exposition of the doctrine, see R.M. Young, 1973b.)

explicit associationist psychophysiology in his definition of insanity. He defined insanity as either the perception of things "which have no external existence in his [the patient's] senses at that time" ("ideal insanity"), or as correct perception in which the powers and importance of the objects of sensation are misjudged ("notional insanity").[1] Arnold accepted that the passions were a frequent cause of insanity in that "every passion is accompanied with a corresponding state of body" which is transmitted to the brain, and "the intense vibrations [the physical mode by which association takes place], once excited in the brain, are disposed to suppress, or obscure, all others that are not immediately connected with them."[2] But when he came to write on management, Arnold fell back on the commonsense platitudes: "firmness and authority must not be forgotten"; the patients must submit "to all due controul"; the physician should gain the patients' "esteem and confidence" and once he has that he should be able to obtain "their obedience to orders"; and so on.[3]

John Haslam, apothecary to Bethlem, provides the most graphic example of the management potential of the doctrine of the association of ideas <u>not</u> being used to underwrite an innovation in the treatment of the insane. In his <u>Observations on Insanity</u> of 1798, Haslam defined insanity as

> . . .an incorrect association of familiar ideas, which is independent of the prejudices of education, and is always accompanied with explicit belief, and generally with either violent or depressing passions.[4]

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1 Arnold, 1782-6, vol. 1, pp. 73-4.

2 <u>Ibid</u>., vol. 2, pp. 332-3.

3 Arnold, 1809, pp. 37, 23, 39, 41. It is an indication of the division in Arnold's mind between the medical treatment of insanity and the management of the insane that there was a gap of 21 years between the dates of publication of his books on these two aspects of mad-doctoring.

4 Haslam, 1798, p. 10.

More importantly, he gave an explicit account of the practical implications of applying associationism to insanity:

> We have a number of patients in Bethlem Hospital whose ideas are in the most disordered state, who yet act, upon ordinary occasions, with great steadiness and propriety, and are capable of being trusted to a considerable extent. A fact of such importance in the history of the human mind, might lead us to hope, that by superinducing different habits of thinking, the irregular associations may be corrected. . .the object should therefore be to prevent such recurrence by occupying the mind on different subjects, and thus diverting it from the favourite and accumulated train of ideas.[1]

And yet, in spite of this awareness that the potential for change was there, all of Haslam's practical writings express a traditional faith in the need to "obtain an ascendency over them" as a prerequisite to acquiring the "confidence, obedience and respect"[2] of the patients. In fact, Haslam fought all his life against the practical innovations that were made in the treatment of the insane.[3]

To summarise, the doctrine of the association of ideas was an intellectual resource of the 1790s, fashionable, used by the medical profession, that could without modification have been used to justify changes in the treatment of the insane.[4] That it was not must be seen in terms

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1 Haslam, 1798, pp. 129-30.

2 Ibid., p. 110.

3 Some idea of Haslam's continuing conservatism can be seen from the title of a paper he gave in 1843: "On Restraint and Coercion; Considered not Merely as Measures of Security, but essentially contributing to the Cure of Insanity" (Haslam, 1850).

4 Psychiatric historians have tended to ignore the place of associationism in the history of mad-doctoring: in two recent accounts of this period (Bynum, 1974; Cooter, 1976) it is maintained that it was not until the introduction of phrenology that a scientific rationale was found on which to develop the management of the insane. A notable exception to this is the paper by Hoeldtke (1967) which provides a detailed summary of the influence of the doctrine on mad-doctoring, although he does not deal with the treatment of the insane.

of the aims of physicians who were, in the main, satisfied with the "commonsense" assumptions as to the nature of the doctor-patient relationship.

The point must be emphasized because there is a strong tradition within both bourgeois psychiatry and Marxism which maintains that the doctrine of the association of ideas is inherently progressive. The essence of this argument is that sensationalism, associationism, and all the other eighteenth-century materialist philosophies were progressive because they attempted to provide a scientific understanding of human nature which rejected the metaphysical belief that man was placed in the world by an omniscient God. According to this tradition, the material understanding of himself provided man with the opportunity to do something about his position in the world; it gave him the scientific basis to reject a social order which was supposedly sanctified by the Word of God.[1] Condillac's imagery of a statue coming to life certainly implied an optimistic approach to man's potential. And it was an optimism that was explicitly recognised in the field of education where sensationalism was seen to provide a philosophical basis for a more rationalist education: one that took account of the aptitudes and needs of the students as well as of the pedagogic needs of the teacher.[2]

What must be stressed, however, is that there is no <u>necessary</u> connection between the provision of the possibility of improvement and its attainment. Too much Marxist writing accepts as necessary a progressivism of science, an error which leads not to false optimism but also to the degradation of what is scientific in Marxism itself. The truth of no theory can be guaranteed, whether it is the doctrine of the

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1 Marx's own contribution to this appears in <u>The Holy Family</u>, <u>MECW</u>, vol. 4, pp. 124-34.

2 On this see Simon, 1960, especially pp. 45-7.

association of ideas or historic materialism, outside of the use to which it is put.

> The question whether objective truth can be attributed to human thinking is not a question of theory but is a practical question. Must must prove the truth, i.e., the reality and power, the this-worldliness of his thinking in practice. The dispute over the reality or non-reality of thinking which is isolated from practice is a purely scholastic question.[1]

A theory which provides the theoretical opportunity for the development of consciousness, as did both the doctrine of the association of ideas and historical materialism, does not in itself provide the practical accomplishment of that opportunity, as demonstrated respectively by the eighteenth-century mad-doctors[2] and by Stalin. History is always a creative process:

> It is by transcending the given toward the field of possibles and by realising one possibility from among all the others that the individual objectifies himself and contributes to making History.[3]

Theories emerge as the creative ideological expression of a particular (scientific, religious, social, or political) practice. They can be used to create a change in that practice or they can be used to create a defence of the status quo. Only in practice can we assess the value of a theory, a practice which must be judged by the degree to which it reduces the alienation of man from the products of his own labour, unravels the mystifications in which he conceals what he has produced, and gives him the opportunity to consciously control the production of

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1 Marx, Feuerbach Thesis No. 2, MECW, vol. 5, p. 3.

2 What must also be stressed is that Hartley himself did not see his doctrine as progressive or materialistic; he devised it to provide a basis on which the mystical and subservient relationship between man and his God could be demonstrated according to the principles of natural science. (On this point see Leslie, 1972.)

3 Sartre, 1968, p. 93.

his own life. In the eighteenth century the doctrine of the association ideas was used for these ends, as Marxism has been in the twentieth; but, and as the above examples demonstrate, associationism could equally well be propounded theoretically, while practice remained repressive.

The one practice that did not remain oppressive (as in the old sense of denying consciousness to the insane) was that of John Ferriar. Having looked at the intellectual resources available to him, we are now in a position to see how his work marks a major break with most of the other mad-doctors in that he did not justify his treatment of the insane from within the various theoretical and commonsense epistemologies of insanity available to him. He still used some of the opinions that were expressed in the various orthodoxies, but his innovation came not from developing them but from applying a number of theoretical and commonsense assumptions in a new way. In his words,

> A system of discipline, mild, but exact, which makes the patient sensible of restraint without exciting pain or terror, is best suited to those complaints. In the furious state, the arms, and sometimes the legs must be confined, but this should never be done when it can possibly be avoided. When the patient is mischievous and unruly, instead of ordering stripes, I shut him up in his cell, order the window to be darkened, and allow him no food but water-gruel and dry bread, till he shows tokens of repentence, which are never long delayed, upon this plan. Previous to this kind of punishment, I find it useful to remonstrate, for lunatics have frequently a high sense of honour, and are sooner brought to reflection by the appearance of indignity, than by actual violence, against which they usually harden themselves.[1]

There is no reliance here either on the personal authority of the physician or on the impersonal authority of theory; this is the authority of the harsh world outside of the asylum, at once impersonal and personal, in which a man was judged by what he himself could do. It was achievement, not obedience, that Ferriar was trying to induce in his patients.

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[1] Ferriar, 1792-8, vol. 3, pp. 109-10.

Within the boundaries of Manchester Lunatic Hospital Ferriar had no constraints placed on his therapeutic innovations. What did act as a constraint was the physical shape of the hospital itself. The public hospitals were generally built on the gallery principle--long wards stretching from one end of the building to the other. Figure 2 shows the New Bethlem of 1815 (now the Imperial War Museum), constructed on this principle. This type of plan provided the building with a grand facade to impress the subscribers with their munificence. It was also a direct descendent of the Bethlem built in the seventeenth century which needed its wide galleries for the visitors to stroll up and down. As far as the patients were concerned, the architecture of the asylum reflected its custodial function but little more.

St Luke's was also built on the gallery principle, with 17 single rooms to a ward; and presumably Manchester Lunatic Hospital was based on a similar plan because Ferriar commented on the difficulty the old model presented in instilling in his patients the virtue of self-restraint. "It has long been my wish," he wrote,

> that a room might be appropriated in our hospital, to convalescents, and that the privilege of admission to it might be made the reward of regular behaviour among the patients. Such a distinction would act powerfully in creating a habit of self-restraint, the first salutary operation in the mind of a lunatic. For in the cure of diseases of this nature, the patient must "minister to himself"; medicine may restore him more early and more completely to the command of his intellectual operations; discipline must direct him in their exertion.[1]

The implications of what Ferriar was suggesting may not appear very revolutionary to us, but this is precisely because we are living within the parameters of this logic: psychiatry <u>is</u> the amnesia of what

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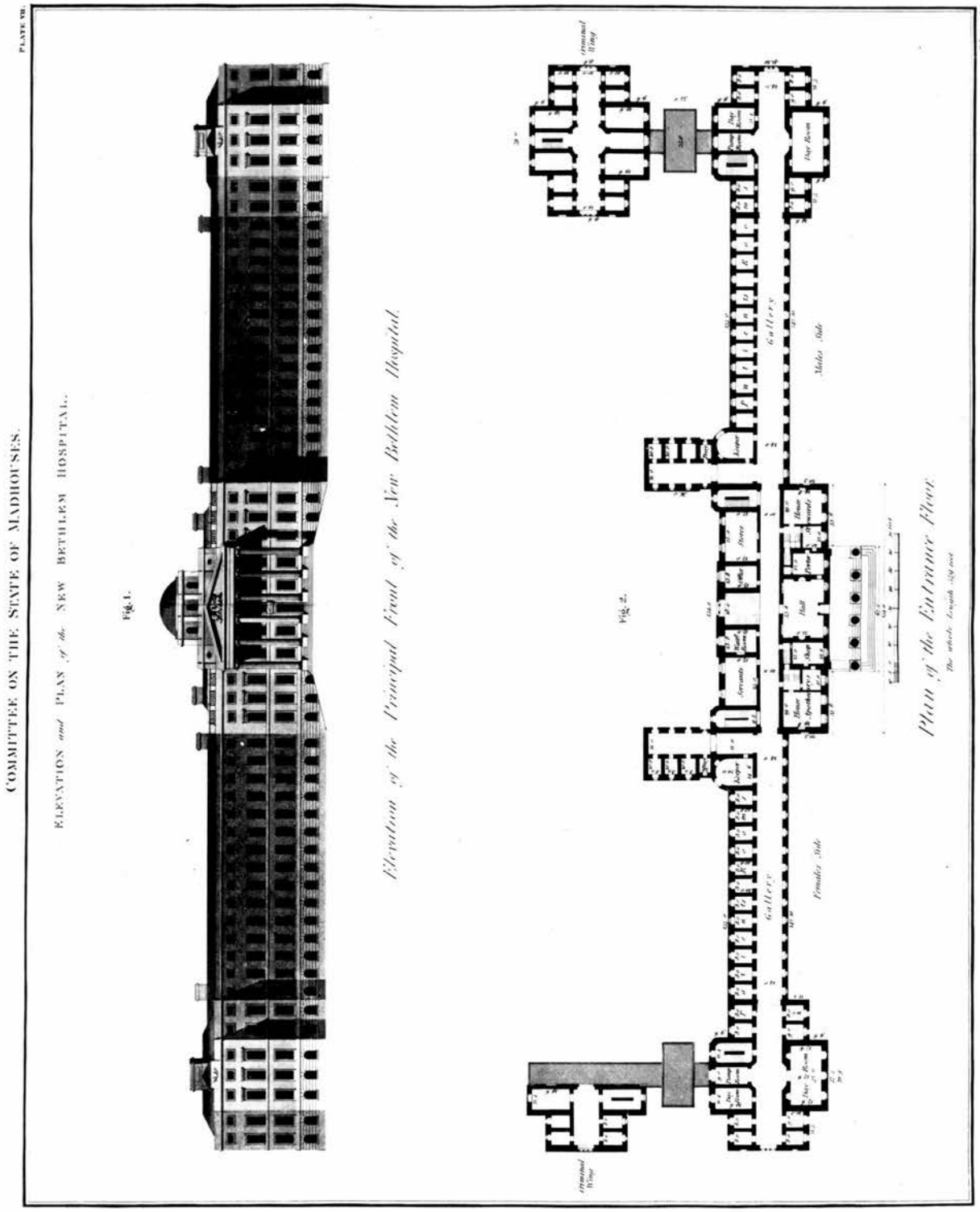
[1] Ferriar, 1792-8, vol. 2, pp. 111-2.

Figure 2

Plan of the New Bethlem 1815



Source: 1815 SC, Report, plate 7.

has been discontinuous in the history of the treatment of the insane. What has to be brought to light here is the reasoning that allowed this new "therapy" to appear as precisely that. If the new method was so effective (and many of its principles are still asserted today), why had no one thought of it before?

In medical terms, what was happening was fairly straightforward. Madness had traditionally been divided into mania and melancholy, but that classification was based on medical reasoning (for example, by identifying which humours were unbalanced) and referred to diagnostic categories. Ferriar was suggesting the classification of patients' behaviour according to their conformity to social norms. Convalescence, and by extension therapeutics generally, were to be defined not around what was wrong with the patient, but what was to be made right with him.

Understanding the significance of this is not so straightforward. True, there is a connection between this change and the social demands of a market economy, but is this enough to override the influence of other factors? What are we to make of interpretations of what Ferriar was doing, such as "matter-of-fact compassion untinged by sensation, moral condemnation, or concealment"?[1] Was there nothing compassionate about Ferriar's methods at all? The answer to these questions can only be given fully in the next chapter, when the focus turns to moral treatment itself. At this stage I wish only to reiterate what was stated in the Introduction, that in the last analysis all value is created by man himself. From a sociological point of view, we can either attempt to provide a completely naturalistic account treating expressions of value as merely interesting productions of social life; or we can attempt to understand the significance of doing this type of research and then

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[1] K. Jones, 1972, p. 45. Ferriar's own interpretation of his method as "A system of mildness and conciliation" (Ferriar, 1792-8, vol. 2, p. 108), has been accepted without comment by Hunter and Macalpine (HMA, p. 544).

subject the expressions of value we find to a rigorous assessment in the light of our values.

The first approach may be called "value-free sociology"; the second is historical materialism. Reasons were given in the Introduction why the latter is being used here. Briefly, it may be said that what was good about Ferriar's method was what is good about capitalism generally. It destroyed the patron-client relationship, the ties to which people were committed irrespective of their worth or achievements. What it had to put in its place has yet to be fully explored, but what can be seen at this stage was a complete dissatisfaction by a number of medical practitioners with the conventional models of care and cure.

Under pre-capitalist social relations the insane, if they had money, could establish a personal relationship with a member of the medical profession. The patient provided the patronage, the physician a wonderful array of therapeutic services in which we may agree that "medical knowledge must be seen as a form of social interaction with the consultative relationship".[1] Those who did not have money were, as has been shown, either given charity, confined on the grounds of their causing a nuisance, or ignored.

By the late eighteenth century, however, these divisions had almost disappeared. By then we may almost accept Sohn-Rethel's statement that

> With capitalist commodity production, moreover, at the stage when it reaches maturity--as it did in England in the eighteenth century--the market penetrates into the entire width and breadth of social life to become coextensive with society itself.[2]

Almost, but not quite. Ferriar after all was an exception; the medical profession as a whole was not eagerly searching for new methods of treating the insane The bourgeois values of equality of opportunity

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1 Jewson, 1974, p. 376.

2 Sohn-Rethel, 1965, p. 118.

had not reached all institutions where the insane were being kept. To understand precisely why this was not so it is necessary to appreciate something of the professional characteristics of the group through whom these values would have to be mediated.

Physicians, like everybody else in the 1790s, were affected by the profound changes in material production and the realignment of peripheral groups to the change in ownership of the means of production. The medical profession does not fit easily into the class model of society, but this is not to say that it is part of a distinct social category which exists outside of class conflict. On the contrary, what we are seeing here is the ideological expression of the medical profession coming to terms with class struggle. The medical profession, unlike merchants such as Cary or Bellers, had always stood aside from the creative source of their society's wealth; but like Cary or Bellers, or indeed anyone else, there were dependent on their relationship to the ownership of the means of production for their livelihood. In other words, they needed someone to pay them for their work.

The decline of aristocratic patronage and the rise of a dependence on the bourgeois institutions of the hospitals and insurance has been noted. By the 1790s these coexisted in mad-doctoring as in all the other medical specialisms. The typology of intellectuals that Gramsci developed[1] is a useful one for understanding the shifting class allegiances of the medical profession at this time. On the one hand, physicians can be considered under Gramsci's heading of "traditional intellectuals". Physicians did all they could to retain their high status in society: as the society changed, so did the rhetoric they used to justify their position. The Monros, with their connections in Court circles, undoubtedly

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1 Gramsci, 1971, pp. 10-18.

saw themselves as part of the ruling class.[1] But so did Ferriar, at least as far as the commercial interests of Manchester were concerned.[2] In this respect, many of the physicians come under Gramsci's other heading of "organic intellectuals". These are the thinking element of a class; a group who, at a time when their class is struggling to achieve dominance, attempt to develop a Weltanschauung in which to assimilate

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1 Thomas Monro (1759-1833), physician to Bethlem from 1791 to 1816, was educated at Harrow and Oxford, where he received his BA and MD degrees. Besides his post at Bethlem, his private madhouse, and his official duties in the College of Physicians, he is mainly remembered as a patron of the arts. He did offer considerable financial and moral support to struggling young watercolour artists such as Thomas Girtin and William Turner. "In winter evenings he [Monro] encouraged young men to make a studio of his house. There they put their sketches into pictorial shape under the doctor's eye, and he gave them their supper and half a crown apiece for their work" (Roget, 1891, vol. 1, pp. 78-9; see also Victoria and Albert Museum, 1976). This "enlightened patronage", as the DNB calls it, may have been appropriate for the state of artistic production at that time, but it was not typical behaviour for a mad-doctor.

2 Ferriar was not only a member of the Manchester Literary and Philosophical Society, the informal administrative body governing Manchester, but was also at various times its secretary and vice president. He was physician to the Lunatic Hospital, the Infirmary, and the Dispensary, as well as influential in establishing the Fever Hospital and the Manchester Board of Health. (On Ferriar's career see Brockbank, 1950.) Another physician who identified strongly with the ascendant middle class was James Currie (1756-1805), the first physician at Liverpool Lunatic Asylum. The son of a Presbyterian minister, Currie started his career as a trader in America. Not having much success at that, he decided to become a physician. He studied at Edinburgh and Glasgow universities and took his MD degree in 1780. He was appointed physician to Liverpool Infirmary, was a very active advocate of the abolition of the slave trade, and gradually became the most successful of all the Liverpool physicians. His recognition of the type of society that had made him wealthy was so clear that in 1793 he published an anonymous letter, attacking Pitt for leading the country into war. His thesis was that "Our prosperity depends on commerce; commerce requires peace, and all the world is at war--this is the short and melancholy history of our situation". (A letter, Commercial and Political, addressed to the Rt. Hon. William Pitt. . . This quotation is from the fourth edition of 1795, reprinted in W.W. Currie, 1831, vol. 2, p. 429. On Currie's career see Thornton, 1963, passim.)

the traditional intellectuals. The suggestion that lunatics should learn discipline and self-restraint is exactly what we would expect from an intellectual representative of the bourgeois class in the 1790s.

In other words, the change from one ruling class to another was not accompanied by a sharp break with all that went before. On the contrary, the class coming to dominance attempted to assimilate all it could of traditional status and knowledge in order to legitimate its own claims to material power. This was made easier in Britain by a very gradual transition from a society ruled by landed property to one ruled by capital. The opportunity for any entrepreneur with money to buy land and thus take on the attributes of a member of the gentry had been a feature of English society for generations.[1] Against this background, the main concern of the medical profession appears to have been to assimilate into as high a status as possible. It is only because of the uncertainty as to what that meant in England in the 1790s that there was no consensus of how deviants from the social order should be handled. If the picture appears blurred it is because it was blurred: the medical profession wanted to hold on to the best of both ruling classes[2] as well as to maintain an ideological purity.

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[1] See Perkin, 1972, pp. 56-62. Engels also commented on this phenomenon and noted caustically the consequences of the failure of the bourgeoisie to emancipate itself ideologically from an earlier ruling class: "The English bourgeoisie are, up to the present day, so deeply penetrated by a sense of their social inferiority that they keep up, at their own expense and that of the nation, an ornamental castle of drones to represent the nation worthily at all state functions; and they consider themselves highly honoured whenever one of themselves is found worthy of admission into this select and privileged body, manufactured, after all, by themselves" (Engels, 1892, p. 277).

[2] An eloquent statement of a commitment both to commercial capitalism and to the paternalism of a class which always knows best was made by Currie, physician at Liverpool Lunatic Asylum: "We may consider a nation as a great trading company. . . .Each partner in the business

With this review of the medical profession, the content of this chapter is complete. What has been described here is the nexus of ideas and practices that constituted the treatment of the insane in the 1790s. If certain aspects have been emphasized at the expense of others, it is because I have attempted to draw out what was most significant for the history of the majority of the insane themselves. King George III, for instance, has received virtually no attention here in spite of his repeated bouts of insanity. This is because the therapies that were devised for the king were not the sort that could be or were applied on a large scale to the pauper population of the public asylums. He was treated by physicians of the highest rank, who had little interest in innovating methods which would benefit anyone other than their own aristocratic patrons. This is not to decry the interest that the therapies used on the king have for indicating contemporary changes of opinion; but this can be done just as easily and, from the point of view of this thesis, more appropriately, by examining changes in treatment which affected the majority of those designated as insane.[1]

For similar reasons I have not directly confronted the concept of insanity itself as an epistemological question, but have preferred

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is not equally concerned, it is true, because every one does not throw the same share of property, talents, and activity, into the common stock, but all are interested in the general success, and the welfare of each is connected with that of the whole. . . .while some plan and regulate, others must labour and execute. . . .This comparison may serve to illustrate the immense consequence of the labouring poor. They demand our constant attention. To inform their minds, to repress their vices, to assist their labours, to invigorate their activity, and to improve their comforts:- these are the noblest offices of enlightened minds in superior stations. . ." (This appeared in a letter to the Liverpool Advertiser as a reason why Liverpool should have its own asylum. In J. Currie, 1805, vol. 2, Appendix 2, pp. 19-21.)

[1] On George III's illnesses and their interpretations, the most comprehensive work is Macalpine and Hunter, 1969. Other accounts appear in Trench, 1964 and J.Q. and R.C. Cantu, 1967.

to let its definition appear in the use that was made of it. The label of "insanity" or "madness" is perhaps applied to people in every society. But what can only be found by empirical investigation is who the people are in every society who do get so described.

In the 1790s a number of such descriptions, of the insane and of the appropriate therapies to which they should be subjected, were being discussed and tried out. Left to itself, the British medical profession might have continued to generate gradual change along the lines already established. Whether it would or not is something we will never know because at that time a number of things happened outside of the profession's narrow ideological and professional concerns. These external developments were to have the effect of transforming the whole future course of the treatment of the insane in Britain. These factors were both social and intellectual, but the overriding influence was that of "moral treatment", a practice which appeared almost simultaneously in a small private asylum in Yorkshire and in a large public asylum in Paris. It is to that practice that we must now turn.

CHAPTER TWO

The Creation of Moral Treatment:
An assessment of the work of Philippe Pinel in Paris and the Tuke family at York.

From the time when Pinel obtained the permission of Couthon to try the humane experiment of releasing from fetters some of the insane citizens chained to the dungeon walls of the Bicetre, . . .a new school of special medicine has been gradually forming.

--"Prospectus", The Asylum Journal, 1853

We do not say that the management at the Retreat . . .cannot be surpassed, - that it has not been equalled, and often approached in private houses. But this we do say, that no writer before Mr Tuke had pointed out the principle of gentleness and attention to comforts as the governing principle in the management of the insane; and that he, in having pointed this out as the governing principle, has rendered a service to humanity of the greatest importance.

--Anon, The British Review, 1815

Two names dominate all discussion of the concept of moral treatment: Pinel and the Tukes. Accurately or not, their work is seen to embody all that is important about moral treatment. More than that, they were the authors in whose work moral treatment was first presented as a coherent and distinctive therapeutic approach to the treatment of the insane. This chapter is devoted to an examination and assessment of these legendary figures; not necessarily to deflate this aura of importance, but to ask what it was about their work that made it appear so valuable to them and to us.

1. Philippe Pinel

First Pinel, perhaps the single most remembered name in the history of psychiatry. His is certainly the name most revered by the medical profession, if only because he was, unlike the Tukes, a member of that profession. And if Pinel's is the most famous name, the most famous image we have of his work is the painting by Robert Fleury showing him ordering the chains to be removed from the patients at the Bicêtre hospital in Paris. With this dramatic gesture Pinel acquired for himself the title of "liberator of the insane", a title which remained untarnished until Foucault's recent assessment of the whole legend. Pinel's contemporary reputation in France rested as strongly on his nosographical theories and his teaching career[1] as it did on his work with the insane, but on this side of the Channel it was his work as a mad-doctor or, more specifically, as the originator of "moral treatment" that was seen as his major contribution to medicine.

His work with the insane began with his appointment as visiting

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[1] Pinel was Professor of Hygiene from 1794, and later of Pathology as well, at the Paris medical school. His work there established him as the founder of a new school of nosography. On this see Ackerknecht, 1967.

physician to Dr Belhomme's private asylum near Paris in 1785. Pinel published a number of articles on insanity in the following decade, and on the 25th August 1793 he was appointed to the staff of Bicêtre public asylum.[1] The reputed "unchaining" took place in September of that year. In 1795 Pinel was transferred to another public asylum in Paris, Salpêtrière, where he instituted similar reforms (and regarding which another picture was painted to show the unchaining). In 1801 Pinel published his Traité médico-philosophique sur l'aliénation mentale, ou la manie, which was translated into English in 1806 as A Treatise on Insanity.[2] He was purged by the restoration government in 1822 and died in 1826.

What was it about this "moral treatment" that was so powerful that it allowed Pinel to release the "furious maniacs" from their chains and shackles and in so doing to start a revolution in the treatment of the insane? There is no evidence that Pinel ever sat down and wrote "moral treatment is. . ."[3] but what he has written can leave us in no doubt

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1 On this period of Pinel's career see Rosen, 1946, p. 336.

2 A facsimile reprint of the 1806 translation was published in 1962. All references, unless otherwise indicated, are to this edition. The introduction to the 1806 edition is by its translator, D.D. Davies, although it does incorporate some of Pinel's material. Pinel's own introduction to the first French edition of 1801 has been translated as pages 30-49 of Riese, 1969. The text of the second, much revised, French edition of 1809 has never been translated in full. Walk (1954, pp. 819-22) gives some extended quotations from it, and Pinel's introduction to this edition has been translated as pages 329-41 of Zilboorg and Henry, 1941, although it is described there as the introduction to the first edition.

3 Pinel of course did not write at all of "moral treatment", as this is an English translation. The phrase he used was "traitement moral" which does, at least superficially, translate as "moral treatment". But, as will be shown, it is the social and intellectual contexts in which these phrases were used that gave them their significance. The difference between the French and English versions of the phrase, which is concealed within the translation, may be of no interest to the history of psychiatry but it does illustrate the different forms that class struggle took in the two countries.

of what he was trying to achieve. It is scarcely an exaggeration to say that the whole of moral treatment can be summed up in the words he is reputed to have said to the first inmate of Bicêtre he set free in 1793:

> Captain, I will order your chains to be taken off, and give you liberty to walk in the court, if you will promise to behave well, and injure no-one.[1]

There is no real difference between the sentiment being expressed here--that is, the need to operate self-restraint--and that which appeared in Ferriar's comments on the management of the insane. The only difference is that Ferriar's suggestions remained as peripheral comments, whereas Pinel's work, flamboyant and expressive, claimed to provide a whole new theory and practice for the treatment of the insane. Not that Pinel ever claimed he was being totally original: he even maintained that "the credit of this system of practice has been hitherto almost exclusively awarded to England".[2] But what the English writers had not done, and what Pinel's work can be seen as an attempt to remedy, was to provide a complete exposition of the new therapeutic principles.

One particularly vivid example demonstrating what Pinel meant by moral treatment was of "An instance of violent mania cured by prudent and vigorous coercion".[3] A patient was sent to Bicêtre, violently insane after his father had lost all his property in the Revolution. "Never did a maniac give greater scope to his extravagance"; he strutted about believing himself to be the prophet Mohammed; he attacked all he met, including his wife and the governor of the asylum. "What could mildness and remonstrance do for a maniac, who regarded other men as particles

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1 Quoted in [Winslow,] 1839, vol. 2, p. 147.

2 Pinel, 1962, p. 107.

3 Ibid., p. 103.

of dust?" Moral treatment in this case consisted of putting the patient in a strait-waistcoat and confining him to his cell for an hour. This did not stop the "maniacal violence"; so a similar punishment was tried again and, when that failed, again. At last

> . . .another explosion of his proud and turbulent disposition made the governor feel the necessity of impressing this maniac with a deep and durable conviction of his dependence. For that purpose he ordered him to immediate confinement, which he declared should likewise be perpetual, pronounced this ultimate determination with great emphasis, and solemnly assured him, that, for the future, he would be inexorable.[1]

This apparently had the desired effect, as two days later "our prisoner very submissively petitioned for his release". However "his repeated and earnest solicitations were treated with levity and derision". At last a deal was engineered between the patient's wife and the governor: the patient was to be released if he would promise to the governess to restrain himself ostensibly without the knowledge of the governor who, the patient was told, would be extremely angry if he found out what his wife had done.

> After this, our lunatic was calm for several days, and in his moments of excitement, when he could with difficulty suppress his maniacal propensities, a single look from the governess was sufficient to bring him to his recollection.[2]

Within six months the patient was discharged cured and "is now indefatigably engaged in the recovery of his injured fortune" concluded Pinel with satisfaction.[3]

Many other examples could be given but they all illustrate the basic point: by a variety of means of sophisticated deception and

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[1] Pinel, 1962, p. 105.

[2] Ibid., p. 106.

[3] One interesting feature of this example is that, as in "catching the eye", the authority of the asylum superintendent or governor remains absolute. The difference is that here the patient is given an opportunity to develop some initiative of his own: the choice appears to be his, albeit within the greater authority of (the representative of) the institution.

intimidation the patients were induced to restrain themselves, to incorporate in their behaviour the principles of discipline that Pinel extended to them. There is no reason why we should not believe that this was far more effective than the direct use of chains or threats to restrain the patients, but one question remains. Why call this "moral treatment"? "Management" perhaps, but not "treatment" in the conventional meaning of the word--and what did it have to do with "moral"? There was certainly nothing mysterious about this phrase to Pinel: in fact the impression his Treatise gives is that the phrase was already in use in England.[1] There is no evidence at all that its use in England does predate Pinel, but this is not the same thing as saying that a similar approach did not exist there. The theoretical principle on which Pinel based his work was no more than that which the English medical writers mentioned as a matter of course: the management of the passions or moral affections. In Pinel's words,

> L'analyse des fonctions de l'entendement humain est sans doute fort avancée par les travaux réunis des idéologistes, mais il est une autre analyse à peine ébauchée et pour laquelle le concours de la médecine est nécessaire, c'est celle des affections morales, de leurs nuances, de leurs degrés divers, de leurs combinaisons variées.[2]

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[1] On page 103 of the English translation (Pinel, 1962) appears a quotation beginning "In the moral treatment of insanity, lunatics. . ." A footnote attributes this quotation to the Encyclopaedia Britannica but it does not appear in any of the three editions published before 1801 (Encyclopaedia Britannica, 1771, 1780, 1797). What happened was that the English translator mistranslated the title of the source of the quotation which is correctly given by Pinel (1801, p. 114) as Bibliothèque Britannique. The article being quoted is by a Swiss physician (DelaRive, 1798) and describes his visit to the Retreat private asylum near York. It was from this asylum that moral treatment was first announced as an indigenous practice in England, but that was not until 1811 (see Hunter and Macalpine, 1965) and after the person who used the phrase had read Pinel's Treatise. This development is examined in the second part of this chapter.

[2] Pinel, 1801, p. xxxv. "The analysis of the human understanding has been much advanced by those who have reconciled various branches of

The long-standing recognition of the importance of the passions in "human nature" was here being reaffirmed by Pinel. As was discussed in Chapter One, the medical profession had never completely ignored the effects of the passions, but neither had they ever incorporated them as a major part of mad-doctoring theory. Scattered references to the subject can be found throughout the seventeenth and eighteenth centuries,[1] and by the late eighteenth century most English mad-doctors mentioned the passions in their various treatises, especially in discussing the etiology of insanity. Haslam, for instance, divided its causes into the "physical", such as heredity, fever, "suppression of periodical or occasional discharges and secretions"; and the "moral", that is, those "applied directly to the mind" such as anger or ungratified desire, "in short, the frequent and uncurbed indulgence of any passion or emotion, and any sudden and violent affection of the mind".[2] But while Haslam recognised the importance of the passions, as he did of the association of ideas, in causing insanity, he was never able to recognize that they might have an equally strong effect in curing it.

One physician who partially recognized the value of the passions in the cure of insanity was William Falconer, physician to Bath General Hospital. In an essay entitled A Dissertation on the Influence of the

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knowledge into a science of ideas. But another study which is barely outlined at present requires the assistance of the physician. This is the analysis of the moral affections or passions--their modifications, their different degrees, and their varied combinations" (translation by Grange, 1961, p. 444). The following discussion leans heavily, at least for its inspiration, on this paper by Grange which, with her other papers on Pinel, contributes more to our understanding of his work than a dozen of the usual hagiographic accounts. For examples of which see Saussure, 1950; Woods and Carlson, 1961; or Zilboorg and Henry, 1941.

1 For an example from 1664 see HMA, pp. 171-3, and for a general discussion of this subject, Grange, 1962a.

2 Haslam, 1798, pp. 99-100.

Passions upon Disorders of the Body (for which the Medical Society of London awarded him its Fothergillian Medal for 1788), Falconer asserted, in discussing melancholia, that "it is obvious that there must be here a large scope for the management of the mind and passions" and went on to suggest travelling, sport, the invocation of shame, music, gambling, and philosophy as means by which suitable passions could be moved to overcome the disorder. But when it came to discussing mania, all Falconer's imagination left him and he fell back on the old sureties. Since mania was "irrationality on all subjects", the aim of therapy must be "to eradicate the former false impressions by others still more violent", either by drowning or the inculcation of terror. And if that did not work, "maniacal persons are almost altogether cowardly" so "that threats will often compel them to act and speak rationally".[1]

Other tentative recommendations of the need to manage or govern the passions were made by Perfect and by Harper, both mad-doctors with whose work Pinel was familiar.[2] On the whole, however, these suggestions as to the place of the passions in therapy remained as principles to be stated, rather than as therapeutic strategies to be applied.

Pinel appreciated the practical contributions of the English authors but he did not think much of their own understanding of what they were doing. After discussing the works of Battie, Arnold, Pargeter, and Ferriar, Pinel concluded

> But a careful, impartial examination discloses nothing but vague dissertations, repetitions, compilations, scholastic formality, and some scattered facts which from time to time serve as rallying-points but which offer no real body

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1. Falconer, 1788, pp. 77-9, 82-3.

2. See Perfect, 1787, p. 268; and Harper, 1789, p. 44. Pinel gives evidence in his Traité of having read virtually all the specialist writings on insanity that were published in England in the eighteenth century.

of doctrine based on a sufficient number of observations.[1]

What Pinel attempted was to draw together the observations of the English physicians into a coherent approach. He took hold of the well-established theory of the passions, so old it was almost a platitude, and developed it into a practical basis by which to extend to the insane the opportunity to create their own recovery. At the end of his discussion of the "instance of violent mania cured by prudent and vigorous coercion" Pinel summed up what he had achieved in both theoretical and practical terms:

> These internal struggles between the influence of his maniacal propensities and the dread of perpetual confinement, habituated him to subdue his passions, and to regulate his conduct by foresight and reflection. He was not insensible to the obligations which he owed to the worthy managers of the institution, and he was soon disposed to treat the governor, whose authority he had so lately derided, with profound esteem and attachment.[2]

This was moral treatment: it was literally <u>treatment</u> effected through the creative manipulation of the patient's <u>moral</u> affections.[3]

There were two ways in which this manipulation took place. One was along the lines of "balancing the passions", the good with the bad, an

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[1] Introduction to the 2nd edition of his <u>Traité</u>, in Zilboorg and Henry, 1941, pp. 334-5.

[2] Pinel, 1962, p. 106.

[3] A contemporary of Pinel, Jean Itard, attempted to use the same method to educate the "Young Savage of Aveyron", the feral boy discovered at this time living wild in a forest. Pinel himself was very sceptical of what could be done with the boy but Itard believed he could use "that sublime art. . .of moral medicine". As he put it, "Guided by the spirit of their doctrine. . .I reduced to five principal heads the moral treatment or education of the Savage of Aveyron. My objects were, (1) To attach him to social life. . . (2) To awaken the nervous sensibility by the most energetic stimulants. . . (3) To extend the sphere of his ideas. . . (4) To lead him to the use of speech. . . (5) To exercise frequently the most simple operations of the mind upon the objects of his physical wants. . ." (Itard, 1972, pp. 101-2, first published 1801). Pinel's assessment of the boy as innately deprived of certain sensory faculties can be seen in a recently translated paper he gave on the subject (in Lane, 1976, pp. 57-69).

idea that originated with Aristotle;[1] the other was through the use of the authority of the hospital governor or physician to subjugate the moral affections of the patients. By this twofold manipulation of the passions, Pinel was able to provide the basis for a radical change in the treatment of the treatment of the insane, although the practice of moral treatment as understood by Pinel marked very little advance on what was already happening in England.[2] It may just be that although the phrase "affections morales" is a direct translation of "moral affections", it was the simple fact that English physicians preferred to write of "passions" rather than the more cumbersome "moral affections" that explains why "moral treatment" did not originate in this country. If one looks only at the intellectual context of Pinel's innovative practice, this would seem a justifiable conclusion to make. But if this intellectual understanding of the importance of the moral affections is placed in the precise

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1 See Grange, 1962a.

2 One of Pinel's best known pupils, J.E. Esquirol, was far more explicit about the role of the passions in moral treatment. The following passage from Esquirol shows something of the therapeutic possibilities that Pinel's work was believed to have created for the control of the passions: "Nothing is more difficult than to control the passions of man in health. How greatly augmented is the difficulty, when we wish to direct those of the insane! A certain address is necessary, and great skill in seizing upon a fitting opportunity for this application. Now, we must oppose, and conquer the most obstinate resolutions, inspiring the patient with a passion stronger than that which controls his reason, by substituting a real for an imaginary fear; now, secure his confidence, and raise his fallen courage by awakening hope in his breast. Each melancholic should be treated on principles resulting from a thorough acquaintance with the tendency of his mind, his character and habits, in order to subjugate the passion which, controlling his thoughts, maintains his delirium" (Esquirol, 1965, p. 228, first published 1820). A similar recognition of the role of the physician in "opposing" individual passions was made by the American physician Benjamin Rush. Rush argued that an essential element of therapy was to encourage "the passions. . .to neutralize and decompose each other, and thus to lessen their influence upon the body" (Rush, 1962, p. 204, first published 1812).

social context within which Pinel was working, it takes on a much deeper meaning and one which goes a long way to explain why this version of moral treatment appeared in France and not in Britain.

In the early 1790s the treatment of the insane in France was far less developed than it was in England. Private facilities existed for the rich, but for the majority there was a far greater reliance on chains and dungeons than there was in England. A survey of 1785 reported that "One could hardly find, in the kingdom of France, four or five places fit for the treatment of the insane".[1] Pinel was fully aware of this and looked with envy across the Channel to what he saw as the impressive reforms taking place in England. In 1789 he published an article entitled "Observations sur le régime moral qui est plus propre, à retablir, dans certains cas, la raison égarée des maniaques".[2] The publication of that article at that particular time is very significant. Not only did it establish Pinel's concern with moral treatment as early as 1789, it also ties his social understanding of the treatment of the insane to specific historical events. In this article, Pinel wrote

> Les égards qu'on témoigne en Angleterre aux Maniaques, & les efforts qu'on fait dans leurs Établissemens [sic] publics pour les ramener à la raison sont certainement dignes de servir de modèle. On a rapporté dernièrement dans un Papier public Anglois que dans l'Hôpital de Saint Luc la proportion de ceux qui avoient recouvré leur entendement avoient été de dix sur douze. Qui diroit que dans une Nation rivale de l'Angleterre pour les lumières on dut trouver un si grand nombre d'asyles où ces malheureux sont comme abandonnés & privés de toutes les ressources de l'Art de guérir.[3]

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1 Colombier et Doublet, Instructions sur la manière de gouverner les insensés et travailler a leur guérison, 1785, quoted in Saussure, 1950, p. 1224. An indication of the quality of care is the authors' statement that it was common practice to have only one bed to every four patients in the asylums.

2 Pinel, 1789.

3 "The regard that is shown in England towards the insane, and the effort

In the same article Pinel discussed a recent French translation of a history of Bethlem.[1] As Grange has pointed out, this translation also had an appendix contrasting the poor conditions in France with the good in England. It concluded with a call for reforms in the treatment of the insane in France "and insisted that France, under a free government, must follow the remarkable lead of the English". And, as Grange continued, "in 1789, when the Bastille fell, this was the book which Pinel recommended".[2]

Pinel was strongly committed to the social aims of the Revolution and saw his work as a contribution to the intellectual improvement of post-Revolutionary France. He was also a close friend of many of the ideologues, and one of the strongest influences on his thought was that of P.J.G. Cabanis,[3] who was also made a professor of medicine at the Paris medical school in 1794. For Cabanis the moral basis of life, its value as a social activity, was laid in the physical construction of human nature itself. Like Locke and Condillac, Cabanis was a sensationalist, believing in sensory impressions as the basic psychological events. From this point of view, abnormal psychology was a result of too-great sensitivity, or violent impressions, as might occur at the time of a

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that is made in the public asylums to recover their reason, is certainly worthy of serving as a model. It has recently been reported in an English paper that the proportion of those who recovered their understanding in St Luke's Hospital has been ten out of twelve. What will people say of a nation that rivals England in reputation yet where there are such a great number of asylums where the unhappy inmates are as good as abandoned and deprived of all the resources of the art of healing?" (Pinel, 1789, p. 14.)

1 This was Bowen, 1784, an extremely idealised account of contemporary practice at Bethlem published in order to raise funds.

2 Grange, 1963, p. 375.

3 At one stage Pinel helped Cabanis to find a hiding place for Condorcet when the latter was being hunted by the police (see Rosen, 1946, p. 332). For an account of Cabanis' medical theories see ibid., pp. 334-5 and Ackerknecht, 1967, pp. 5-6.

social revolution. The moral world affected the physical body through the central nervous system, so medicine must be the moral science participating in man's infinite improvement. "It is now beginning to be perceived," Cabanis wrote, "that medicine and moral philosophy form but two branches of the same science."[1] The influence of Cabanis can be seen in Pinel's construction of his medical theory[2] but also in his approach to the practice of medicine. Cabanis believed that by knowing and improving our physiological constitution we will at the same time be able to improve our moral condition. And conversely, argued Pinel, a moral improvement in man such as the increase in liberty that a social revolution provides will in itself lead to physical improvement. Before the Revolution there was much "maux de nerfs", "toutes les affections spasmodiques", "les maladies catharrales" and other complaints. But now, wrote Pinel in 1790, "Une année s'est à peine écoulée, et tout a pris une face nouvelle."[3] The political change, according to Pinel, was directly responsible for the improvement in physical well-being. Everyone noticed the change: "Je me porte mieux depuis la revolution",[4] a commonly-heard phrase in 1790, was for Pinel a physical recognition of the moral effects

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1 Cabanis, 1806, p. 304, first published in 1804. This conjuncture between medicine and philosophy can be seen in the title of Pinel's Traité but it is lost in the English translation: "Treatise on Insanity". The full French title is Traité Médico-Philosophique sur l'Aliénation Mentale.

2 In terms of the dichotomy used in the previous chapter to describe hierarchical and constructivist theories of human nature, it can now be seen that Pinel used the imagery of one (the role of the passions) in a way which had up to that time been the prerogative of the other (the role of the sensations). There was nothing intellectually profound in his use of these resources; indeed, what is perhaps most noteworthy is that Pinel extended a theoretical interpretation of human nature hardly at all.

3 Pinel, 1790, p. 366.

4 Ibid., p. 367.

of the Revolution.[1]

We are now in a position to appreciate the full significance of the word "moral" to Pinel. It referred not only to the moral affections that were to be manipulated in therapy, but also to the moral normality of post-Revolutionary France that was to be lived by its citizens. "Traitement moral" was an explicit practical expression of the moral science that Cabanis called for, based on the aims of the Revolution and on a knowledge of physiology: it was both prescription and description; an affirmation of faith as well as the material basis on which a new society could be built of healthy citizens. In Pinel's quite unambiguous words,

> The doctrine of balancing the passions of man, by others of equal or superior force, is not less applicable to the treatment of the insane than to the science of politics.[2]

In the revolutionary period of the 1790s this doctrine had quite specific implications. It will be seen later how short-lived was Pinel's "revolutionary optimism", tied as it was to the interests of bourgeois normality. But initially Pinel did have extremely high hopes for the moral improvement of his patients, as he did for mankind in general. At the same time it must be stressed that Pinel's idea of improvement was not a limitless one in the sense that, say, William Godwin's philosophy was.

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1 This equation of moral and physical improvement, propounded by Cabanis and taken up by Pinel, was not uncommon in pre-Revolutionary France. Darnton (1968) has pointed out that it was not only the sensationalists who held this belief; it was also energetically spread by the mesmerists. Mesmerism was based on very different theoretical principles to sensationalism, but its advocates did believe, like the sensationalists, in a natural order to which men ought to try and align their moral order. The mesmerists believed that "morality issu[ed] from the world's general physics" and consequently "any change, any alteration of our physical constitution thus produces infallibly a change, an alteration of things in our moral constitution. Therefore, it suffices to purify or corrupt the physical order of things in order to produce a revolution in its morals" (Nicolas Bergasse, writing in the 1780s, quoted in Darnton, op.cit., pp. 114, 120). This appears almost as an incitement to insurrection, but in fact the mesmerists took little part in the Revolution, and as Darnton points out, they preferred to spend their physical energy in large wooden tubs purportedly massaging each other into harmony with nature.

2 Quoted in Spurzheim, 1817, p. 244

Pinel was always very conscious of the social normality his patients were to return to and never attempted to create in them a desire for anything except the normality of post-Revolutionary France.[1] One aspect of this was that Pinel had very little sympathy for some categories of deviance: for these the tolerance of the physician was quickly exchanged for the punitive repression of the moralist. After describing one case of a former nun, "a perverse and untameable character" who was "a source of trouble and strife" to all, Pinel continued,

> But is it not a fact that one can only expect such a return of insight and gratitude from women of pure morals? How can one expect it of certain undisciplined and perverse women whose alienation results from shameful vice, loose living, drunkenness and vile intrigues? One dissipated young woman, for instance, did nothing but grumble during her stay at the Salpêtrière; she seemed to have sworn implacable hatred against all who prevented her from having her way. Every method of treatment tried for proved useless, and so we had her charged with various delinquencies of a grave nature which she had committed before her admission, and taken away to the St Denis remand prison; the same thing has happened on several occasions to other women who were brought to the Salpêtrière in consequence of loose living and drunkenness.[2]

An interesting contrast with this essentially conservative use of the theory of the passions is provided by the French utopian socialist

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[1] An interesting comparison with Pinel's revolutionary optimism is that used in the treatment of mental illness in the present-day Peoples' Republic of China. According to one visitor (Sidel, 1973) the Chinese explicitly incorporate their social optimism into their therapeutic programmes for the mentally ill. Sidel describes four aspects of Chinese life which make up the specific practice of revolutionary optimism in psychiatry there: (a) the principle of subordinating the feelings of the individual to the needs of the groups of which he is a member; (b) the belief that the individual is part of the revolution which will ultimately be victorious; (c) the belief that participation in this revolution gives meaning and purpose to life; and (d) the belief in the infinite capacity of man to learn and improve himself (op.cit., p. 736).

[2] This is from the 2nd edition of Pinel's Traité (1809), quoted in Walk, 1954, p. 821. Note that the women were only charged with penal offences after Pinel's treatment of them as insane had proved unsuccessful.

Charles Fourier. Fourier, writing in the 1820s and '30s, conceived of a communitarian settlement which he named "Harmony". The name referred to Fourier's ideal that in this settlement all man's passions would be harmoniously orchestrated so that he would live in peace and happiness. In his words,

> My theory is limited to utilizing the passions, just as nature gives them and without changing anything. That is the whole mystery, the whole secret of the calculus of passionate attraction. The theory does not ask whether God was right or wrong to endow human beings with particular passions; the societary order utilizes them without changing them and just as God has given them.[1]

While Pinel had used this same theory to justify the social normality of post-Revolutionary France, Fourier saw in it the possibility of a completely new and socialist community. Whatever the theoretical justification for this, Fourier's socialist ideals remained hopelessly impractical because he was so selective as to which passions he actually took notice of. Amongst other omissions, he left no place in his society for what would prove to be the disruptive passions of anger or of hate.

In concluding this assessment of Pinel it must be said that he was convinced that moral treatment was an established fact in England. This was because he drew his evidence from a few select sources, written by physicians who were concerned about the lot of the insane, but who could hardly be said to be caring for the majority of them. We can even go so far as to say that because the break between the old and new societies was so much more distinct in France than in England there was more interest there to a radically different approach in medicine as in other intellectual fields. Few physicians in England had anything like Pinel's commitment to building a new society; they were too conscious of their status within the old one, or at least within the society that was

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1 Fourier, 1972, p. 205.

gradually coming into being in England. It is partly because of this that much of the impetus to reform the treatment of the insane in this country came from outside the medical profession altogether. Certainly many of those who established an approach to the insane at this time had a very different position within the social relations of production to that of Currie or Ferriar. These other groups devised therapies appropriate to the expression of the social values they considered important, and in so doing they used the intellectual resources available to them in ways often very different from those used by the medical profession in either England or France.

In order to appreciate the meaning of "moral treatment" in the English context it is now necessary to turn to one of these alternative approaches. This is the work of the Tukes; reformers who, for reasons very different to those of Pinel, developed what they also called "moral treatment".

2. The Tukes

The institution at which the Tukes developed their version of moral treatment was a small private asylum near York called "The Retreat". A number of reasons have been passed down to us to explain why the Retreat was founded, but one which must be remembered is the existing provision of care for the insane at York at that time. It is possible that the Retreat would never have been founded at all if the York public lunatic asylum had been fulfilling a similar function to that of the public hospital in Manchester. York Asylum had been founded by public subscription in 1777 in a similar blaze of philanthropic glory to that which heralded all the subscription hospitals but, unlike some of the other hospitals, it did not maintain its sense of dedication. From the beginning there was difficulty in getting enough pauper lunatics because the

parish authorities would not pay the eight shillings per week the hospital charged to look after them. In 1784 a limited number of "superior" or "opulent" patients were admitted to "create the means to relieve the necessitous".[1] By 1792 there were 12 patients paying "a considerable sum", 42 parish paupers paying eight shillings, and 18 patients being kept for less than eight shillings because they did not receive parish assistance.[2] The generous paternalism of this policy was not all it seemed. In 1791 a female member of the Society of Friends was a patient at York Asylum. Her family in Leeds asked some of the local Quakers in York to visit her, the asylum refused to allow a visit to take place, and a few weeks later the patient died.[3] As a result of this incident the Quaker membership in York decided to do something positive about what they saw as the lack of suitable care for the insane,[4] and the foundation of another lunatic asylum in York was proposed. It was to be a cross between a subscription hospital and a private madhouse in that it depended on subscriptions to raise the necessary capital, but admission, and the chance to become a subscriber, was to be solely for members

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1 Gray, 1815, pp. 14, 17.

2 A. Hunter, 1792, Appendix, pp. 2-5.

3 Description, p. 22. It was not until the mid-1810s that the conditions inside the asylum were made public. For details see Gray, op.cit.; Higgins, 1816.

4 Initially they experienced difficulty in persuading other Quakers of the validity of this belief. A first proposal for funds in 1792 received little response so that a second one a year later included a long section answering the objections that had been made. These were overruled on the grounds that (a) there were enough insane Quakers to justify such a venture; (b) the new asylum would be for the entire country--already patients often had to travel long distances to an existing madhouse so the siting of a new institution in York would not exclude members of the Society living in another area; and (c) York was a good place because land was cheap there, the air was healthy and free from the smoke of manufacturing towns, and agricultural produce was cheap and plentiful (Description, pp. 34-9).

of the Society of Friends.[1] This private hospital, to be known only as "The Retreat", was built in 1795 and opened its doors to its first patients in June of the following year.

The person primarily responsible for founding the Retreat was William Tuke, a tea merchant and small-scale cocoa manufacturer who was aged 64 when the Retreat was opened. Tuke knew nothing about the treatment of the insane when he started his new venture, so he employed Timothy Maud, a distant relative and retired surgeon, to act as superintendent to the Retreat. Maud died within two months of the opening of the Retreat, and Tuke was left without a superintendent. He tried to get John Hipsley, the former headmaster of a school he (Tuke) had also founded, to take the post, but Hipsley refused. As an interim measure Tuke took on the job himself. There were not many patients at this time, only 18 being admitted in the first 12 months, but Tuke did not have an easy time of it. The head-keeper was careless and allowed a suicidal patient to strangle himself, so he was sacked. The housekeeper was not really capable enough for the job and when another patient died she had to leave. The sum of three shillings and sixpence had to be spent on searching for a missing patient.[2] A combination of these and other incidents led Tuke almost to despair: as he wrote to the Retreat's medical adviser, "Thus thou wilt see the Family has been greatly deranged indeed".[3]

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[1] Although the Retreat has always been, and still is, an institution run strictly in accordance with the ideals of the Society of Friends, only two years after opening it was taking in non-Quaker patients. The reason appears to have been financial, in that by taking non-Quakers at a higher rate of charges it was possible to subsidize more poor Quakers at the minimum rate (Minutes of the Committee appointed by the Subscribers of the Retreat, 28th June 1798, Ms in RA).

[2] Waste Book, entry for 5th November 1796 (Ms in RA).

[3] Letter to William Maud (Timothy Maud's son), 1st December 1796 (Ms in RA, emphasis in the original).

At last a replacement superintendent was found. This was George Jepson, a 54-year-old ex-weaver who had no medical qualifications but had practised medicine as a lay doctor in the West Riding. Jepson was already working as the "Keeper to the Men Patients" at the Retreat, and Tuke initially had doubts as to whether he should give him the greater responsibility. Tuke confessed that

> Had he been more experienced in the Government and order of a pretty large Family, I should not have much doubt respecting him. I consider him as a steady religious Friend, and in that respect to be fully confided in.[1]

By the summer of 1797 Jepson had apparently proved himself and was given the job. He remained until he was retired at the age of 80. Under Jepson's superintendence the Retreat evolved the particular therapeutic approach for which it became famous.[2]

When the Retreat opened its doors its approach to the "management" or control of the unruly patients was not particularly original. The aim was always to give the insane members of the Society of Friends better accommodation than that usually provided at private asylums. The first Annual Report proclaimed that

> We have strenuously avoided that gloomy appearance, which frequently accompanies places appropriated for those who are afflicted with disorders of the mind.[3]

But many of the early patients had been insane for a long time: once a

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1 Letter to William Maud, 13th February 1797 (Ms in RA).

2 The following discussion might give the impression, by constantly referring to the "Tukes'" contribution to moral treatment, that Jepson did not exist, or was at least unimportant. While not wishing to undervalue Jepson's contribution to the Retreat or for that matter that of his wife, the "female superintendent", it was the members of the Tuke family who remained the spokesmen for the Retreat, and it must be assumed that they retained the ultimate authority, at least in the early period. Apart from a few early Reports by William Tuke, the bulk of the published material on the Retreat was by Samuel Tuke, William's grandson, treasurer to the Retreat who made the asylum famous by the publication in 1813 of his Description of the Retreat.

3 Retreat, State of the Institution, 1797, p. 8.

specifically Quaker institution was opened many of them were transferred from St Luke's or a private madhouse and presented a particular problem of control. The second Annual Report admitted that "out of 23 cases now in the House, all of them, except two or three, were, at their admission, of so long standing as to be considered incurable".[1] With this kind of patient, long used to the constraints of chains or straps in another institution, some form of external control was considered necessary.

The most detailed description we have of the early years is in a letter by a Swiss physician who visited the Retreat in mid-1798.[2] This doctor described at length the facilities for the furious:

> On the ground floor, there are cells in which the maniacs are confined in their fits of fury, during which time their liberty would be dangerous. A small window gives them light, of which they can be deprived at pleasure: a little door which opens to the outside, gives their keepers an opportunity of observing them, without their being able to perceive it. The only furniture of these neat and wainscotted rooms is a bed. . . . In endeavouring to keep the patient in entire dependance, everything which could convey any idea of terror, has been carefully avoided. He is not fastened with cords, nor bound like a criminal. Two strong bandages are nailed to the floor and pass under the bed without his perceiving them: on the back of the waistcoat are two buckles which receive these bandages; the patient is in this manner more or less secured and has power at the same time to turn himself to the right or to the left. The feet are secured in like manner. He is thus kept under the greatest restraint, without appearing to be so. He is retained in bed by a kind of enchantment. He does not hesitate to acknowledge that he is at the discretion of those who surround him. The necessity

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1 Retreat, State of the Institution, 1798, p. 9. In order to attract more recent, and curable, cases to the Retreat it was early decided to provide more financial inducements. The 1799 Annual Report stated that "in derangements not exceeding six months from their first appearance" patients usually admitted at the eight-shilling rate would be charged half that for up to one year, and patients on the four-shilling rate would be admitted *gratis*. In 1800 two patients were admitted under this rule, recovered within six months, and were discharged, without paying any charge at all (Anon, 1828, p. 17).

2 Dela Rive, 1798. A small part of this letter was published approvingly (in English) in an Appendix to the Description (pp. 221-3). A much longer translation appears in Walk, 1954, pp. 815-7.

> which presses him on all sides soon subdues the most furious and malicious inclinations.[1]

Mildness and firmness: the greatest restraint with the least excitement; but this was a policy only for the very bad cases. "This is the severest punishment that they employ, it is seldom that they have occasion to use it."[2]

For the majority of patients the strongest restraint that was used on them consisted of local and temporary control. "Strong Leather Mittins" and "a Strong Leather Cap"[3] were bought but the most usual expense of this kind was for "strait-waistcoats". Of the first 15 patients, five were charged for a waistcoat or repairs to one.[4] As with the more extreme forms of restraint, the waistcoat was not used indiscriminately but only to control the outbursts of unwanted behaviour as and when they occurred. The case notes on John Baker are typical:

> He requires no particular attention but to prevent him from tearing or sullying his Clothes & to guard against any sudden starts of Passion when he strikes the other Patients if not well watched & has often attempted to strike his Physician. On such occasions it is found proper to put on a strait waistcoat for a Day or two to make him ashamed of his Conduct.[5]

"To make him ashamed of his conduct": in this phrase we can hear again the echo of Ferriar's and Pinel's plans to make their patients reflect on their actions, to make them realise that their minds were not completely destroyed but could, with the right encouragement, recover sufficiently to rejoin normal society again. By this criterion the threat

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1 Walk, 1954, p. 816.

2 Ibid.

3 Cash Book, entries for 16th February 1798 and 24th February 1798 (Ms in RA).

4 Patients' Disbursements, 1796 (Ms in RA).

5 Case Book I, entry for John Baker, 24th November, 1798 (Ms in RA).

of the straitjacket was a crude instrument of control: it was virtually the only one known to William Tuke and his colleagues when the Retreat was opened, but it was soon discarded once more sophisticated forms were found.

There was one other means of control used initially, again because it was common practice to do so. This was the use of fear. An account of the early days of the Retreat, written for subscribers in 1828, admitted that

> The basis of the system at that time generally adopted, was the position, that fear is the great principle by which the insane are to be governed and the practical consequences deduced from it, were, that their attendants should commence their intercourse with them, by an appearance of austerity, and perhaps the display of physical prowess; in fact, that in some cases of violent excitement, the cudgel and the whip were the most suitable instruments of coercion. We believe it may be said that the Retreat commenced with an assent to the general correctness of these views.[1]

Over the years a number of innovations were made in the way patients at the Retreat were cared for. By 1811 the practice at the Retreat constituted enough of a consistent and thought-out therapeutic programme for William Tuke to ask his grandson Samuel to write up and publish a Description of the Retreat. This was done and in this work Samuel Tuke described the core feature of the regime at the Retreat as "moral treatment". This was the first time this phrase had been used in English to describe an indigenous practice in this country.[2]

In the Description Samuel Tuke never actually defined what he meant by moral treatment although he devoted the longest chapter in the book

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1 Anon, 1828, p. 10. For a confirmation of this by Samuel Tuke see S. Tuke, 1846, pp. 14-15.

2 The work's full title is Description of the Retreat an Institution near York for Insane Persons of the Society of Friends; containing an Account of its Origin and Progress, the Modes of Treatment, and a Statement of Cases. There was one earlier use of the phrase "moral treatment" in an article which Tuke published anonymously in the Philadelphia medical journal The Eclectic Repertory and Analytical Review in 1811 (see Hunter and Macalpine, 1965), but there is no evidence that this article ever became known on this side of the Atlantic.

to it. At one stage he referred to moral treatment as "management"; elsewhere as the "means [by which] the power of the patient to control the disorder, is strengthened and assisted", as well as "modes of coercion" and even "the general comfort of the insane".[1] In the pages of the Description is, however, a full account of what, in the everyday practice of the Retreat, moral treatment did come to mean. In order to bring out the dominant features of this practice, it will be discussed here under three main headings: (a) the lunatic as child; (b) the social world recreated in the Retreat; and (c) work.

a. The lunatic as child. There are a number of comments by Samuel Tuke and others referring to the similarity between the insane and children; both needing socialisation into the correct norms of society, both having to learn the "normal" way to live. Dela Rive was the first to comment on this phenomenon as it appeared at the Retreat:

> You will perceive that in the moral treatment of the insane, they do not consider them as absolutely deprived of reason; or in other words, as inaccessible to the motives of fear, hope, feeling, and honour. It appears, that they consider them rather as children, who have too much strength, and who make a dangerous use of it. Their punishments and rewards must be immediate, since that which is distant has no effect upon them.[2]

Samuel Tuke himself agreed that "There is much analogy between the judicious treatment of children, and that of insane persons".[3] What he meant by "judicious treatment of children" can be seen from the comments he made in his diary on the occasion of his daughter's first birthday:

> It appears to me that in our little girl the faculties and

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1 Description, pp. 131, 138.

2 Quoted in ibid., p. 223.

3 Ibid., p. 150. See also p. 178 for a description of how the "assiduity" of the superintendent's "parental. . .affection" was rewarded by the patient's "almost filial attachment".

> the passions have advanced together, and that from the first indulgence of anger she has fully understood the consequent conduct of her excellent mother as marking disapprobation. How necessary is it, then, to check evil in its first appearance, and to study to teach the control of the passions whilst they are yet tender and flexible![1]

To teach children to have total control over themselves so that they would grow up to be good members of society was central to the Tukes' philosophy of life. It is only within this philosophy of life that it is possible to appreciate what Tuke understood by the "passions" or by other terms which up to now have appeared in a predominantly medical context. The Tukes made use of the same types of control over their patients as Pinel had done, but whereas he saw his work in terms of medical doctrine, the Tukes saw theirs in terms of a specifically religious one.

This religious doctrine was the one propagated by the Society of Friends.[2] God is the ultimate source of all reason and morality; man on his own is both irrational and evil. According to the Quakers, man can only become rational or good by allowing the "Spirit of God" which exists in every man to be allowed to express itself. To do this, argued the Quakers, required Reason to keep its dominance over the passions. "Reason" for the Quakers was thus an essentially mystical concept, the function of man's rational faculty which only retained its ability to function correctly because man acted in accordance with the wishes of

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[1] Diary entry for 25th November 1812, in S. Tuke, 1860, vol. 1, p. 189.

[2] In many ways Quaker doctrine was not dissimilar to that of other eighteenth century Protestant sects, but it is one with sufficient interest of its own to be treated separately. The account given here refers to Quaker beliefs at the end of the eighteenth century: it does not purport to describe present-day ideology. The main contemporary source used is Clarkson, 1807. Clarkson was not a Quaker but he was sympathetic to their aims, especially when expressed in social action as in the movement to abolish slavery. His Portraiture remains the most extensive description of Quaker practice we have for this period. Secondary sources used are mainly Tolles, 1960; Isichei, 1970; Raistrick, 1970; Grubb, 1930.

the Spirit of God. The passions or moral affections of love, joy, fear, anger, etc., are what God gave to man to control his nature. Only too often, argued the Quakers, these passions are allowed to indulge themselves and man loses simultaneously his moral dignity and his reason.

This is familiar imagery but there is nothing in the Description to suggest that Samuel Tuke was interested in the various medical theories to which the same concepts were often tied.[1] A number of present-day commentators have emphasized that the Tukes' commitment to treatment of the mind, rather than to medical remedies of the body, placed them in a contentious position vis-à-vis contemporary medical opinion.[2] The essence of this argument is that insanity at that time was believed to be primarily a physical derangement, that its mental manifestations were just the external visible sign of underlying pathology. Non-physical causes of insanity were accepted but once physical degeneration had set in what was the point of using non-physical methods to cure it? Or, to use a metaphor popular with modern exponents of this approach, if a television set has a faulty tube, there is no point in trying to change the station.[3]

What those who emphasize this argument ignore is that medicine has always worked with an implicit recognition that the mind and the body

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1 Very little will be said here of the medical personnel employed at the Retreat or of their policies as very little importance was placed on this aspect of care. However there was always a visiting physician on call, the first being Thomas Fowler from 1796 until his death in 1801. As with the use of fear, "Bleeding, blisters, seatons, evacuants, and many other prescriptions, which have been highly recommended by writers on insanity, received an ample trial" (Description, p. 111); but Fowler and his successors only used them, as they did fear, cautiously and without reference to the medical theories of insanity with which they were usually associated. In the Description Tuke discussed all the medical therapies that had been tried at the Retreat, but the only one he was at all encouraging about was the warm bath.

2 See Bynum, 1974, pp. 329-31; Scull, 1975a, pp. 250-4.

3 See R. Hunter, 1973.

influence each other.[1] Humoural theories, the doctrine of the association of ideas, sensationalism: these are all attempts to provide a scientific explanation of this influence. And they were all being used in the eighteenth century, by mad-doctors, to explain the causation of insanity. The Tukes did no more than Pinel in pointing out that what worked as a cause could just as easily work as a cure. In Samuel Tuke's words:

> If we adopt the opinion, that the disease originates in the mind, applications made immediately to it, are obviously the most natural; and the most likely to be attended with success. If, on the contrary, we conceive that mind is incapable of injury or destruction, and that, in all cases of apparent mental derangement, some bodily disease, though unseen and unknown, really exists, we shall still readily admit, from the reciprocal action of the two parts of our system upon each other, that the greatest attention is necessary, to whatever is calculated to affect the mind.[2]

If anything offended the medical profession it was not that this constituted an attack on the Cartesian dualism they were all supposed to be committed to, but that the Retreat's version of moral treatment did not use any of the sophisticated forms of knowledge that physicians had to spend so much time and money in acquiring.[3]

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1 As far as the <u>concept</u> of disease is concerned, there is an alternative view, the "ontological", which holds that disease is not a physiological deviation from normal but the intrusion by bacteria, demons, or other foreign bodies which run an independent and self-sufficient course of their own. The "physiological" concept of disease, on the other hand, accepts its definition as being dependent on the social norms of health or, as Galen put it, on the state "in which we neither suffer pain nor are hindered in the functions of daily life" (quoted in Temkin, 1963, p. 637, on which paper this discussion is based). A vivid commentary on this dichotomy is provided by a Professor Pettenkofer who tried to disprove Koch's claim that it was the virulent cholera bacillus that was the sole cause of cholera. Pettenkofer ate a sandwich containing a pure culture of the bacilli. He suffered no ill effects and thus was able to continue to maintain that the bacillus was not sufficient cause for the illness--it also depended on the patient's consititution, his mental and physical health (example given in Offer and Sabshin, 1966, p. 6). As far as psychiatry is concerned, it is continually made evident that whatever concept of disease is used to account for the existence of insanity, in treatment the distinction cannot so easily be made.

2 <u>Description</u>, pp. 131-2.

3 Also, as will be argued, there was often a large discrepancy between the

One lay source that Samuel Tuke acknowledged as having an influence on his thinking was John Locke's work on education. In 1811 he wrote in his diary how much he was impressed by Locke's insistence on the need for man to achieve "a mastery over his inclinations".[1] To Samuel Tuke this was a fundamental aspect of the real needs of human nature. The passage from Locke which Tuke cited continues in a similar vein, emphasizing the conventional hierarchical imagery of man and of society:

> . . .he that knows not how to resist the importunity of present pleasure or pain, for the sake of what reason tells him is fit to be done, wants the true principle of virtue and industry, and is in danger of never being good for anything.[2]

"To obtain the power here spoken of," added Tuke, "is the true object of wisdom in its spiritual and genuine sense."

The words are clear enough, although they seem on the face of it to contradict some of the argument that has been developed thus far. Here is a commitment to the same hierarchical view of human nature that in Chapter One was seen to be recognised as a block to improvement in the treatment of the insane. But whereas most medical writers up to the mid-eighteenth century saw the insane as deprived of reason and thus beyond

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conception of social normality held by the medical profession and that held by many of the lay reformers who entered into the debate.

[1] Diary entry for 19th September 1811, in S. Tuke, 1860, vol. 1, p. 164. Tuke stated that he was quoting from a work entitled "Beauties of Locke", p. 206.

[2] Ibid., p. 165. Locke's writing on education includes many sentiments which could have been repeated without modification by Samuel Tuke. For instance, in 1693 Locke wrote of how parents were helped in the education of their children by the natural tendency of children to take "a Pleasure in being esteem'd and valu'd, especially by. . .those they depend on". If the parents "caress and commend them when they do well, shew a cold and neglectful Countenance to them upon doing ill [this]. . .will of itself work more than Threats or Blows, which lose their Force when once grown common, and are of no Use when Shame does not attend them" (Locke, 1934, p. 34). But if the principle was old, it took a creative thinker like Samuel Tuke to be able to apply it to the insane in a meaningful way.

normal therapeutic approaches; for the Tukes, as for all Quakers, the full source of reason existed only in God and therefore everyone was equally imperfect and amenable to improvement before Him. Pinel worked with a similar model of human nature, except that he located the "reason" his patients lacked in his own authority, the authority of the physician. The Quakers saw their use of reason as grounded in their religion. It was a theory of man's place in the world which, for the Tukes at least, meant that groups like the insane could now be treated as fully human. What the insane lacked in human nature, all men lacked as soon as they let their passions get out of control. This humanist aspect of moral treatment has been made much of by present-day claimants to its inspiration. Without denying that the Quaker epistemology did indeed extend its offer of humanity to all sections of society, we must not forget what the precise formulation of that humanity was: a stark image of man, relegating many of the richest and most popular aspects of conventional behaviour to the status of "problem". Every activity which created excitement or stimulated the imagination was likely to be classified as dangerous. On playing cards, for instance, one commentator wrote,

> I have been told that large drops of sweat have fallen from [the card players'] faces though they were under no bodily exertions. Now what must have been the state of their minds when the card in question proved decisive of their loss? Reason must unquestionably have fled: and it must have been succeeded instantly either by fury or despair. . .It is not necessary to have recourse to the theory of the human mind to anticipate the consequences that would be likely to result to grown-up persons from such an extreme excitement of the passions.[1]

Like this writer, Samuel Tuke was aware of holding no explicit "theory of the human mind" but he did accept the need to keep it firmly disciplined along the lines that God was believed to sanction. Besides card

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1 Clarkson, 1807, vol. 1, p. 29.

playing, other proscribed activities were theatre-going, music, dancing, and reading novels.[1]

As Tuke pointed out, "the faculties and the passions advance together". In children and lunatics could be seen the raw material of human nature. Only be constantly exerting discipline over the baser parts of this nature could they receive the Spirit of God and thus grow into fully human creatures. It was a central belief of the Quaker philosophy that every member of the Society had a duty not only to discipline himself but all others with whom he came into contact. "Vigilance" over the moral conduct of individuals was a Christian duty . . .and any interference with persons who might err, was solely for their good."[2] At the local and national Quaker meetings this precept was institutionalised into the post of "Overseer" which was created to "admonish" any deviants. What was more natural than that the Tukes should attempt to instil this precept into the everyday life of the Retreat?

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[1] Samuel Tuke accepted the official doctrine in these matters but he was sufficiently sensitive to try and understand why such activities should not be allowed. The following comments on Ann Radcliffe's The Mysteries of Udolpho (1794) are typical of his approach towards culture generally, a perspective which was on the liberal end of Quaker opinion at that time: "The intention of this romance appears to be good. 1st--its object appears to be to show the advantages of a careful education, and the necessity of discouraging that sickly sensibility too common in females in high life, and which so much undermines their powers of usefulness and happiness. 2nd--to discourage that love and ready belief of the marvellous, so common to the human mind, by relating a number of incidents which have had every appearance of supernatural, but which were found to proceed from natural causes. These illustrations are excellent; but I am nevertheless of the opinion that the work is, on the whole, likely to do more harm than good. It represents man in a state which he is not in; viz., a state in which he requires no superior aid to be innocent and happy. The incidents are so extraordinary that it makes common life appear insipid, and lessens the relish for the world in which imagination is less conspicuous than understanding and truth" (diary entry for 26th August 1811, in S. Tuke, 1860, vol. 1, pp. 163-4).

[2] Clarkson, 1807, vol. 1, p. 181. As with all Quaker social behaviour, explicit justification for it was held to exist in the Bible. In this case the appropriate text was Matthew XVIII, verses 15-18.

Within this general aim there was even a place for fear, not as used by the medical profession in the treatment of the insane to induce abject terror, but within "that degree which naturally arises from the necessary regulations of the family".[1] As "in the education of children, whose imperfect knowledge and judgement, occasion them to be less influenced by other motives", fear helps to lead people along the right path.[2] According to Tuke, the trouble with using the effects of fear on the patients was that, being a violent passion, it had the effect of inducing equally violent reactions. If we want the patients to act in a mild manner like obedient children, he argued, then they must be treated with mildness.

A milder passion than fear was, according to Samuel Tuke, the patients' "desire for esteem". What he meant by this was that once it had been established that certain behaviour would not be tolerated, as with small children, it was possible to manipulate the patients' need to be approved and liked, and thus get them to conform in order that they might satisfy this need. Tuke's comments on the "desire for esteem" are similar to the ones Ferriar made on the privilege of admission to his convalescent room:

> This principle [the desire for esteem] in the human mind, which doubtless influences, in a great degree, though often secretly, our general manners; and which operates with peculiar force on our introduction into a new circle of acquaintance, is found to have great influence, even over the conduct of the insane. Though it has obviously not been sufficiently powerful, to enable them entirely to resist the strong irregular tendencies of their disease; yet when properly cultivated, it leads many to struggle to conceal and overcome their morbid propensities; and, at least, materially assists them in confining their deviations, within

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1 Description, p. 141.

2 Ibid., p. 142. Again, this was a point which John Locke had made as early as 1693. In Locke's words, "Fear and Awe ought to give you the first Power over their Minds, and Love and Friendship in riper Years to hold it" (Locke, 1934, p. 28).

> such bounds, as do not make them obnoxious to the family. The struggle is highly beneficial to the patient, by strengthening his mind, and conducing to a salutary habit of self-restraint; an object which experience points out as of the greatest importance, in the cure of insanity, by moral means.[1]

Whether this desire for esteem is described as a passion or, as Tuke saw it, as "a principle in the human mind", the point to be noted is the enlargement of the concept of human nature to take into account one of the most pervasive of all bourgeois values. It is not a universal feature of human psychology to worry about others' recognition of individual achievements. In most societies each individual is ascribed a position in life and conforms to it. As individuals gradually broke away from the material and ideological constraints of feudalism they developed a self-awareness of themselves as individuals.[2] For the middle-class Quakers of eighteenth-century England a prominent feature of their self-image was their material achievements as traders, shopkeepers, and small-scale manufacturers.[3] Individual achievement was the basis for both their material success as entrepreneurs and for their consciousness of themselves as successful men and women. But consciousness of this kind does not exist for long on its own: it needs continual confirmation in the eyes of others. The Quakers, and other marginal middle class groups at this time, felt a necessity both to express the rationality of their existence, and to make sure that it was reproduced

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1 Description, pp. 157-8.

2 On this see the discussion by Stone (1977, pp. 221-69) of the "growth of affective individualism", the changing conception by man of himself as he came to value self-awareness and individual autonomy.

3 A survey of 217 Quaker marriages about 1780 showed the following breakdown of Friends' occupations: professionals (bankers, schoolmasters, physicians), 21%; merchants (including dealers and shopkeepers), 65%; craftsmen and artisans, 14%. There were no unskilled occupations at all (from Raistrick, 1950, p. 32). On the social background of Quakers see also Isichei, 1970, pp. 173-6.

as widely as possible. As Quaker children were socialised into a constant awareness of the importance of this principle, so at the Retreat were the insane similarly to be enclosed within an evocation of a family. Not an abstract timeless family, but one where the restraint of the patients' baser nature was effected through their need to be approved, their need to do something worthwhile.

b. The social world recreated at the Retreat: The strictly disciplined family into which the insane were to be resocialised was also a reflection of the social world that the Tukes inhabited. The class structure of contemporary York was reproduced in the daily life of the Retreat. Those who could afford it were allowed to have their own rooms and to keep their own servants. The "upper class" patients were also, when in a state of convalescence, allowed to eat their meals at the same table as the superintendent, and with similarly-placed patients of the opposite sex. The "lower class" of patients were also occasionally allowed to eat at this family table, to remind them of the condition to which they should all aspire. Although everything about the Retreat, from the rules of eating to the quality of the wood the beds were made from, confirmed the hierarchy of the social world, this hierarchy was seen to exist only within the deeper authority of the Society of Friends. At the York public lunatic asylum the rich patients received personal and lavish attention from the physician while the poor were ignored. This sort of behaviour was unimaginable at the Retreat, where the patients were both Quakers and inhabitants of a class structure. The class structure was still constantly being reproduced in the Retreat, but only as a mediation of the Quaker religious doctrine.[1]

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[1] For documentation of this aspect of life at the Retreat see Description, pp. 99-103.

All the refinements of polite society were emphasized. The female superintendent occasionally gave a tea-party to which all the patients were invited. "All who attend, dress in their best clothes, and vie with each other in politeness and propriety."[1] Visitors were appointed by the Subscribers' Committee to visit the patients and encourage them in correct ways of thinking. Some idea of the philosophy behind this venture can be seen from the remarks of one particularly zealous visitor, Catherine Cappe. According to Cappe,

> something towards preventing every species of moral depravity [amongst lunatics] might be done, and probably much more than is commonly apprehended, by the introduction of those general habits of order, and that sense of propriety and decency in conversation and behaviour, which the frequent visits of respectable ladies would have a powerful tendency to produce. . .[2]

Not that this was believed to be all that necessary at the Retreat. At that institution, according to the Tukes, the only "moral depravity" likely to be found was that brought there by patients who had been forced to stay in non-Quaker institutions and who had learnt there "ill language", "vicious habits", and "other exceptionable practices".[3]

The "mildness" of the regime at the Retreat was announced, not only in the daily attitudes of the staff, but in the construction of all the physical features which turned it into an asylum. The doors locked, but with a small spring lock instead of the usual noisy bolt. "In pushing the door without noise, it shuts as with a key. This small attention spares the captive a painful humiliation."[4] The iron window frames,

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1 Description, p. 178.

2 Cappe, 1816, p. 375. Cappe did most of her visiting at the York public lunatic asylum. In the essay quoted here Cappe also comments approvingly on what Samuel Tuke had written about building on the patients' desire for esteem (ibid., p. 378).

3 Retreat, State of the Institution, 1797, p. 8

4 Dela Rive, 1798, p. 322, translation from Walk, 1954, p. 816. But see the Description, p. 101 on the continuing use of bolts.

designed to prevent escape, were also covered with wooden sashes in order to give the appearance of being ordinary windows. The better behaved patients were allowed knives and forks to eat with, instead of the usual degrading spoon.[1]

Religious observance, a core feature of Quaker society, was of course present in the therapeutic programme of the Retreat. Like all other aspects of life at the Retreat, the major worth of religion was seen to be the extent to which it banished the anti-social behaviour from the order being established there.

> Many patients attend the religious meetings of the Society, held in the city; and most of them are assembled, on a first day afternoon, at which time the superintendent reads to them several chapters in the Bible. A profound silence generally ensues; during which, as well as at the time of reading, it is very gratifying to observe their orderly conduct, and the degree in which those, who are much disposed to action, restrain their different propensities.[2]

For fervent Quakers like the Tukes, to engage their patients in religious activities was an obvious course to take. As Samuel Tuke pointed out, where "the precepts of our holy religion. . .have been strongly imbued in early life, they become little less than principles of our nature".[3] Religion to the Quakers meant much more than Bible readings; it was the main intellectual resource by which they expressed the rationality of their material life. Of course, according to Quaker belief, this is the inverse of the truth: rationality derives from God and man attempts to develop institutions and laws in which God's will and spirit can be expressed. But from a materialist point of view what is interesting about

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1 That spoons had to be used at all was a matter of concern. See Description, footnote to p. 174.

2 Ibid., p. 161.

3 Ibid., p. 160.

Quaker ideology is the way that long-standing tenets of Christian belief were modified to fit in with the material interests of those who developed the Quaker doctrine.

The particular blend of commodity production and Christianity that appealed to the Quakers can be seen in most of the pronouncements of their leaders. George Fox, founder of the Society, worked as an itinerant preacher affirming the moral need for commerce built on a basis of honesty and trust:

> In fairs, also, and in markets, I was made to declare against their deceitful merchandize, cheating, and cozening; warning all to deal justly, to speak the truth, to let their Yea be Yea, and their Nay be Nay; and to do unto others as they would have others do unto them; forewarning them of the great and terrible day of the Lord, which would come upon them all.[1]

An efficient trading system was one aspect of the new society God was to bless: another was practical knowledge, as William Penn pointed out:

> For their learning be liberal. . .but let it be useful knowledge, such as is consistent with Truth and godliness . . . .I recommend the useful parts of mathematics, such as building houses or ships, measuring, surveying, dialing, navigation. . .[2]

Since the Bible was the reputed source of all this inspiration, it was a common practice to provide textual commentary which demonstrated the Lord's approval of capitalism. Thomas Chalkly, a Quaker merchant and philanthropist, wrote the following rather curious passage in his journal for 1749:

> Our Saviour saith, Labour not for the Meat which perisheth, but for that which endureth for ever, or to eternal Life. By which we do not understand, that Christians must neglect their necessary Occasions, and their outward Trades and Callings; but that their chief Labour, and greatest Concern ought to be for their future Well-being in his glorious Kingdom; else why did our Lord say to his Disciples, Children,

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1 Journal entry in 1648, quoted in Grubb, 1930, p. 20.

2 Letter to his wife on the occasion of leaving England in 1682, quoted in Raistrick, 1950, p. 32.

> have you any meat? They answered, No; and he bid them cast their Nets into the Sea, and they drew to land a Net full of great Fishes; and Fishing being their Trade, no doubt they sold them, for it was not likely they could eat 'em all themselves. . .[1]

No doubt they did, but how Chalkly could equate in his mind "meat . . .which endureth for ever" with fish that had to be sold at a profit because there was too much to eat before it went bad demonstrates an extreme example of a contradiction that always occurs when written doctrine is used to justify change. The requirements of commercial capitalism also found their way into the moral code by which so much social activity was proscribed. Gaming, betting, and lotteries were, of course, forbidden but Friends were allowed to buy stocks on the market if they were "under the idea that they are likely to obtain better security, or more permanent advantages".[2] But if they bought stocks for speculative purposes only, for reasons unconnected with investment, they were considered to be gambling, and thus acting below their moral dignity. Given this interpretation of religious activity, it is therefore not surprising to find Samuel Tuke writing that "Of all the modes by which the patients may be induced to restrain themselves, regular employment is perhaps the most generally efficacious".[3]

c. Work: In terms of Quaker religious teachings, productive and profitable labour was thus one of the central social activities by which man expressed his moral dignity. With hindsight it is perhaps not surprising that it was accorded an important place in the therapeutic programme of

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1 Quoted in Tolles, 1960, pp. 61-2. These quotations are not meant to suggest that the Quakers had a monopoly on such sentiments. They are merely examples of the particular Quaker expression of what was a wide-ranging, if still a minority, attitude.

2 Clarkson, 1807, vol. 1, p. 19

3 Description, p. 156.

the Retreat, but also in terms of contemporary therapeutic practice it was recognised as the greatest innovation that the Tukes made in the treatment of the insane.

Not all of the impetus for this came from the Tukes themselves. One patient's relative wrote to William Tuke of the patient in question that "if he was under strict discipline, I am fully of the mind he be made to earn his Bread".[1] In the same year, 1797, the first Annual Report announced the value of employment in controlling insanity:

> In describing the particular benefits of this Undertaking, it seems proper to mention that of occasionally using the Patients to such employment as may be suitable and proper for them, in order to relieve the langour of idleness and prevent the indulgence of gloomy sensations.[2]

By the following year, Dela Rive was able to write of the provision of employment at the Retreat.

> As soon as the patients are well enough to be employed, they endeavour to make them work. The women knit, sew, make beads, sweep the rooms, and the men do works of straw and twigs and other works of ingenuity according to their different capacity. The superintendent had made an experiment a few days before, which had answered very well. The house is surrounded by some acres of land which belong to it, he had undertaken to make the patients cultivate this land, giving to each a task proportioned to his strength, he found that they were fond of this exercise, and that they were much better, after a day spent in this work, than when they had remained in the house, even when they had the liberty of taking a walk.[3]

Once the value of getting the patients to work was established the practice was never stopped. Samuel Tuke had little to add in 1813 to Dela Rive's description, except that by that time the practice of encouraging employment was no longer experimental. One dominant feature of the type of work that was done was that each patient was allotted a task appropriate to his or her class position. For the educated and upper

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1 George Withy, letter to William Tuke, 9th January 1797 (Ms in RA).

2 Retreat, State of the Institution, 1797, p. 9

3 Dela Rive, 1798, p. 325, translation from Walk, 1954, p. 816.

class patients "regular employment" meant regular exercise of the body through walks in the garden and exercise of the mind through the useful study of "mathematics and natural science".[1] The lower class patients were expected to do the manual labour in the garden, to assist in the domestic chores, and to give help when needed with the refractory patients. There is not a lot in the Description about the value of work at the Retreat, apart from the above statement that Tuke considered it the most important aspect of moral treatment, but what there is suggests that Tuke had an imaginative understanding of how work, if meaningful to the patient, could be used as a means of self-restraint.[2]

It was not at the time unheard of for physical labour to be recommended for lunatics or for hospital patients generally, but it was not an established principle. Abel-Smith, in his history of hospitals, mentions in passing that at Radcliffe Infirmary in Oxford in 1784 patients carried coal to the wards, helped in the laundry, and were "employed on the water engine".[3] William Blizard, writing in 1796, admitted that the use of work in general hospitals was a neglected subject but maintained that

> Some kind of work would often prove salutary in the view of their recovery, and the perfect re-establishment of their health, as well as useful in its effects upon their habits.[4]

Blizard suggested that patients be encouraged to work both in and out of doors. Because he was writing at the time of the Napoleonic wars he

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1 Description, p. 183.

2 See for instance ibid., pp. 153-5 for an example of a gardener who was found to benefit from suitable work but for whom the institution was unable to provide enough appropriate supervision to enable him to be suitably employed.

3 Abel-Smith, 1964, p. 11, note 2.

4 Blizard, 1796, pp. 69-70.

mentioned the usefulness of patients making lint for bandages and thus helping their injured comrades, as well as training the women patients in useful jobs by which they could support their families.

There were also occasional recommendations on the value of work by mad-doctors,[1] although there was also some isolated criticism from the medical profession at the emphasis laid on work tied to social regeneration rather than to the medical needs of the patient. John Haslam, the apothecary at Bethlem, was probably the most outspoken exponent of this point of view. In a monograph entitled Considerations on the Moral Management of Insane Persons, published soon after the Retreat had become famous, Haslam very pointedly wrote,

> The different forms of the disease would necessarily require different modes of occupation. . . .Some skill, and much caution, are also required, to seize the proper time when employment will become beneficial: as I have known many persons relapse, in consequence of having been prematurely, and injudiciously urged to active occupation.[2]

But Haslam, as usual, was behind the times when it came to approving new methods.

A private asylum run by another Quaker comes closest to the Retreat's particular version of "occupational" therapy. This was Brislington House, a private asylum near Bristol opened by Edward Fox in 1806. According to Fox, his treatment was based on "assimilating the regimen of the Insane to the regular ordinary and wholesome occupations of the soundest intellect".[3] What he meant by this can be seen by his installation of a bowling green and a fives court, and by the fact that whenever

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1 For examples of suggestions, see Cullen, 1784, vol. 4, p. 164; Cox, 1804, pp. 52-3; Arnold, 1809, p. 44.

2 Haslam, 1817, p. 72.

3 Fox, [1809] p. 2. Another prospectus for his asylum appears as pp. 71-7 of Duncan, 1809. See also Parry-Jones, 1972, pp. 112-5.

possible he employed his patients. According to an advertising brochure, more than one patient had paid for his cure and residence at Brislington House by the work he had done there. One painter and plasterer was paid £73 in one year, on top of the money he had earned to pay for his keep. The Retreat was thus not unique in its methods, but it is the institution which has dominated the mythological tradition which has been bequeathed to us. Pinel in France, Chiarugi in Italy, Tuke in England, "Universal Liberators of the insane"; these are the images we must confront.[1] Even Pinel, who was fully convinced of the necessity "to carry into decided and habitual execution the natural law of bodily labour"[2] in the treatment of the insane, produced no detailed plans of how to employ his patients. On the basis of the comments he made in his Treatise it seems his recognition of its value was more in the nature of a symbolic attack on the idleness of the aristocracy than a real attempt to work out how the bourgeois virtue of productive labour could be applied to the treatment of the insane.[3]

In concluding this section it may be said that, although work therapy did not originate at the Retreat, it was one of the central tenets

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1 Chiarugi is often mentioned alongside the names of Pinel and Tuke as being an initiator of moral treatment, in his case at Florence as early as 1788-9. From the little secondary material available in English it seems as if his version of moral treatment was as different from Pinel's and Tuke's as theirs was from each other (see Mora, 1975; Grange, 1963). Chiarugi's work is omitted from this present account purely for reasons of language (he wrote in a Florentine dialect) but, as Mora points out, this is the same reason that was partly responsible for his non-recognition in the 1790s.

2 Pinel, 1962, p. 216.

3 Nearly half of his total remarks on the subject concern an (unnamed) Spanish asylum where those who were engaged in agriculture and horticulture were much more likely to be cured than "the Spanish nobless. . . whose pride of birth and family presents unsurmountable obstacles to a degradation [i.e. work] so blessed and salutary" (ibid., p. 218).

of the therapeutic programme there. It was not the most important, but it was received as being an important contribution to the treatment of the insane. The reasons this should have been so have already been raised to some extent in the discussion in Chapter One on workhouses, and they will be examined in more detail below (in Chapter Three, section 3) in the assessment of the place of work in the county asylums. We may turn now to a deeper assessment of the place of work at the Retreat, as an aspect of the overall regime of moral treatment from which it derived its significance.

3. Assessment of Moral Treatment

The first question that ought perhaps to be asked is, "what was different about Pinel's 'traitement moral' and the Tukes' 'moral treatment'"? Both used the word "moral" in its ethical sense of invoking norms and values by which men, and specifically the convalescent insane, were to live. At the same time both Pinel and the Tukes drew on very different bodies of knowledge in order to support their actions as intellectually meaningful. Pinel's model of man had its roots deep in Greek medicine and medieval theology. The belief that God had given man his moral affections to control his body along the lines laid down by God's purpose in the world was turned by Pinel into a secular optimism: that the insane could be helped to overcome their isolating disabilities with the aid of the therapist in manipulating these same moral affections. Tuke, on the contrary, saw little hope for man's salvation in this world; all that man could do was to follow the moral laws established by (the Quaker version of) Christianity. What this effectively meant was a humanistic, if bourgeois, extension of opportunity to all. Everyone was equal, albeit evil, under the omnipotence of God's Reason. The insane were as capable of accepting this discipline as anyone else. Here then were two intellectually different theories. In practice, however, when they were used

to underwrite moral treatment as a meaningful activity they appeared to have similar possibilities.

One point that does need clearing up is the extent to which Pinel or the Tukes could be said to be "influenced" by each other. Pinel started work at Bicêtre in 1793; the Retreat opened in 1796. Dela Rive visited the Retreat in 1798 and wrote of its "traitement moral" there in an article which Pinel had seen by the time he wrote his Traité. This Traité of 1801 was reviewed in the Edinburgh Review in 1803.[1] There is no evidence that the phrase "moral treatment" was used to describe the therapeutic practice of any institution in this country before Samuel Tuke described it as the programme of the Retreat. His earliest announcement in print was in 1811[2] but in this the phrase is used as though it were a commonly-used expression unworthy of note. We do know that while Samuel Tuke was working on his Description he read Pinel's Treatise. On the 7th January 1811 Tuke wrote in his diary that he "made some selections from Pinel". Two days later he recorded that he "wrote on moral treatment of the Retreat".[3] This timing suggests at least that Tuke considered he was working in the same reformative tradition as the "Great Man". In any case, the important factor is that Tuke's reading of Pinel's usage of "moral treatment" was unproblematic precisely because they both used it to invoke similar norms of social behaviour: obeying the superintendent or governor, employment, self-discipline. In this meaning of the word "moral" the superficial resemblances were sufficient to justify the use of the same term.

All the examples of moral management or treatment which have been

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1 Reeve, 1803.

2 See Hunter and Macalpine, 1965.

3 S. Tuke, 1860, vol. 1, p. 156.

given up to now have this invocation of behavioural norms in common. Whatever intellectual resources were drawn upon to justify or provide a theoretical framework in which to conceptualise moral treatment, the practices remained remarkably similar. Two points need to be made about this similarity. Firstly, the patients were treated as individuals suffering from individual complaints. This was a dramatic change from the mad-doctoring (or lay approach to madness) that conceived of insanity as essentially a symbolic expression of man's place in the world. Manipulation of the passions may have been an old established principle, but in the Middle Ages it remained a principle, like the present-day prescription of antibiotics, to be applied according to general conceptions of pathology and not to the individual requirements of the patient. In many ways the understanding of the meaning of madness in the eighteenth century is closely analogous to that of creative literature at this time.[1] Before the mid-eighteenth century novels had heroes, but only as idealised models or symbolisations of good or evil (or other universal principles). Similarly, the madman in that period (when he was not being ignored or merely confined) was often used as a vehicle for expressing a fundamental truth about human nature, or man's place in society.[2] But with the growth of a bourgeois consciousness that broke up the old hierarchies, both in the material world and in the ideological representations of that world, madness and the novel began to take notice of "real" people. The novels

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1 The following account of the changes in the novel draws on the discussion in Hauser, 1962, vol. 3, pp. 61-5.

2 The types and forms of this symbolism are unfortunately ouside the boundaries of this thesis. For examples of the various "uses" to which madness was put in the seventeenth and eighteenth centuries see Jonathan Swift's "Digression on Madness" (in Swift, 1958, pp. 162-80) and the examples given in Lindsay, 1927. Foucault provides a recent commentary on this phenomenon (Foucault, 1971, pp. 65-76). The last institutional display of the madman as symbol--patients who could be visited for purposes of entertainment at Bethlem--was stopped in 1770.

of Fielding and Richardson, for instance, show an obsession with the everyday trivia of their heroes' existence. The old absolutism crumbled before the daily achievements of a class to whom the symbolism of the world resided precisely in what could be achieved in that world.

This leads onto the second point: that although the growth of bourgeois sensibility gave to the madman and hero an attention which was missing before, it was an attention which was closely circumscribed by the material demands of commodity production. The insane were liberated from their chains and immediately captured within the weft of a mysterious and altogether more amorphous fabric, bourgeois freedom.[1] It is in the practices of the Retreat that there can be seen, perhaps more than in any other institution, a synonymity between the ethical injunctions of the middle-class way of life and the practical forms needed to produce that way of life. Moral treatment as teaching of right and wrong, and moral treatment as practical treatment of the mind were established as one practice. This was so obviously necessary to Samuel Tuke that he did not remark on it; to have done so would have been to raise the possibility of alternative moral systems.

It was not until some years later that the medical superintendent of the Retreat commented on this conceptual ambiguity of the word "moral" as it had been established by Samuel Tuke. This was done by John Thurnam, who in 1845 published reviews of the statistics of the Retreat and of the general incidence of insanity throughout the country.[2] Thurnam

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1 There is an interesting parallel here with our recent abolition of the Chimpanzees' Tea Party at London Zoo. This freedom from being imprisoned as a symbol or as entertainment did not result in all chimpanzees being set free or in the closing down of zoos. It merely changed the rationale under which they are confined--and the chimps don't even have the opportunity to "get better".

2 Thurnam, 1845a; 1845b.

acknowledged that although he believed that moral treatment was a branch of practical medicine, in his Statistics of the Retreat he had dealt with moral treatment "more perhaps as a branch of ethics than as one of psychology and practical medicine".[1] This statement was made in the context of a discussion of general non-medical therapies a physician should use with his patients,[2] therapies which "include[d] everything capable of acting either on the intellectual or affective part of our nature".[3] This was definitely moral treatment as a branch of psychology. And yet, as Thurnam himself admitted nine pages later, moral treatment at the Retreat was based on

> calling into activity, as much as practicable, the remaining mental faculties, of cultivating in the patient the moral sense of right and wrong; and as a consequence, the power of self-restraint.[4]

In other words, the ethical and behavioral aspects of moral treatment could not be separated. Moral treatment involved "treating them [the patients] in fine, as much as possible, as responsible beings and as if they were sane".[5]

Thurnam did not attempt to resolve any possible ambiguity between the two meanings of "moral", nor is it likely that he was conscious of their distinction in the way that has been discussed here. The practice of moral treatment at the Retreat was successful[6] precisely because there

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1 Thurnam, 1845a, p. 101.

2 See ibid., pp. 101-12. There was also of course the changed wider intellectual and social context within which Thurnam was writing, a context in which the ethical content of moral treatment was no longer freely admitted. See below, Chapter Four.

3 Thurnam, 1845b, p. 30.

4 Ibid., pp. 38-9.

5 Ibid. Emphasis in the original.

6 This statement refers to its ideological success; that is its recognition

was no disjuction between the moral behaviour required and the social and psychological behaviour required of the patients. Foucault has described the regime there as "a milieu as much as possible like that of the Community of Quakers".[1] What Foucault has not emphasized is that the programme was agreed by all. The "Community of Quakers" with all its religious (moral) and social (behavioural) connotations existed prior to the establishment of individual Quakers as therapists or as patients. It was this unity that gave moral treatment its strength but which at the same time concealed its limitations.

Something of the limitations that were to appear as moral treatment emerged from the specific milieu of the Retreat can be seen in a distinction that a recent philosopher has made between "scientific" and "phenomenological" psychiatry.[2] The former invokes a "causal viewing of phenomena" which presupposes the very "what it is that's wrong" that it is the purpose of enquiry to find out. A nice example of this "scientific" approach is provided by a historian of mental disorder, Basil Clarke. According to Clarke,

> Having an awareness of the patterns and ranges of behaviour among one's fellows, and what changes them, is of the same order as the impulse which causes people to learn and sort out the local flora and its uses, and the local fauna and the physical environment in similar terms. The classificatory logics used for all these may sometimes be rough and home-made out of hints from other experience within the same society--such as the legends or myths or social customs and relationships--and in some cases perhaps they suffer also from the effort to explain them comprehensibly to exotic anthropologists; but in the long run and at their best they represent the dispassionate comprehensions of a cool collective eye. Sciences, and medical expertise in particular,

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as a success by all the relevant parties. Nothing is implied about the ability of moral treatment to "cure" insanity.

1 Foucault, 1971, p. 243

2 Natanson, 1969.

> can not unreasonably be seen as elaborated from this primary exploratory impulse.[1]

Science, according to this schema, is an objective measuring of the world. The tools are devised by the observers in accordance with the existing characteristics of the objects to be measured. The success of scientific techniques is taken as the justification for their use. But, like the logic of the inhabitants of the Country of the Blind, this method is grossly inadequate when it comes to measuring human potential.

It is here, according to Natanson, that "the real challenge is to locate the individual in the texture of his immediately given reality as he lives it."[2] Natanson (following Husserl) calls this "immediately given reality" the patient's "lebenswelt" (life-world). It is a term with a particular significance in phenomenological philosophy but it is also appropriate in the present context because it helps to clarify the distinction between the therapeutics that moral treatment was (at least sometimes) in the Retreat and what it became when the same injunctions were applied outside. What Natanson emphasizes is the need of the therapist to appreciate his patient's "Lebenswelt":

> Without such structural <u>seeing</u> of the individual's Lebenswelt therapeutics becomes a mode of rhetoric, an instrument of persuasion. And persuasion if it fails gives way to violence. When therapeutic violence fails, the right of the patient to his morbidity is acknowledged: nothing further can be done "for" him because nothing more can be done "to" him. Acknowledged failure then assures the accommodation of the patient in a special stratum of the social order. Lost to the Lebenswelt, he nevertheless secures a special status within it.[3]

This progression from a "structural seeing", through "persuasion", and at last to "acknowledged failure" was to be the fate of moral treatment.

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1 B. Clarke, 1975, pp. 303-4.

2 Natanson, 1969, p. 106.

3 <u>Ibid.</u>, p. 107.

It was a fate that was not given by anything intrinsic in moral treatment itself; what was given were the social and political interests within which all treatment of the insane had to accommodate itself. The Retreat provided comfortable confirmation to its administrators that not only was human nature constituted as the Quaker religion maintained; it also appeared to demonstrate that their bourgeois values could be instilled into very unpromising human material.

It is of course debatable just how much "structural seeing" of the patients there was, even in the Retreat. Certainly in terms of the highly verbalised and psychoanalytic practice of therapy that Natanson is committed to, the term is hardly appropriate at all. And yet Thurnam's assertion that moral treatment consisted of "treating them [the patients] in fine, as much as possible, as responsible beings and as if they were sane" implies at least a commitment to understanding the normative qualities of the patients' lives. What it does not imply, any more than does Natanson's use of the term, is an appreciation of the structural forces within which all individual therapy is given meaning. The scientific approach emphasizes the objective understanding of the world independent of the subjective characteristics of its objects; the phenomenological approach emphasizes the "lived experience" of each individual object. What is needed is a research methodology which makes clear the unity of the two but which does not diminish the full importance of either aspect.

To repeat the quotation that was used as a synonym for praxis in the Introduction,

> Men make their own history but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past.[1]

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[1] Marx, 18th Brumaire of Louis Bonaparte, in Marx and Engels, 1958, vol. 1, p. 247.

Only by appreciating these circumstances in any particular case is it possible to fully understand the activities being investigated, either from the subjective or from the objective point of view. The passage just quoted continues:

> The tradition of all the dead generations weighs like a nightmare on the brain of the living. And just when they seem engaged in revolutionising themselves and things, in creating something that has never yet existed, precisely in such periods of revolutionary crisis they anxiously conjure up the spirits of the past to their service. . .

This passage is particularly applicable to the Tukes, existing as they did in a contradictory position within the class struggle. Eighteenth-century Quaker beliefs were an expression, on the ideological plane, of the material interests of a class which was trying to achieve a gradual infiltration into the ranks of the ruling class. The absence of a radical break between the landed aristocracy and the commercial bourgeoisie has already been noted. The primary aim for many of those who made their wealth out of trade or manufacturing was to assimilate themselves into the ranks of a ruling class based on privilege and not achievement. They expressed this material contradiction in their ideology by developing a religion that emphasized both man's worthlessness in the face of an absolute God as well as the need for practical, utilitarian knowledge by which man could mould his future. This religion was both conservative and radical, but it fitted exactly the material position of the eighteenth-century trader, especially in a small town like York, where the civic authority of the Merchant Adventurers remained strong without adapting itself to the changed commercial requirements of the eighteenth century.[1]

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[1] William Tuke had direct experience of the authority of the York Company of Merchant Adventurers. When a young man, he was apprenticed to his aunt, Mary Tuke, who had opened a tea wholesalers' in York. To trade in York at this time it was necessary to be a Freeman of the City, and a member

The Tukes' use of moral treatment at the Retreat was thus a creative expression of their own praxis, a visible representation of the values that gave their lives meaning. When moral treatment was applied only to those already committed to these values, it could be seen as a genuine recognition of "what is", or at least an attempt to reproduce that "what is" amongst a few who (for reasons outside their control) were temporarily not normal. As such, it involved both a phenomenological "seeing" and a scientific recognition of the material elements of which their praxis was constituted.

At the same time it must be noted that this interpretation of moral treatment as an expression of praxis is not the only one that can be made. Moral treatment involved a forceful intervention into peoples' lives. It was soon to be taken up as providing the practical basis for a major change in the mode of treating all the insane. This dual function of moral treatment can be clarified by reference to a typology which was devised to account for the popularity of the Campaign for Nuclear Disarmament movement of the 1960s.[1] This typology involves describing political activity in terms of its expressive and instrumental functions.

Expressive activity is that in which an individual directs his attention, not primarily towards the achievement of practical changes, but

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of the Company. Mary Tuke was a Freeman by virtue of her father being one, but she was not a member of the Company and was refused membership because she was neither the daughter nor the widow of a member. She traded in spite of this and was subjected to numerous fines (which she refused to pay) and indictments (which she ignored). After seven years' harassment she agreed to pay a moderate fine and was subsequently left alone (see Mennell, 1926).

[1] Parkin, 1968, pp. 33-55. He bases the typology on a distinction made by Max Weber between an "ethic of ultimate ends" and an "ethic of responsibility" in his (Weber's) essay "Politics as a Vocation" (in Gerth and Mills, 1970, chap. 4, especially pp. 120ff.).

towards those

> which reflect his cherished beliefs and his self-image. The reward to the person in these instances is not so much a matter of gaining social recognition or monetary rewards as of establishing his self-identity and confirming his notion of the sort of person he sees himself to be. . . .Just as we find satisfaction in the exercise of our talents and abilities, so we find reward in the expression of any attributes associated with our egos.[1]

Expressive political activity emphasizes the principles underlying a particular stance, whilst instrumental activity is that directed towards the achievement of narrowly practical ends. Whereas instrumental activity frequently falls short of its stated aims, expressive activity can never be said to have failed "because political activity in support of the values it upholds can be claimed to be beneficial in and of itself".[2] As Parkin has pointed out, most political activity involves both instrumental and expressive motivations, but the analysis remains a useful one, certainly from the point of view of making sense of the Campaign for Nuclear Disarmament, but also of the phenomenon being examined here.

Its use lies, however, not in the fact that such motivations exist, but in the underlying reasons that may be given as to why individuals should be moved by such motivations. Again Parkin's analysis is a useful one. He argues that whereas instrumental political activity against the status quo is what we would expect from working-class political movements (that is, they want to change the basic social structure of society), for middle-class deviant groups there are strong material reasons for them to take up more "expressive" activities. Parkin points out that

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1 D. Katz, "The functional approach to the study of attitudes", 1960, quoted in Parkin, 1968, p. 34.

2 Ibid., p. 39. Parkin provides an interesting quotation of Richard Crossman's in which he stated his belief that the role of the Labour Party was not to attain power at any cost, but that it must express fundamental principles; and if that meant being in opposition for a time, so be it (ibid., p. 35).

although large numbers of middle-class intellectuals, students, and professionals are profoundly dissatisfied with the norms and values of contemporary capitalism, they have a considerable vested interest in not upsetting the status quo too much. Most of these middle-class groups enjoy greater material security than the majority of the working class as well as the more obvious better economic rewards. Given this ambiguous position of many middle-class individuals within the class structure--where their self-identity conflicts with their material interests--there is a strong attraction for them in taking part in radical political movements of a predominantly expressive kind.

> By directing the main focus of grievance on to issues of a moral nature, movements based on the middle class are in a sense able to avoid any direct challenge to the legitimacy of the existing social structure. . . .Such problems can generally be treated as isolated and distinct matters, each of which requires a separate solution, rather than as offshoots of one basic problem whose solution requires fundamental social change. Campaigns against hanging, colour discrimination, the Bomb, and so forth, put forward distinct and limited demands, each of which can be met without thoroughgoing re-adjustments in property or class relationships; they could in fact be aspects of any society, and not necessarily a capitalist one, and are treated as such.[1]

A further point is that, whereas activity in the mainstream of political life is likely to contain large elements of both instrumental and expressive influence, it is on the margins of society, in the groups who do not fit easily into the class structure, that the clearer "types" emerge. Although the main focus of his book is on political movements, Parkin extends his analysis to fringe religious sects. He suggests that the popularity of fundamentalist sects like Jehovah's Witnesses and Primitive Methodism amongst lower-status groups in society is that they call for revolutionary changes, changes which would improve the material

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[1] Parkin, 1968, p. 54 (emphasis in the original). Parkin does provide ample evidence, on the basis of questionnaires administered to CND supporters, that this is a valid interpretation of "middle class radicalism" (the title of his book).

condition of these groups. On the other hand, religious sects such as the Moral Rearmament Crusade and the Quakers, which appeal most strongly to dissatisfied sections of the middle class, emphasize the expression of moral values through individual contemplation and personal adjustment.[1] The total picture is of course a complex one and this sketch does not do justice to the range of reasons that may be given as to why particular beliefs should be held by particular individuals. What it does do, however, is to clarify the practical significance of moral treatment. The treatment of the insane provided a vehicle for the Tukes, as members of a middle-class religious sect, to express their high moral position vis-à-vis the rest of society, but without attacking any of the fundamental problems of that society. The Quakers in the late eighteenth century had lost their earlier aggressiveness towards authority and were at that time predominantly a quietist sect.[2] The Tuke family especially believed in strict conformity to traditional values. Samuel Tuke described his father Henry as "a zealous Tory",[3] a man whose political judgement could be seen to agree entirely with Pope's opinion that "whatever is, is right".[4]

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1 Parkin, 1968, p. 55.

2 Isichei, 1970, pp. 190-200.

3 S. Tuke, 1860, vol. 1, p. 96.

4 Samuel quoted the following letter from his father, written in 1807: "Bad men will mix with and disgrace every party; but I do not think that this is sufficient ground to set any administration aside, and when I know that one is preferred by the King to another, and treats him with more propriety and respect, that alone I acknowledge would give a considerable bias to my mind in their favour, and I think it is a principle of action which is supportable by all those considerations which should regulate the actions of men" (ibid., pp. 96-7). It is perhaps also significant that Henry Tuke was never involved with the Retreat but spent all his time in the family business.

Against this context, Samuel's commitment to moral treatment can be seen as one of "middle class radicalism", an expression of moral superiority in an imperfect society. It must also be seen, however, as an instrumental attempt to implement change in that society. This latter emphasis can be seen in Samuel's approach to moral treatment generally,[1] and in his limited forays into the world of politics. In 1807 Samuel upset his father and grandfather by giving £50 of the family company's money towards the election expenses of William Wilberforce. Such direct action offended his father's quietist philosophy, as well as the fact that Wilberforce was opposing Henry Tuke's choice of candidate.[2] In 1833 the Parliamentary seat for York again became vacant and this time Samuel himself was proposed for the position of Liberal condidate, by a petition signed by nearly 300 people. He refused the candidature but he did support the man chosen in his stead, Thomas Dundas. A speech Samuel gave in support of Dundas is interesting for its clear portrayal of the "expressive" motivations underlying Tuke's thinking:

> It [the "moral principle"] is the foundation on which all that is excellent, all that is glorious in private or public character, is built. . . .Rise Freemen to the moral dignity of your character. . .though it is abundantly easier to shrug our shoulders in despair than to put them to the wheel--yet let us not be of those who less steadily pursue the course of moral truth, the course of reason and intelligence; and then brother Freemen, though it seem an arduous

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1 This can be seen especially in his discussion of the place of work at the Retreat, as well as in the following comment on singing: "In the early part of the experiment some of the patients wished to have singing introduced at the close of the reading, to which I readily acceded. One of them brought me the book, and pointed out the hymn they had chosen, which I read and they sang. I was doubtful whether the exercise left so good an impression as a psalm of David read impressively. I did not, however, in the least discountenance the practice; but they have gradually given it up" (diary entry for 3rd March 1819, quoted in Tylor, 1900, p. 67).

2 On this see W.K. and E.M. Sessions, 1971, pp. 79-80.

task, you will succeed.[1]

But while this speech is a clear example of the expressive orientation to political activity, the very fact that Tuke gave it at all, in favour of a particular candidate, is an indication of the instrumental elements in his political and social convictions.

It is especially in the activities which were likely to affect the fortunes of the working-class members of society that Tuke's instrumental orientation emerges most clearly. At the Retreat, an essentially middle-class institution, work retained a primarily expressive function. But at the county asylums, as will be seen in the next chapter, the same practice lost its moral aura and was presented as a straightforward method for producing work and reproducing workers.

This division of the inspiration for moral treatment into instrumental and expressive elements is one method of expressing its significance without denying either its progressive or its reactionary aspects.[2] Another method, complementary to the above, is the Gramscian one used in Chapter One to locate physicians within the class structure.[3] It was argued there that physicians occupied an ambiguous place in the class struggle of the late eighteenth century and that sometimes they ought to be seen as "traditional intellectuals" and sometimes as "organic intell-

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1 Speech given 9th November, 1833, quoted in Tylor, 1900, pp. 111-2.

2 It is interesting that a similar use of Parkin's expressive/instrumental typology has been made use of to analyse the work of the eugenist Francis Galton. MacKenzie (1976) discusses the explanation of another writer that Galton's motivation to develop eugenics was essentially an expressive one. Not so, argues MacKenzie, who suggests that while it is possible to see some expressive force in Galton's work--i.e. that "Galton was interpreting generally and naturalistically a salient facet of his own social experience" (p. 509)--a more important feature of Galton's work was "the advancement of the interests of the professional middle class. The middle-class 'expert', rather than the priest, aristocrat or plutocrat, should exercise power in an efficient modernised eugenic society" (ibid.).

3 See above, pp. 88-90.

ectuals". A similar case could be made for Samuel Tuke (and a number of other moral therapists). In moral treatment as "expressive" activity it was still in an embryo stage, the rhetoric of an essentially traditional intellectual that all was not well with his society but that he had no wish to do more than express his moral discontent with the order of things. Moral treatment as "instrumental" activity, on the other hand, is a proclamation of an organic intellectual of the new middle class, a commitment to a practical creation of a new society. The work of Samuel Tuke, like that of ambitious physicians such as Currie and Ferriar, is an example of the change in the ruling class at the end of the eighteenth century, and of the need by groups marginal to the ruling class to align themselves to it.

Another feature of the meaning of moral treatment is the way in which it concealed its own identity. The Tukes developed a coherent social practice which Samuel Tuke called "moral treatment". But in the same moment that this concept was created and given meaning in specifically human terms, the Tukes explicitly concealed from themselves the rationalist basis of their own creative work. As already discussed, moral treatment was not only a socially constructed therapeutic of the mind; it was believed to derive its validity and importance from its invocation of a specific moral code. But moral theories do not drop from the sky; they are created out of specific struggles by individual people in order to defend their material interests on an ideological plane. One of the distinctive characteristics of bourgeois thought is the way it conceals its commitment to a particular class and expresses its partial interest as a total interest. This is why morality is not revealed as the expression of material interests that it in fact is: that is, as the normative "substance" that maintains the social relations

of production; but is presented as injunctions which are supposedly based on natural or supernatural knowledge. As Engels has put it,

> All moral theories have been hitherto the product, in the last analysis, of the economic conditions of society obtaining at the time. And as society has hitherto moved in class antagonisms, morality has always been class morality; it has either justified the domination and interest of the ruling class, or, ever since the oppressed class became powerful enough, it has represented the indignation against this domination and the future instincts of the oppressed.[1]

Only in Marxism, the confrontation by man of the possibility of making his own history, can morality be revealed for what it is.[2]

This does not in itself explain why morality was being announced so aggressively in the 1790s. As will be seen, the "moral" part of moral treatment was soon dropped as unnecessary: what else could non-medical treatment of insanity be except moral--that is, the inculcation of correct behaviour? We only call morality to our aid when we want to change society (or resist change to it). But as one commentator has pointed out, the "moral challenge to transform society only sounds when the practical means of its realisation are at hand".[3] For some of the groups connected with the treatment of the insane, the time was right in the late eighteenth century and morality provided the right kind of

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1 Engels, Herr Eugen Duhring's Revolution in Science, quoted in Ash, 1977, p. 59.

2 That is, morality does not disappear with socialism but is recognised as the ideology that it is. In Lenin's words, "we repudiate ethics and morality in the sense that it is preached by the bourgeoisie, who derived ethics from God's commandments. We of course, say that we do not believe in God, and that we know perfectly well that the clergy, the landlords and the bourgeoisie spoke in the name of God in pursuit of their own interests as exploiters. . . .We say that our morality is entirely subordinated to the interests of the class struggle of the proletariat. Our morality is derived from the interests of the class struggle of the proletariat" ("The Tasks of the Youth Leagues", 1920, in Lenin, 1947, vol. 2, p. 667.

3 Ash, 1964, p. 83.

ideological cover by which they could justify their change of practice.

The enthusiasm which groups like the Quakers had for morality can be seen in terms of the particular status of their social class at that time. On the one hand, they were members of a class which wanted to establish its moral right to rule. In terms of a debate with representatives of the older ruling class, it had to establish in areas like that of the treatment of the insane that its approach was better than what had existed before. Since it was very difficult to do this in terms of numbers of cures or other quantitative measures, the obvious criterion to turn to was the qualitative one of moral superiority. There is much more to it than this of course--for one thing, the insane only became a problem as the relations of production changed. But, from the point of view of the form of cultural production known as morality, the rising bourgeois class had to establish its credentials and its credibility.

This was made much easier by the fact that in many respects aristocratic and bourgeois interests coincided. Insofar as both classes wanted a stable society with the mass of the population working quietly and not expecting more than the basic means of subsistence, they could unite in their production of moral rhetoric. And this is precisely what they did. To put it in terms of the intellectual concepts that have appeared frequently in these pages, the Tukes lived in a world governed by God's Reason. So did the High Tories of the Anglican Church; but so, it began to appear, did the atheistic rabble who had overturned all that was believed to be correct and natural in French society.

On the one side was the imagery that equated social order with moral order, and that the Tukes themselves used a variant of:

> Society requires not only that the passions of individuals should be subjected but that even in the mass and body, as

> well as in the individuals, the inclinations of men should frequently be thwarted, their will controlled, and their passions brought into subjection.[1]

But Burke did not appeal to God so much for his beliefs as to that other great legitimator, Nature. "Why do I feel so differently from. . . [defenders of the French Revolution]? For this plain reason--because it is natural that I should."[2]

On the other side were those who despised everything that Burke stood for and who saw the Revolution as an inspiration for change in Britain. One of these was John Thelwall, "the outstanding leader of the Jacobins",[3] who invoked the same "nature" to oppose Burke's mysticism:

> State hypocrites preach about hostile interests, patriotism and natural enmity! Natural enmity! Are not all men brothers by the law of Nature that submits them all to the same physical conditions and the same moral impulses?[4]

Nature, Reason: all the old certainties were now being taken up by the ideologists of reform and revolution, men like Paine and Godwin who wanted these universal concepts to act as the basis for change, not order.

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1 Burke, 1910, p. 57 (first published 1790).

2 Ibid., p. 77 (emphasis in the original). Not that Burke was above quoting the Bible himself to make his points. At one stage he quoted Ecclesiastes to show that "The occupation of a hair-dresser, or of a tallow-chandler, cannot be a matter of honour to any person--to say nothing of a number of other more servile employments" (ibid., p. 47).

3 Thompson, 1968, p. 173.

4 Thelwall, Spies and Informers, 1795, quoted in Cestre, 1906, p. 55. The real importance of Thelwall's rhetoric was of course not its theoretical argument but the practical implications of its message. No member of the ruling class could ignore such inflammatory language as the following appeal to the working class, especially when it was published as part of a polemic against Burke himself: "Rouse then, once more, to the investigation of your rights: for, if ye will be ignorant, ye must be slaves. . . .Compare what ye are with what ye have a right to be. Compare your powers and your faculties with your condition: the bounty of nature with your scanty enjoyments, and unsatisfied wants; the wealth resulting from your productive labour, and the abject wretchedness of your general state. Compare these things, and consider well the causes" (Thelwall, 1796, pp. 90-1).

If Nature was temporarily redundant as a means of ideological control, what was needed was something more potent, something that would unite all in the interests of the few. That force, as we now know, was that other perennial ideology, religion, this time in its guise of evangelical Christianity.[1] The Tukes were not evangelicals, but their ideas and those of other enthusiasts of moral treatment were, as will be seen, very similar.

One of the basic tenets of evangelicalism was that man was fundamentally evil.

> . . .man is an apostate creature, fallen from his high original, degraded in his nature, and depraved in his faculties; indisposed to good, and disposed to evil; prone to vice, it is natural and easy to him; disinclined to virtue, it is difficult and laborious; that he is tainted with sin, not slightly and superficially, but radically and to the very core.[2]

This is our natural lot, according to William Wilberforce, "the greatest name among the Evangelicals".[3] Evil existed for reasons that only God could be entirely sure of; but no matter, its necessity was now assured. If there had been no evil

> there would have been no room for the exercise of faith and patience, no conquest to have been obtained over passion, and consequently no virtue.[4]

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1 On this point see Kiernan, 1952, pp. 45-8.

2 Wilberforce, 1834, p. 21 (first published 1797). Note the similarity with Samuel Tuke's beliefs: "My principle is this: That moral evil in man, individually, is the root of the chief social evils which exist in the world or in nations. . .man is by nature prone to indulge himself in things which are not good. . .he lusteth to evil" (letter from Tuke to his son, 30th November 1848, quoted in Tylor, 1900, p. 199).

3 According to Henriques, 1961, p. 217. Other extended discussions of the evangelicals occur in C.I. Foster, 1960 and Howse, 1952.

4 W. Allen, 1811, p. 1. This homily appeared on the opening page of a new journal, The Philanthropist, to which Samuel Tuke was himself to become a contributor.

So in religious terms this doctrine meant that before the omnipotent God man could only cringe in his fear and impotence, and in social terms it meant that rational social change was impossible because man's intrinsically immoral nature would continue to thwart his rational hopes. But what man, or at least the self-appointed defenders of public morals, could do was to make the social order work efficiently in the face of threats from across the Channel and from the restless masses in the cities.

"Moral imperialism"[1] did not of course originate with this period but it did experience a frenetic renaissance. From the point of view of the treatment of the insane, its value was that it provided another basis on which to locate moral treatment. Moral treatment in the Retreat was based on the praxis of a class which considered that it had a right to rule, at least in terms of its receiving the benefits of its economic domination of large sections of British society. This was a praxis which asserted its authority against the moral decadence of the older ruling class, but it was also a praxis which had to establish a relationship with the other emerging class of that time. It was this other class, previously known only as the "poor" of the rural villages, which appeared to be taking on a new and frightening identity as it filled the manufacturing towns. And the principles of moral restraint, given intellectual respectability by the evangelicals, and practical illustration by reformers like the Tukes,[2] appeared to provide just the right medium of control.

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1 The phrase is from Perkin, 1972, p. 282. Unfortunately Perkin does not delve very deeply into the nature of this phenomenon. For a recent commentary similar to that developed here but from within the context of the sociology of deviance, see Scull, 1974, pp. 97ff.

2 It was not only the poor and insane who were to be restrained. In contrast to the optimistic rationalism of belief in the "Noble Savage",

Why was all this necessary? One answer that has been given is that there was no direct relationship between the ruling class reaction to the French Revolution and the philanthropic enterprises.[1] The evangelicals themselves were under no such illusion. As God had established order in the moral world, so it was the duty of the natural rulers here on earth to maintain order in the social world. Wilberforce and the other members of the Clapham Sect who made up the core of the evangelicals were aristocrats, "the praying section of the Tory party", as one of their number put it.[2] Their concept of moral right is almost too transparently a reflection of the social right they were trying to defend during the social instabilities of the years of the Napoleonic wars. "For to the present the poor must be taught their duties by Combination laws, and the rich must be taught their responsibilities by the Bible" wrote Wilberforce in 1797.[3] But as we have seen from Thomas Chalkly and his spare fishes, this was a Bible that could teach anything. That it should teach such things as the edicts of the Proclamation Society can only be seen as a function of the interests of those who ran such organizations.[4]

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statements began to appear like "The social state is a state of restraint, and its duties cannot be well performed by those who, from habit or restraint, have not imposed on their passions and inclinations the restraints rendered necessary for the welfare of the whole. The inhabitants of the islands of the Pacific Ocean were genuine portraits of man in his unrestrained state" (Sir R. Phillips, 1813, p. 380).

1 D. Owen, 1965, pp. 97ff.

2 Maldwin Edwards, quoted in C.I. Foster, 1960, p. 32.

3 Quoted in J.L. and B. Hammond, 1917, p. 246.

4 This society, whose full title was the "Society for Giving Effect to His Majesty's Proclamation against Vice and Immorality", was founded by Wilberforce in 1787. Its most famous activity, "a piece of pious cruelty for which there can be no defence"--and this from an apologist for Wilberforce (Howse, 1952, p. 119)--was the persecution and enforcement into a state

It could be argued that writers like Wilberforce or Hannah More are extreme examples of what, at least as far as the insane are concerned, was generally a far more benign attitude towards the "lower orders" of society. But if the harshness, the moral imperialism that is always present in Wilberforce's rhetoric, does not appear in that of his friend Samuel Tuke, we must not assume that Tuke did not agree with it. It is rather that the Quakers at the Retreat did not need talking down to quite so brusquely: they were, after all, already members of the same moral community. But once we shut the Retreat gates behind us and look outwards to the public asylums, all the suggestions about "self-restraint" and "modes of coercion" appear to take on very different and much harsher implications. Once outside the Retreat gates all the constituent elements of what was an expression of the Tukes' living praxis appear as so many fragments. A practice devised for the respectable bourgeois followers of a small religious sect was to be adopted as the basis for the treatment of the insane who were neither respectable, middle class, nor Quaker. The practice of the Retreat was to be recognised as incorporating a number of general therapeutic principles capable of infinite modification. But in terms of the Tukes' own praxis they had become what can only be described as petrified fragments of practice and knowledge. Moral treatment had been established; it was a social fact. It is true that the subsequent history of moral treatment owes much to the Tukes' work in the Retreat and in the nascent asylum movement. But it is a truth, like all such, that depends on the recognition of those who have received it. In the case of moral treatment this was an acceptance by the other reformers that the Tukes' work was a suitable basis on

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of destitution of Thomas Williams, a publisher of Paine's Age of Reason. On this see also J.L. and B. Hammond, 1917, pp. 242-3.

which to build. The petrification of the fragments of moral treatment that was to take place outside of the Retreat gates must not be seen as a degeneration of the principles that were established within them. The praxis recognised at the Retreat was intended to establish a final hegemony over certain forms of deviance. It was precisely this that made moral treatment appear so attractive to other reformers.

PART TWO

PETRIFICATION

CHAPTER THREE

The Emergence of Moral Treatment:
A survey of the practice of moral treatment as it developed outside of the Retreat.

> The savage, the rustic, the mechanical drudge, and the infant whose faculties have not had time to unfold themselves. . .may, for the most part, be regarded as machines, regulated principally by physical agents. But man, matured, civilized, and by due culture raised to his proper level in the scale of being, partakes more of a moral than of an animal character, and is in consequence to be worked upon by remedies that apply themselves to his imagination, his passions, or his judgement, still more than by those that are directed immediately to the parts and functions of his material organization. Pharmacy is but a small part of physic; medical cannot be separated from moral science without reciprocal and essential mutilation.
>
> --J. Reid (a London physician), 1816

> We treat mankind as constituted of habits, and our principle is to eradicate those which are bad, and to implant others that are better.
>
> --J.T. Becher (founder of Nottingham County Lunatic Asylum), 1811

In 1813, with the publication of the Description of the Retreat, moral treatment was made easily available to the world, or at least to that section of it concerned with the treatment of the insane. It was released from the praxis which had given it its meaning, to be used according to the intentions of other men and according to the religious and medical conceptions of normality through which these other men attempted to understand their world. The immediate course it took has been well documented and there is little that can be added here to our knowledge of the external features of the recognition of moral treatment. The Description was published almost simultaneously with the discovery of cruelty and neglect at York Lunatic Asylum and at Bethlem,[1] disclosures that were to lead to the Select Committee enquiries of 1815 and 1816--- probably the most exhaustive investigation into the state of the insane ever made in this country. Whatever the effect of these enquiries, their immediate result was to make public the immense variety of conditions under which the insane were held. Alongside the graphic horror stories they demonstrated the existence of private madhouses and asylums where conditions were every bit as humane as at the Retreat, and without the Quaker zealousness for discipline. What they demonstrated, in fact, was the existence of the insane in a free market, in a series of institutions still governed by financial profit and not by ideological concerns of reform. Those who could afford to pay for the best got the best, and those who were boarded out at minimum cost by their parishes got minimum care. There were exceptions to this rule, such as Manchester Lunatic Asylum and the Retreat, but institutions like these were not a real

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[1] On this see for instance K. Jones, 1972, pp. 64-78; and Hunter and Macalpine, Introduction to Description, pp. 6-19.

alternative for the majority of the insane.

Before proceeding any further it is necessary for a moment to shift the focus away from the immediate problems of the insane to the social world in which they existed as an increasingly visible group. The quarter century following 1790 was arguably one of the most traumatic in the history of this country. A number of events and processes were taking place at that time which produced a qualitative and irreversible change in the nature of life here. One of these events, the French Revolution, has already been commented upon. The overturning of established order just across the Channel had the effect of causing many to reassess their ideological position towards the status quo. Few would have gone so far as to agree with Joseph Priestley that

> Now is the time to speak out without any fear, both on Civil and religious subjects, while the advocates for tyranny are overawed.[1]

In fact, it was precisely because Priestley and others were announcing such subversive opinions that so many of the traditional ruling class felt the need to state the exact opposite and further, to do something about it. For all, the effect of the French Revolution was to ensure that things would never be the same again.

By the time the Description was published the French Revolution was a distant event. There was no longer a real threat of widespread insurrection here. And yet the England of 1815 was more unsettled than that of a quarter century before. There were two major causes of this, not unconnected; and certainly between them they created a volatile situation. One was the war with France, the other the rapid growth of industrial capitalism. There is no space here to review all the effects

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1 Letter to Dr Lindsey, quoted in Simon, 1960, p. 64.

of these events, nor is there any need. As far as the treatment of the insane is concerned two points only need be stressed. These are the changes in the numbers of the insane and the social status of those recognised as such. The two factors are closely tied together because if any one thing typified the content of social thought at that time it was the concern with an increase in the numbers of the poor. The provision of specific types of accommodation for the insane in the 1810s must be seen in the context of the overwhelming increase in the number of dependents on poor relief. By 1803 there were supposed to be over a million people, or one in nine of the population, in receipt of relief.[1] And this was at a time when England was in a war economy and in a healthy trading position on the world markets. After the war ended in 1815 the massive capital expenditure by the government fell dramatically (from £106 millions in 1815 to £53 millions in 1818). Overseas markets dried up as they developed their own plant and resources. Exports dropped by £7 millions. All this had the effect of putting large numbers out of work. In Shropshire, for instance, 24 out of the 34 blast furnaces stopped working and 7000 workers were made redundant.[2]

Another effect of the ending of the war was the flooding of the labour market with discharged soldiers and sailors. By 1817, 300,000 had been discharged since the peace was signed. Many of these ex-servicemen found their way into the asylums and madhouses; indeed, one of the Hoxton madhouses made a speciality of confining naval lunatics.[3] As

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1 Perkin, 1972, p. 22.

2 J.L. and B. Hammond, 1917, pp. 104-5.

3 Hoxton House in east London, owned by Sir Jonathon Miles, was authorised by the Admiralty to confine members of the Royal Navy who had become insane. During the war the numbers kept there increased from two officers

Scull has pointed out, the number of identified insane rose from 2248 at the time of the 1807 Select Committee Report to 6000 in 1819. Even when the rise in population is taken into account, this still represents an increase from 2.26 to 5.40 per 10,000.[1] Alarmist statements began to appear in the press, such as John Reid's well-known "Madness strides like a Colussus in the country".[2] The reality was less vivid, but there was some increase, however it is measured. One indicator is the number of licensed madhouses, which increased from 45 in 1807 to 72 in 1815.

It is impossible to assess the relative importance of the various reasons for this growth.[3] The war was obviously one, the state of the economy another. Another was undoubtedly the increasing percentage of the population which lived in urban as opposed to rural areas. The mental abnormalities which could be supported or concealed in the rural community became disabling when the person concerned was confronted with the exacting discipline of factory production.[4] All of these factors are well known.

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and 16 seamen in 1792 to 17 officers and 133 seamen in 1814. Five years later the population of Hoxton House was 348, although this does include an undisclosed number of non-servicemen (1815 SC Report, Appendix 2; Parliamentary Returns, 1819a).

1 Scull, 1974, p. 566.

2 J. Reid, 1808, p. 166. For other, more considered, opinions, see Parry-Jones, 1972, pp. 11-13.

3 It will be noted that nothing is said here of the possible organic, psychological, or sociogenic causes of insanity. These are questions of interest to social scientists but are not the focus of enquiry here. Insanity is accepted in this thesis as a social phenomenon. How it "got there" is seen as important only to the extent that it can be answered within the question, "what was done with it?" This might narrow the range of enquiry but it requires the researcher to maintain a consistently sociological approach and not to reduce the argument to another level (psychological, biological, etc.) when it suits him.

4 Most of the statistics of lunacy at this time do not make the distinction between the mentally ill and the mentally subnormal. The latter would have been particularly vulnerable to "breaking down" or becoming visible once they moved out of their familiar village environment.

To us there is no doubt that they are social factors existing independently of the intentions of the individual members of the growing working class. But for those who saw it as their responsibility to get rid of unemployment, the problem appeared not so much a social as a moral one which could be solved by the moral control of individuals.

This was a time of great insecurity for those who had traditionally assumed the mantle of the ruling class. Here was society in a state of unprecedented turmoil: how best could they ensure that its traditional order would be maintained? A whole spectrum of solutions were put forward for "policing the poor", to quote a contemporary phrase. It is possible to point to a number of representatives of the rural land-owning class as well as to ideologists of the manufacturing towns who made attempts to deal with this problem. Educational and Poor Law historians have long made use of this spectrum of ideas to locate the policies that were put forward in their various fields.[1] In the field of the history of the treatment of the insane this social context has hardly been touched on by other writers, so it will be necessary here to establish at least the main parameters of the debate. If moral treatment is to be described as an ideology of this or that class, or even if it is only to be labelled as "progressive", or not, this can hardly be done without knowing what it was that counted as radical and as conservative thought at the time.

The crux of the problem was that the mass of the population of the growing towns were no longer constrained within the traditional ideologies that had enclosed the peasantry, quite literally, in a series of obligations and duties from birth to death. The traditional Tory view was that there was an organic relationship between the different "ranks"

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1 See for instance Poynter, 1969 (on poor relief); and Silver, 1965 (on education).

of society. It had been possible to hold this view in a stable agrarian economy; but the combination of the French Revolution and the growth of the manufacturing towns had provided material proof that the old social relationships need not last forever. And yet, as we know, when the bourgeois class attained economic and political power it did not abolish the aristocracy. In many ways it attempted to emulate the Tory paternalism toward the "lower orders" in order to convince itself that there remained a place in ruling-class ideology for the values and attitudes of the aristocracy themselves. Not all High Tory philosophy was acceptable to the reformers, of course: it was, after all, the House of Lords which blocked one Reform Bill after another all through the first half of the century. But some members of the aristocracy accepted what they saw as their responsibility towards the poor; just as the poor had a responsibility to work and obey, so the rich had a responsibility to govern and to look after those who could not look after themselves. This was the basic philosophy of one influential reformer, Lord Ashley, better known by his later title as the seventh Lord Shaftesbury. Ashley realised that to "help" the poor was a necessary task in order to maintain the status quo, a point that his friend Robert Southey made to him in 1832:

> I agree with you that the state of the poor cannot be discussed too much, for till it is improved physically and morally and religiously we shall be in more danger from them than the West Indian planters are from their slaves.[1]

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[1] Letter of January 1832, quoted in Finlayson, 1974, p. 161. Finlayson also provides an example of Ashley's class motivation: "[My] whole life [has] been spent in endeavouring to build up the moral, social, political and religious estimation of the Aristocracy" (1867, quoted ibid., p. 177). On Ashley's philanthropic career see any of his biographies, for example J.L. and B. Hammond, 1923; Battiscombe, 1974; and for his work specifically in lunacy reform, K. Jones, 1972, chap. 6.

It is of course unlikely that Ashley ever thought that inmates of lunatic asylums were going to cause an insurrection. What he did think was that unless the ruling class fulfilled its duties towards the unfortunates of society, they would have no moral right to continue to rule. It is in this sense that Ashley may be called an evangelical, a reformer like William Wilberforce who believed that the purpose of reform was to reinforce the moral fabric of society. Like Wilberforce and the Tukes, Ashley's conception of reform was essentially a metaphysical one, as can be seen from a remark he made when making a presentation to John Conolly, a renowned moral therapist of the next generation:

> I cannot confine my views merely to the physical results of the new system. I look, also, to the moral results, and I find that while the class of lunatics has been raised in the moral scale of existence, society generally has benefitted.[1]

Tory paternalism then, remained an influential feature of the reform movement. Its representatives were few but as an ideology it held an attraction far beyond the ranks of the old ruling class. It conferred a moral legitimacy on the attempts at social control of the "lower orders". But it was only one strand in the reform movement. The other, main, impetus for reform came not from isolated members of the aristocracy but from representatives of that other claimant to the ruling class--the industrial bourgeoisie. They had a more direct awareness of the social problems of the manufacturing towns, and while usually seeing the solution still in moral terms, they also tied their rhetoric to specific social solutions. An eloquent representative of this approach was Patrick Colquhoun, a Scottish merchant and founder of the Glasgow Chamber of Commerce, who looked into the question more rigor-

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[1] From a speech given in 1851, quoted in Hunter and Macalpine's introduction to Conolly, 1973, p. xi.

ously than most ideologists of his class. In his Treatise on Indigence of 1806 he attempted to define the causes of unemployment or, as he put it, of "indigence, . . .the state of any one who is destitute of the means of subsistence, and is unable to procure it to the extent nature requires".[1]

Colquhoun accepted that there were such causes as the "stagnation of manufactures" or severe frosts which interfered with outdoor work, but he was overwhelmingly convinced that the main cause of unemployment lay elsewhere. In short, he believed

> that it is in the character of the labouring people that the cause of the great and unexampled extent of indigence is to be found.[2]

The problem, Colquhoun argued, was not a social one at all but one of individuals who did not fulfil their duty to society. And if the problem was an individual one, so was the solution. We can "only find a remedy", Colquhoun maintained,

> in such restraints as shall improve the morals, and produce habits of industry among this noxious class of the community, whose numbers have become exceedingly burthensome and alarming, occasioning a vast pressure on the more virtuous and industrious classes of the people.[3]

These two phrases, "improve the morals" and "produce habits of industry", will appear repeatedly in this chapter. They indicate above all the class nature of the argument, whether it was directed towards the poor in general or towards the insane. These phrases are the injunctions of a class whose major problem was no longer to establish itself within the ranks of the old ruling class but one who now had to establish control over the class which was to support it as the new ruling class.

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1 Colquhoun, 1806, p. 9.

2 Ibid., p. 239

3 Colquhoun, 1815, p. 113.

The substance of that control can be seen in all the ideological productions of the bourgeois class, in moral treatment as in the regulations pasted on the factory doors. The subject of this chapter is moral treatment as it existed in this world of class struggle, and not in the rarified air of the Retreat when class antagonisms were concealed within the religious rhetoric of the Society of Friends. Because of this it will no longer be possible to treat moral treatment as universally applicable to all the insane. The need to "produce habits of industry" did not occur to the moral therapists when treating patients of their own class. In practice they often did something very similar, but to understand this practice we must respect their own consciousness of what they were doing and accept their own class-based distinctions. Numerically the overwhelming majority of the insane at this time were classified as paupers, or at least within the "labouring classes", and they will be given the bulk of attention here.

So far the main specialist provisions of care that have been discussed for the pauper insane were the subscription hospitals and the private madhouses. There was one other type of institutional care which has not yet been mentioned because it was hardly a real alternative in 1815, although by the end of the century it was to become virtually the sole means of confining the insane. This was the county asylum, an institution that, in the physical form of its buildings at least, is still with us. The county asylum movement was to be the main expression of moral treatment, as it was for the birth of modern psychiatric theory and practice. But by 1815 there were only three county asylums in operation and they could hardly be said to embody all that was progressive in the treatment of the insane.

Before tracing the history of the county asylums and the development of moral treatment within them, one point must be emphasized about the

personnel involved in the reform movement, and their motivations. The treatment of the insane has been presented so far as making use of (a) medical therapies which are applied to the faulty organ or physiological process and (b) precepts of management which are applied to the lunatic as a whole in his capacity as being dangerous, capable of self-restraint, or whatever. This dichotomy had always existed and various theoretical and practical approaches to insanity had emphasized one aspect or another. In the late eighteenth century the management aspect was emphasized because of the changing conceptions of human nature which, rather than banishing slaves, criminals, lunatics and other outcasts to a region outside the moral universe, considered that they were capable of reform within it. In other words, the impetus for reform did not come from within medical advances in knowledge or, on the whole, from the custodians of that knowledge. Some members of the profession even argued that medical knowledge proscribed the possibility of moral treatment. It has already been argued that the reason for this must be sought not in the forms of knowledge themselves but in the intensely conservative nature of the medical profession, who were more interested in preserving their own status than in applying knowledge to the changing social problems of their time.

The impetus for reform in the treatment of the insane came not from the medical profession but from that section of the population which was interested in social problems; indeed, had its rationale in trying to eliminate them. This was the magistracy, or the Justices of the Peace, the basic unit of local government at this time.[1] Before the

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[1] Moir, 1969. In class terms the justices represent a complex group. They were quite often financially independent, not because their families were established gentry, but because their fathers had made large amounts

establishment of a police force or of standardized approaches to the control of deviance, it was these Justices who were responsible for dealing with problems of order as and when they arose. Because of their proximity to local conditions all over the country, they were in a particularly good position to notice the extent to which existing facilities for the insane were inadequate. As the magistrates found out, in the metropolitan areas where some of the physicians took an active interest in the insane, there were, at least, asylum facilities. But in most of the country, away from the larger madhouses and hospitals, the insane were still being dealt with in the ad hoc manner they had always been. One of the Justices wrote to the Secretary of State in 1806, pointing out what he considered to be the typical lot of a lunatic:

> I believe there is hardly a parish of any considerable extent, in which there may not be found some unfortunate human creature of this description, who, if his ill treatment has made him phrenetic, is chained in the cellar or garret of a workhouse, fastened to the leg of a table, tied to a post in an outhouse, or perhaps shut up in an uninhabited ruin; or if his lunacy be offensive, left to ramble half-naked and half starved through the forests and highways, teased by the scoff and jest of all that is vulgar, ignorant, and unfeeling.[1]

Other magistrates obviously felt the same because in January 1807 a Select Committee was formed "to inquire into the State of Criminal and Pauper Lunatics in England, and the Laws relating thereto." The members of this committee were C.W.W. Wynne, George Rose, Sir Samuel Romilly, William Wilberforce, and Samuel Whitbread, names which were to recur often in the reform movements of the time. The committee saw a need for the erection of a number of public asylums, to be based on

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of money in commerce and manufacturing. The implications of this background for their policies can be seen below, in the career of John Howard.

[1] Sir George O. Paul, address to Earl Spencer, in 1807 SC Report, Appendix 4, p. 85.

similar principles to the hospitals already established at Manchester, Liverpool, etc. They felt that

> public opinion appears to be so favourable [to the idea of having public lunatic asylums] that it may be sufficient for the legislature, at least in the first instance, rather to recommend and assist, than to enforce the execution of such a plan.[1]

They thus proposed authorising magistrates to charge the capital expense of erecting asylums to a county rate, and for the patients then to be maintained by their parishes. The report also recommended that the asylums should be as large as possible, up to a maximum of 300 beds; and that they should not be solely for paupers but also for paying patients and for the poor who could be paid for or subsidised out of charity.

The Committee's proposals were enacted the following year, in "Mr Wynne's Act" of 1808.[2] This Act embodied the Committee's optimism about the need not to enforce provision. It was a permissive act which merely empowered magistrates to erect asylums for either one or a combination of counties, wherever they recognised the need. In the first 20 years of the operation of the Act, only eight counties saw the erection of an asylum. These are listed in Table 3, together with the numbers of beds available in 1826.[3] As can be seen from this table,

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1 1807 SC Report, p. 6

2 48 Geo III, chap. 96.

3 There is nothing intrinsically important about this particular year. It is used here because a survey of the provision available had recently been published. It is, however, indicative of the changes taking place in that it stands mid-way between the County Asylums Act of 1808 and the Lunatics Act of 1845, the final legislative recognition of the need for county asylums.

Table 3

English County Asylums erected by 1826[1]

County	Town	Date of Opening	Number of Beds Occupied in 1826
Nottinghamshire	Nottingham	1812	67
Bedfordshire	Bedford	1812	53
Norfolk	Thetford	1814	112
Lancashire	Lancaster	1816	294
Staffordshire	Stafford	1818	152
Yorkshire (West Riding)	Wakefield	1818	246
Cornwall	Bodmin	1820	43
Gloucestershire	Gloucester	1823	75
			(Total: 1042)

provision in county asylums was hardly extensive, especially in view of the more than 3000 persons held as insane in private madhouses, the 53 in gaols, and the unknown number in workhouses and single confinement[2] at the same time. These figures are given to provide a context within which the discussion of the "importance" of moral treatment must be seen. The few clear examples of moral treatment never coped with more than a small minority of the insane. But if they were not important in a practical sense in the history of psychiatry, as the discovery of chlorpromazine was, their ideological importance is undisputed.

Not surprisingly, given the social aims of the founders of the early county asylums, there was often conflict between their approach

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1 Source: Parliamentary Returns, 1826.

2 The public subscription hospitals of the eighteenth century which figured so prominently in Chapter One receded very much into the background in the nineteenth century. They kept to their original sizes, and when they became overcrowded the county asylums took on the extra patients. These older hospitals also tended to concentrate on the private sector so that in 1844, for instance, Manchester Lunatic Hospital had only 36 patients, all private.

to the care of the insane and the concerns of the medical profession. Not that there was anything in the concept of a publicly-financed asylum necessarily antithetical to the medical profession--some of the early county asylums were planned as subscription hospitals and built partly by subscription and partly from a county rate.[1] What was antithetical to the interests of the medical profession was that although medicine was not excluded from these asylums,[2] as institutions they were envisaged, at least by the social reformers, as a solution to a social problem. Medicine was necessarily peripheral to this purpose of the asylums while moral treatment, a doctrine which emphasized rehabilitation through taking part in "normal" social activities, was not.

This whole topic of the conflict between the medical profession and the lay reformers has recently been exhaustively dealt with by

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[1] Gloucester and Nottingham Asylums are two documented examples of this (Bailey, 1971; Nottingham, 1952, pp. 29, 92). Lincoln Asylum was financed entirely by subscriptions and donations (Walk, 1970). In fact a close examination of the hospitals founded about this time reveals that the distinction between subscription hospitals and county asylums was not as clear-cut as psychiatric historians have tended to make it. True, there was the 1808 Act which was the legislative base for the county asylum movement, but its recommendations were themselves based on a recognition of existing practice. A major cause of dissatisfaction with the subscription hospital model was due to the war-time inflation. Subscriptions did not keep up with running costs, as Paul pointed out when the Gloucester Infirmary accounts went into deficit (Paul, 1796, pp. 38ff). For this and other reasons the old style patronage of hospitals was proving inadequate. Partial subscription and partial public finance was seen as a real solution, which in a sense it was until the stigma of association with paupers made all the administrating bodies realise that such a method was not going to attract the necessary private patients.

[2] It is perhaps significant that the relatively new term "asylum" was used, and not "hospital". However, the idea of calling a medical institution for the insane an "asylum" did not originate with the county asylum movement. The subscription hospitals at York, Liverpool, and Leicester were always known as "asylums". The OED dates this usage of the word to 1776.

Andrew Scull and there is no need to rehearse all his arguments here.[1] Since the main focus of this essay is the ideological production of moral treatment rather than professionalisation of psychiatry or other structural changes, the above conflict will only be dealt with here insofar as it bears directly upon the course of moral treatment. All that needs to be stated at this stage is that conflict did exist between these groups because of their different understandings of the aims of therapy. To express the alternatives in the starkest terms, on one side was the medical approach to insanity with all its arsenal of chemical and depletive techniques; and on the other the social need to confine and if possible reform the insane in the cheapest possible way. Moral treatment occupied the main site on which the confrontation occurred. On some occasions it is possible to see this clearly in terms of the medical profession and the magistracy expressing their different social motivations in their allegiances to different forms of knowledge. On other occasions the debate was internalised by individual asylum superintendents who attempted to embody the medical and social aspects in one practice.

One thing is certain: whatever the particular social praxis which the Retreat attempted to express, with the publication of the Description moral treatment became one more resource in the treatment of the insane, bearing as much or as little relation to moral treatment

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1 But see the discussion on Bedford Asylum at the end of this chapter. My only difference of opinion with Scull on this point concerns the emphasis he lays on the "capture" by the medical profession of insanity (see his 1975a, passim.). My impression is that he overstates his case to the extent that he ignores how much they were involved with it before the county asylum movement. In other words, the birth of modern psychiatry should be seen not as a newly developing ideological imperialism, but as the ideological expression of the medical profession coming to terms with the social reformers, who were in effect trespassing on the traditional province of that profession. The evidence to support this position (that the medical profession were involved with the insane in the eighteenth century) has already been presented in Chapter One.

in the Retreat as the readers of the Description wanted to give it. Moral treatment was set free from the constraints of the Retreat, only to be captured--like all expressions of freedom--as soon as an attempt was made to apply it to real conditions in the world.

The rest of this chapter will deal with the various manifestations of moral treatment as they appeared in the day-to-day practice of caring for and attempting to cure the insane in the first third of the nineteenth century. Each aspect inevitably contains something of the others, and it would be a denial of the totality of capital-property relations to attempt to describe any ideology as discrete. On the other hand, moral treatment was taken hold of by a variety of reformers. Some were physicians, others primarily interested in prison reform or in education. Some may be described as "organic" intellectuals, others as "traditionals"; some were dominated by "expressive" motivations, others by "instrumental" ones. As such, they brought to the treatment of the insane different emphases, different assumptions about the importance of therapy.

The major part of this chapter will deal with moral treatment in the specific context of the county asylums. It was here that it received its greatest development, albeit one narrowly circumscribed by the vicissitudes of the class struggle, with which it will be seen to be closely tied. At least three major themes can be perceived in the practice of moral treatment in the county asylums.[1] These may be described as (1) the idea of moral community, (2) the structure of order, and (3), the imperative to work. These three themes will now be examined in detail.

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[1] That is, in the period up to the mid-1830s. After that time moral treatment began to change under the influence of what was known as the "system of non-restraint". This will be examined in Chapter Five. The themes examined in this chapter did not disappear with the emergence of non-restraint so there will be some overlapping in time, although this will be minimised in order to keep the thematic fragments distinct.

The chapter ends with a section on moral treatment as it developed outside of the pauper institutions, namely (4) moral treatment as a commodity. This occurred predominantly in small private asylums run by the middle class for their own use, and was even less extensive than the moral treatment in the public asylums. A discussion of middle-class moral treatment will, however, throw an illuminating light on the number of ways in which the therapy could be practised, and how closely moral treatment was tied to the class struggle whenever it was taken out of the textbook and applied to real life.

1. The Moral Community of the Asylum

The emphasis that the Description laid upon the total environment, the creation of a moral community in which a damaged mind could be made whole again, was one which appealed to many in a period when industrialization appeared to be destroying those moral communities in which social and behavioural deviance had not so far been a visible feature. Especially for those conservative thinkers whose security stemmed from their status within the old order (or for those who believed in the necessity of such a world) the reproduction of a moral community based on natural order was a dominant theme in the social rhetoric of the time.[1]

> A time there was, ere England's griefs began,
> When every rood of ground maintained its man;
> For him light labour spread her wholesome store,

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[1] A number of writers have pointed out that it was not only the conservatives who looked back to the "good old days" on which to base their belief in the possibility of a better world. The London Corresponding Society called for universal suffrage by appealing to the model set by Saxon England. And the widow of the working-class leader, John Thelwall, maintained that her late husband was "descended from a Saxon family" (quoted in Thompson, 1968, p. 96). Sedgwick has captured the mystical quality of this phenomenon: "We may see our hankering for the 'natural' as a kind of tribute that men pay to use-value, to unmediated sensual enjoyment, in an age dominated by exchange value, where the proper qualities of things are overlaid and distorted by the mystifying equivalences interposed in the commodity transaction and its social apparatus" (Sedgwick, 1966, p. 171).

> Just gave what life required, but gave no more:
> His best companions, innocence and health;
> And his best riches, ignorance of wealth.
> But times are altered; trade's unfeeling train
> Usurp the land and dispossess the swain; . . .[1]

This era which Oliver Goldsmith was mourning in 1769 was gone for ever, but this never prevented wistful poets and thinkers striving to recreate its moral certainty in numerous if short-lived experiments. Foucault has been one writer to see within the Retreat the resemblance to a return to nature of this kind. In the Description there are certainly references to such features as pollution-free air, the view over unspoilt country, the fertile garden, and the therapeutic value of working on the land.[2] On the basis of these remarks Foucault has written,

> Toutes les puissances imaginaires de la vie simple, du bonheur campagnard, du retour des saisons sont convoquées ici pour présider à la guérison des folies. . . .les saisons et les jours, la grande plaine d'York, cette sagesse des jardins, où la nature coïncide avec l'ordre des hommes; doivent incanter jusqu'à son plein réveil la raison un instant cachée.[3]

Foucault appears to be suggesting that the Retreat was trying to recreate

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1 "The Deserted Village" (in Davison, 1973, pp. 128-9). Or, as the Tory Quarterly Review expressed itself in 1816, "all the freshness and delightful simplicity of rural happiness is gone!" (Anon, 1816, p. 399). This reviewer also drew the not uncommon corollary to this belief: that insanity was actually caused by the "artificial state of society which grows necessarily out of a constant advancement in civilization". The argument he used, the essence of which is still heard today, was that "in proportion as man emerges from his primeval state, do the Furies of disease advance upon him, and would seem to scourge him back into the paths of nature and simplicity" (ibid., p. 398).

2 Description, pp. 36, 93-6.

3 Foucault, 1972, pp. 492, 493. "All the imaginary strength of the simple life, of rustic happiness, of the return of nature's order are summoned here together in order to preside at the recovery of sanity. . . .the passage of time, the open country around York, that wisdom of the garden where nature coincides with the order of men; all this must work its spell until the full awakening of the momentarily hidden reason."

something that had gone for ever. Given the settled nature of York society in the 1790s[1] it is perhaps more true to say that the Description does not plead for a return to a natural moral order; it merely states its existence within a world where that moral order had not yet been destroyed. But whatever the case about the world which the Retreat attempted to reproduce, there is no doubt that, by the time the Description appeared, the social relations of capitalist production were far more extensive. Not that this meant that the idea of moral community was abandoned in the 1810s and '20s; merely that those who used it then had to take into account the realities of the changed world. One of these realities was the need to find and maintain a disciplined work force to man the factories; another was the feeling of many that the social relations engendered by factory production were inhumane and themselves the cause of many social problems.

One well-known figure who confronted this problem was Robert Owen, and although he had nothing to do specifically with the treatment of the insane, his ideas and schemes do cast some light on the contemporary meaning of moral treatment. Owen's most famous project, his industrial village of New Lanark, became known to the general public with the publication of his A New View of Society. This appeared in 1813, the same year as the Description of the Retreat. The precept with which Owen opened his description might equally well have been applied to the

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[1] Although the population of York rose by about a third between 1760 and 1800 there was little work for the extra population and the pauper rate has been estimated at between a quarter and a third of the population (Tillott, 1961, p. 295). That the world seemed to be passing York by did not go unnoticed. As one correspondent to the York Chronicle wrote in 1790, "If the inhabitants of this city would rouse themselves to some spirited exertions. . .and the Corporation open the gates to all tradesmen and manufacturers inclinable to settle among us York might once again lift up its head and recover its ancient consequence" (quoted in Armstrong, 1974, p. 20).

regime at the Retreat:

> Any general character, from the best to the worst, from the most ignorant to the most enlightened, may be given to any community, even to the world at large, by the application of proper means; which means are to a great extent at the command and under the control of those who have influence in the affairs of men.[1]

The difference was of course that the Tukes vehemently denied the rationalist basis of their work, whereas Owen was constantly proclaiming it for his. This rationalism about which Owen was very proud certainly offended his business partners; but if we look at the type of society that Owen envisaged, his apparent radicalism soon disappears.[2]

As far as Owen was concerned, New Lanark was never more than a compromise between his ideals and the physical constraints that the construction of that particular village laid upon them. It is in his later works, where he expressed his vision of an ideal society, that

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1 R. Owen, 1970, p. 99.

2 The narrow parameters of Owen's radicalism are well known and probably appeared even more so to his contemporaries than to those later writers who insist on emphasizing his socialism. Owen's conception of rationality was the inverse of that informing this account: that is, one that recognises man's own powers <u>and</u> the necessity to bring those powers under conscious control. In Marx's words, "The materialist doctrine that men are products of circumstances and upbringing, and that, therefore, changed men are products of other circumstances and changed upbringing, forgets that it is men who change circumstances and that the educator must himself be educated. Hence this doctrine is bound to divide society into two parts, one of which is superior to society (in Robert Owen, for example)" (<u>Feuerbach Thesis No. 3</u>, in <u>MECw</u>, vol. 5, p. 7). Owen himself had become conscious of the need to change society but he was not able to recognise the rational basis of this achievement of consciousness in himself. Because of this his "rationalism" became as metaphysical in its assertion of universal laws as the mystical beliefs of William Allen or Samuel Tuke. To say this is not to deny that Owen held some socialist views. This aspect of his work is expressed in such statements as "it is <u>only</u> in a state free from the fear of poverty, and of unjust opposition from wealth and power, and when placed upon an equality, to the extent of age, with all his fellows, that man can know himself, or the state of excellence and happiness to which he can attain" (R. Owen, 1841, p. 60).

can be found a clearer picture of the moral community he would really have liked to establish. In 1841 Owen published a book on what he called "Home Colonies". The aim of these "Colonies" was described in the book's subtitle:

> A most secure and profitable investment for capital, and an effectual means permanently to remove the causes of ignorance, poverty and crime; And most materially to benefit all Classes of Society; by giving a right application to the now greatly misdirected powers of the human faculties, and of physical and moral science.

Like William Allen[1] and Rowland Hill,[2] two other authors of books on "Home Colonies", for Owen the New Society was to be a replication of the old--but without the antagonisms between classes.

The primary underlying aim of all these writers was to establish a moral imperative within the minds of the working class.[3] This was one

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[1] There is a nice irony in the fact that William Allen wrote a book on Home Colonies. Allen was originally one of Owen's partners at New Lanark who disagreed with Owen's principles. He was a fervent Quaker to whom Owen's avowed rationalism appeared as blasphemy. A comparison of their criticisms of each other with the practical suggestions they both made for the reform of society provides a vivid example of the use of incompatible beliefs to serve nearly identical ends. For Allen on Home Colonies see his 1827 and 1832 (first ed. 1826), and for a review of Owen's New View see W. Allen, 1813. See also his Life (W. Allen, 1846-1847). For Owen on Allen see his Life (R. Owen, 1967, vol. 1). For Owen on Home Colonies see specifically his 1841, although most of his published works contain references to his concept of a "New Society".

[2] For Hill on Home Colonies, see his 1832.

[3] This is not to say that their proposals were all directed to identical ends. Owen's scheme was originally intended to accept only those who were already aspiring to middle-class norms of individual achievement: "mechanics, artisans, and the superior kind of servants" (R. Owen, 1841, p. 41). For Hill, on the other hand, "the first settlers should consist of the most industrious and able among the paupers" (R. Hill, 1832, p. 21). And whereas Hill saw the need for Colonies in terms of the social problems and the needs of the industrial towns, for Allen "the most natural and most healthy employment for man, is the cultivation of the soil" (W. Allen, 1832, p. 3). These, or any other differences of practical application, do not affect the argument being presented here: that the Home Colony movement constituted a source of ideas and concrete proposals that could be used by enthusiasts of moral treatment in the

of the reasons the past was invoked so much. If only, the home colonists argued, it were somehow possible to re-establish the social relationships between worker and capitalist that had been so powerful when they had existed between Lord and peasant. As Owen put it,

> the [children] were generally trained by the example of some landed proprietor, and in such habits as created a mutual interest between the parties, by which means even the lowest peasant was generally considered as belonging to, and forming somewhat of a member of, a respectable family. Under these circumstances the lower orders experienced not only a considerable degree of comfort, but they had also frequent opportunities of enjoying healthy rational sports and amusements; and in consequence they became strongly attached to those on whom they depended; their services were willingly performed; and mutual good offices bound the parties by the strongest ties of human nature to consider each other as friends in somewhat different situations; the servant indeed often enjoying more solid comfort and ease than his master![1]

Ah, those "feudal, patriarchal, idyllic relations"[2] which were gone but not forgotten. But, as Owen and others realised, the mutual dependence of the old society placed a responsibility on the ruling class as well as on those who were to be ruled. What was needed was not a dependent class but, literally, a working class, a class whose benevolence was its own industry.

> The very pith and marrow of a Poor man's happiness is self-dependence. . .The man who is self-dependent is more comfortable, more virtuous, more dignified, than either patronage, or bounty, can ever make him; and he who would be the true friend of the Poor must teach them to be their own benefactors.[3]

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lunatic asylums. For a general discussion of the Home Colonies see J.F.C. Harrison, 1969.

1 Observations on the Effect of the Manufacturing System, 1815 (in R. Owen, 1967, vol. 1a, p. 40).

2 Marx and Engels, Communist Manifesto (in MECW, vol. 6, p. 486).

3 Nicoll, 1819, p. 31. Nicoll did not write specifically about Home Colonies, but his work on the Poor Law and lunacy reform shows a concern with the same problems.

Many statements similar to this appeared in the first two decades of the century. Societies were formed to propagate the message. One such was the Society for Bettering the Condition and Increasing the Comforts of the Poor, and its aim was amply expressed by its founder, Sir Thomas Bernard:

> Let us give effect to that master spring of action, on which equally depends the prosperity of individuals and of empires--THE DESIRE IMPLANTED IN THE HUMAN BREAST OF BETTERING ITS CONDITION.[1]

These types of statements express a profound, if familiar, contradiction. On the one hand was the proferred reward--independence, dignity, freedom from patronage. And on the other was the force of the injunction itself, a form of moral coercion backed up with often severe physical measures. This much-vaunted "independence" was above all an assertion, by the ideologists of capital-property relations, of their independence from responsibility towards the labour force on which they were so dependent. Or, to put it in more abstract terms, capitalism as a mode of production needed to take moral authority away from the individual agents of benevolence and locate it in the system itself, or at least in those who were to be its driving force. It needed, not slaves or serfs, but "independent" workers. This motivation towards "independence" in the minds of the working class was not something its members were supposed to consciously work out as a result of considered reflection. It was to be manufactured in the workers' minds, just as material

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[1] Quoted in Poynter, 1969, p. 92, emphasis in the original. Bernard's own motivation was a self-consciously ideological one. In his words, "When I thought I had acquired in my Profession such a competence as satisfied my desires, I determined to quit the law, & try what useful Occupation I could find that was not likely to increase l'embarras des richesses. The Endeavour to meliorate the domestic habits of the labouring Classes, was the first amusement that occurred" (Bernard, Pleasure and Pain, 1830, quoted in D. Owen, 1965, p. 105).

commodities were manufactured by the machinery in the factories. The key sentiment underlying all this thinking is summed up in the phrase "habits of industry". These habits were to be the machinery that would reproduce correct behaviour just as the factory machinery would reproduce the commodities devised for it by the capitalist.[1]

It is often forgotten today just how much this fact was explicitly recognised by the ideologists of capital themselves. Two well-known manufacturers, with very different reputations today, both spoke out strongly on this point. According to the "socialist", Robert Owen,

> If. . .due care as to the state of your inanimate machines can produce such beneficial results, what may not be expected if you devote equal attention to your vital machines. . .

Owen continued,

> You will discover that the latter may be easily trained and directed to procure a large increase of pecuniary gain. . . . Give but due reflection to the subject, and you will find that man, even as an instrument for the creation of wealth, may still be greatly improved.[2]

Some of Owen's methods for the moral control of his workforce are well known. Like Tuke's exploitation of the "desire for esteem", they played on the employees' attempts to improve their own evaluation of themselves.[3]

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1 As with so many aspects of moral treatment, the germ of this one was stated by Samuel Tuke in the Description. When writing about the effectiveness of the "desire for esteem" as a means of raising his patients' consciousness of their behaviour, Tuke admitted that with some patients it was not entirely successful. But, he continued, even if it has no benefit to the patients as individuals, it "at least materially assists them in confining their deviations, within such bounds, as do not make them obnoxious to the family" (Description, p. 157). For an example of this social effect of the desire for esteem in practice see his 1815, p. 29.

2 "To the Superintendents of Manufactories", prefixed to his Third Essay on Formation of Character, 1813, in R. Owen, 1970, p. 95. Owen spoke with some authority in that in terms of numbers employed, New Lanark was the largest centre of cotton manufacture in Britain at that time.

3 One well-known example is Owen's "Silent Monitor" system, which he

Another manufacturer who pointed out the need for moral control in the factory was the now infamous Andrew Ure.[1] If we are to take Ure at face value, he really believed in the superiority of the factory system over any other, exploitation of five-year-old children notwithstanding.[2] More important here, though, is his quite explicit recognition that moral control is a branch of the social control of the workforce that every manufacturer needed to maintain. In Ure's now famous words,

> It is, therefore, excessively the interest of every mill-owner, to organize his moral machinery on equally sound principles with his mechanical, for otherwise he will never command the steady hands, watchful eyes, and prompt co-operation, essential to excellence of product.[3]

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devised to improve conduct in the mills. This consisted of a four-sided block of wood placed by each worker. Each side of the block was coloured: black, blue, yellow, and white. Whichever colour was visible denoted the conduct of the worker on the previous day. Each department had "books of character" in which each worker's daily behaviour was entered, the four colours being listed as numbers one to four. Owen was fully aware of the moral omnipotence that this gave the mill master. In his words, "The act of setting down the number in the book of character, never to be blotted out, might be likened to the supposed recording angel marking the good and bad deeds of poor human nature" (R. Owen, 1967, vol. 1a, p. 81). Nor was Owen entirely original in this approach. He got the idea from Samuel Oldknow, cotton master at Mellow and Marple in Cheshire.

1 Ure has long been known as one of the sources that drew Marx and Engels' venom in Capital and Condition of the Working Class in England. It has been suggested that Ure was an easy and atypical target to attack. A recent book, however, on The Ideology of Work (Anthony, 1977) shows very clearly that "The organization of the moral machinery remains to this day a very good description of the purpose of the ideology of work; the only development in the twentieth century is that the machinery has been secularized" (ibid., p. 60).

2 Take for instance his statement that "It is, in fact, in the factory systems alone that the demoralizing agency of pauperism has been effectively resisted, and a noble spirit of industry, enterprise, and intelligence, called forth. What a contrast is there at this day, between the torpor and brutality which pervade very many of the farming parishes, as delineated in the official reports, and the beneficient activity which animates all the cotton factory towns, villages and hamlets!" (Ure, 1835, p. 354).

3 Ibid., p. 417.

The difference between human and mechanical machinery was, of course, that the latter needed only minor servicing. Once it had been made it could be relied upon to do its job. No such guarantee could be obtained with the human element. This was the basis for all the ideology: that the working class did not recognise itself as imbued with the habits of industry. Especially for many of those recently dispossessed from the land, or discharged from the Army or Navy, little inclination was shown for accepting the discipline of factory production. They wanted to work only to the extent of their recognition of their needs, not as a habit, tied to the rhythm of machinery they did not own.[1]

The Home Colonies were envisaged as one of the means by which this inculcation of moral and social habits could be accomplished. In the cities there were too many other influences: drink, promiscuous sex, indiscriminate charity--influences on the mind of the working man which sapped his belief in the necessity to work. But in the Home Colonies it would be possible

> (i) To wean the Poor from a dependence on the Parish, and what is falsely called Charity, and to put them in the way of providing for all their wants by their own industry.
> (ii) To enable them to procure an education for their children, in moral, religious and industrious habits.
> (iii) To raise such a moral and independent feeling in the Poor, as may induce them to consider it a disgrace, and shame, to receive alms from the Parish, or to engage in marriage, until they shall have made a reasonable provision for a family.[2]

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[1] On the difficulty of getting the labour force to accept the discipline of factory production see the detailed account provided by Thompson, 1967.

[2] W. Allen, 1827, p. 1. Or as Hill put it, "The habits of industry and regularity which the members will acquire, will, in many cases render it possible soon to restore them to society, with a security that they will not again fall into a state of Pauperism" (R. Hill, 1832, p. 25). There is a striking parallel here with the re-education centres of the newly-Communist states of Southeast Asia. This is not to say that the content

Or so the enthusiasts for Home Colonies argued. Of course these sentiments are not specific to Home Colonies. Similar rhetoric can be found surrounding the establishment of workhouses. But the Colonies, like some of the lunatic asylums, do represent a trend at this time to destroy deviance by resocialising what they saw as its causes; not at the sites at which they occurred but at centres of moral and social excellence uncontaminated by the realities of class struggle.

However much any particular asylum superintendent agreed with moral treatment or understood the principles of the Home Colonies, the very existence of separate institutions indicates that the new philosophy had some effect. There is nothing natural or necessary about treating social or behavioural deviants away from their homes. What the enthusiasts for this approach to social control had to argue was that it was more effective in creating social order than older, less rigorous, methods. Not everyone involved in the asylum movement thought this way; but one man who did was the superintendent of two of the largest asylums and a strong influence on the future course of moral treatment. This was William Ellis, a man whose contemporary recognition included a knighthood in 1835. In view of the dichotomy of interests already noted that often existed between the aims of the lay reformers and the members of the medical profession, Ellis must be seen as one of the key figures of this period in that his work appears to transcend the sectional interests of one side or the other. Unlike most reformers, Ellis was committed not only to the aims of moral rehabilitation, but also to

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of these centres and the Colonies was the same, merely that each mode of production (feudal, capitalist, or socialist) requires its own social relations which have to be taught, and that this is more easily done in isolation.

medicine.[1]

Ellis' opinions on the various aspects of moral treatment will be commented upon below,[2] but it must be noted here that he was fully aware of the similarities between the regime he attempted to create in his asylums and that at the proposed Home Colonies. As he wrote in the Annual Report for Hanwell Asylum in 1836,

> The Establishment of itself thus presents rather the appearance of a little independent colony, than of a sick hospital; each one taking a share in promoting the general welfare. . .[3]

Closer examination of the annual reports and methods of treatment practised show just how much of an idealised picture Ellis was presenting here. But insofar as Ellis believed in the establishment of "a little independent colony" as an aim of therapy, the assertion is important.

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1 William Ellis was born in 1780, the son of a village rector, and began his professional career as an apprentice to a surgeon in Hull. He received his Membership of the College of Surgeons in 1800, and in 1814, together with Dr John Alderson, he founded the Hull Refuge, a small private asylum whose name and avowed philosophy were modelled on the example of the Retreat. The following year Ellis wrote to Thomas Thompson MP, a member of the 1815 Select Committee, expressing his thoughts on the treatment of the insane (W.C. Ellis, 1815). His initiative was soon rewarded in that he was offered the post of superintendent at the West Riding of Yorkshire County Asylum, soon to be built at Wakefield. He then obtained an MD degree from St Andrews University, and when the asylum opened on 23rd November 1818 Ellis, together with his wife as matron, took charge and remained its superintendent for 13 years. In 1831 he was chosen from 23 applicants to be the superintendent at the newly-opened County Asylum for Middlesex at Hanwell. In 1838 Ellis left Hanwell to run his own private asylum, but he died the following year. (On Ellis' career see [H.W. Ellis] 1868; Hunter and Macalpine's introduction to Conolly, 1964, pp. 10-11; and J.A.R. and M.E. Bickford, 1976, pp. 14-15, 25.)

2 See especially pp. 229ff.

3 Quoted in Hunter and Macalpine's introduction to Conolly, 1968, p. 18.

Another exponent of moral treatment who appears to have drawn heavily on a belief that a moral community could be established in the asylum was W.A.F. Browne. Like Ellis, Browne has been remembered as one of the "great men" of early nineteenth-century British psychiatry; and if anything his influence was even stronger than that of Ellis. He was a Medical Commissioner in Lunacy for Scotland from 1857 to 1870, and President of the Medical-Psychological Association in 1866.[1] The difficulty in assessing his work here is that it took place in Scotland, in asylums founded upon a very different rationale to that of the English county asylums. Moral treatment in the latter was specifically for paupers; it was dominated by the attitudes of its administrators to this lowest class of society. In Scotland on the other hand, the asylums were usually founded by acts of private philanthropy for the insane of all classes. The County Asylums Act of 1808 did not apply in Scotland, and although a bill was introduced in 1818 to establish something similar it was rejected as a result of petitions protesting against the introduction of a Poor Rate.[2] In other words, the Scottish asylums presented a better opportunity to establish a complete moral community within themselves because they held a more representative selection of the population within their walls.

From the time of his appointment as medical superintendent to Montrose Asylum in 1834, at the age of 29, Browne showed his lifelong interest in

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1 Browne's medical career began with an MD from Heidelberg and an LRCS from Edinburgh. He was superintendent of Montrose Royal Asylum from 1834 to 1838, and of the newly-opened Crichton Royal Institution at Dumfries from 1838-1857. For a summary of his career see HMA, pp. 865-6.

2 Greenland, 1958. For more detailed material on the founding of individual asylums see Poole, 1841 (Montrose, established 1781); Duncan 1809 and 1812 (Edinburgh, established 1813); Stark, 1807 and Rice, 1974 (Glasgow, established 1814); Tait, 1972 and Easterbrook, 1940 (Dumfries, established 1839).

developing the creative possibilities of moral treatment. Only three years after this appointment he published a short but influential book aptly entitled What Asylums were, are, and ought to be.[1] No asylum ever looked like Browne's vision of the future; but as ideology, lodged on every asylum superintendent's bookshelf, it was a powerful force for the continuing commitment to moral treatment.

As Browne and many others realised, the urban world was rent by struggle, pain and exploitation. But in the lunatic asylum, under the paternal eye of a gentle administrator, all differences might be reconciled, all anguish forgotten, and all unfairness eliminated.

> Conceive a spacious building resembling the palace of a peer, airy, and elevated, and elegant, surrounded by extensive and swelling grounds and gardens. . . .The inmates all seem to be actuated by the common impulse of enjoyment, all are busy, and delighted by being so. The house and all around appears a hive of industry. . . .There is in this community no compulsion, no chains, no whips, no corporal chastisement, simply because these are proved to be less effectual means of carrying any point than persuasion, emulation, and the desire for obtaining gratification. . . . When you pass the lodge, it is as if you had entered the precincts of some vast emporium of manufacture; labour is divided, so that it may be easy and well performed, and so apportioned, that it may suit the tastes and powers of each labourer. You meet the gardener, the common agriculturalist, the mower, the weeder, all intent on their several occupations, and loud in their merriment. . . .For those who are ignorant of these gentle crafts, but are strong and steady, there are loads to cary, water to draw, wood to cut, and for those who are both ignorant and weakly, there is oakum to tease and yarn to wind. . . .But there are gradations of employment. You may visit rooms where there are ladies reading, or at the harp or piano, or flowering muslin, or engaged in some of those thousand ornamental productions in which female taste and ingenuity are displayed. . . .The curious thing is, that all are anxious to be engaged, toil incessantly, and in general without any other recompense than being kept from disagreeable thoughts and the pains of illness. . . .In short, all are so busy as to overlook, or all are so contented as to forget their misery.[2]

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1 Browne, 1837.

2 Ibid., pp. 229, 230, 231.

The dream of establishing a community in the asylum, with all the patients acknowledging their places in the moral order, was obviously an attractive one to the superintendent who was to preside over this order. One of the fundamental legacies of the example of the Retreat was the recognition established there that control over the insane was possible purely through moral injunctions. The Retreat had been successful because there the patients had occupied the same moral universe as their therapists; they had, before their lapses into "irrationality", been committed to the maintenance of the same values. But, as has been stressed repeatedly, as well as this recognition of what is normative behaviour there was a strong element in all moral treatment of what ought to be. Certainly, outside the Quaker community the moral bonds that the Quakers had been able to take for granted had almost disappeared in the England of the 1820s and '30s. The attempts to establish Home Colonies, Owen's "New View of Society", the "little independent colony" of Hanwell Asylum, and Browne's vision of "What Asylums ought to be" can all be seen as attempts to rebuild in their inmates' minds similar moral bonds to those that some ideologists believed existed in an earlier time when everybody was supposed to have known his or her place in the order of things.

In none of the discussion up to now has there been any mention of the benefits of medicine. It might be argued that, if the influence of the social ideologies was so strong, why did the institutions for the insane have medical superintendents; why were there separate "asylums" and not specialist colonies or houses of industry where all deviants might be resocialised together? This issue has been discussed at length by Andrew Scull, who points out that the early asylums were not medical institutions and that the history of the county asylum movement

may be seen as the history of expanding influence by a nascent psychiatric profession.[1] It has already been argued that Scull overstates the case for this development, but as far as moral treatment is concerned it seems that the most enthusiastic moral therapists were men who were influenced by both social and medical theories. Or, to put it another way, moral threatment manifested itself theoretically both as social and as medical knowledge. Purely for ease of analysis, this chapter is devoted to social theories and the next to medical ones. In practice the two were indivisible, but in order to understand how praxis continually reconstitutes itself out of disparate fragments it is necessary to analyze them discretely.

One point that does perhaps need to be emphasized is the ideological, almost romantic quality of so much of this "moral community" rhetoric. It was expressive, but hardly instrumentally directed to what it proclaimed as its aims. It was not scientific in the sense that moral treatment at the Retreat had been, in its rational application to the realisation of specific and realisable goals. Samuel Tuke was one of the hardest-headed of the moral therapists: unlike some of his more romantic colleagues Tuke always based his attempts to develop moral treatment on a very realistic understanding of what was possible. Writers such as W.A.F. Browne were, at least in the 1830s, still rather young and idealistic. Their commitment to reform was still one that was more expressive of their rebellion against the injustices of their society, rather than any clearly formed attempt to change that society. Tuke, on the other hand, increasingly took a more instrumental attitude towards the control of deviance. He realised that moral injunctions would not be enough when the patients

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1 Scull, 1974, 1975a, 1976.

were "common" paupers, men and women who were more at home in the gin-shops and workhouse dungeons than in the refined air of the Quaker or Methodist chapels. For this growing proletariat, large numbers of whom were to find their way into the new asylums, moral restraint had to be backed up with more than mere words and encouragement. Moral restraint had to be built into physical restraints, a particular "Structure of Order" that would be strong enough to impose normality upon the most degenerate lunatic. The ideal of moral community did not disappear, but it had to co-exist in the public asylums with this more realistic attempt to achieve the same end. It is to this attempt that we must now turn.

2. The Structure of Order

It has been argued that moral treatment at Bicêtre Hospital and at the Retreat developed as an attempt to produce in the minds of the patients at those institutions a commitment to the order of the world. This was done through a variety of methods, but was dominated by the optimistic belief that the patient could internalise far more control than had previously generally been accepted as possible. Another dominant factor was that this optimism was specific to a narrowly-defined time and place. In England the site of optimism was occupied by the Quakers, the predominantly middle-class members of an exclusive sect whose patients had already been heavily socialised with the norms of "sane" behaviour that the Tukes attempted to re-instil in them.

In France the parameters of this optimism were not so much social as temporal. As already noted, it was the euphoria induced by the revolutionary upheaval of society that encouraged Pinel to believe that his patients were capable of equally dramatic feats of rehabilitation. But when the original hopes of the Revolution faded, so too

did Pinel's enthusiasm for miracle cures. This change can be seen quite dramatically from a comparison of the two editions of his Traité. In the first edition of 1801 (based on his experience in treating the insane since being appointed to Bicêtre in 1793) Pinel devoted the major section of the work to "traitement moral". By the time of the second edition in 1809, everything had changed, in the Traité as in the society that gave it its meaning. In this later edition there was no separate section on moral treatment, merely a chapter entitled "Preceptes generaux à suivre dans le Traitement moral" in the section on "Police intérieure". The emphasis in this chapter was not on individual cures but on bureaucratic surveillance. The contents of the chapter were summed up in the first paragraph. In Pinel's words, there was a need for "un centre general d'autorité. . .ce juge suprême doit être le surveillant de la police intérieure".[1]

The possibility of this authoritarian transformation of moral treatment had been apparent from its earliest announcements. The control of the passions was always invested in the authority of the physician, a surrogate "Reason" whose duty it was to represent the normality towards which the patient had to return. In Pinel's earlier work this control was attended by a great deal of imaginative manipulation of situations in order to effect the desired result. In his later work this disappeared. All the optimism that Pinel had expressed in the wake of the Revolution, all that belief in the infinite improvement of the passions, was forgotten in the face of the more pressing need to maintain order in society and in the asylum.

In England an equally dramatic change in the concept of moral

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[1] Pinel, 1809, p. 251. Although the 1809 edition is much longer than the 1801 edition (496 pages instead of 318), most of the extra space is taken up with theoretical discussion about the nature of insanity, and not its treatment.

treatment can be seen once it left the Retreat. Even within the general theme of creating a moral community around the insane, the structure of order was envisaged very differently for those who were not already committed to Quaker doctrine. As will be seen, Pinel's concept of a "Police intérieure" dominated by a "juge suprême" would prove to be a very apt description of the main concerns of moral treatment in the English attempt to institutionalise it.

As already stated, legislation had been passed in 1808 enabling magistrates to authorize the erection of public lunatic asylums. Aside from the initiatives of the magistracy themselves, who were the main force in founding the early asylums, there were a number of philanthropists who attempted to raise interest in the subject of public asylums. One of these was Edward Wakefield who, in 1812, wrote an article in The Philanthropist calling for a number of asylums, each one to serve an area of about six counties. Wakefield's intention was a catholic one:

> As well as Lunatics and idiots, I propose extending relief to cripples, blind persons, and those who may be afflicted with confirmed disgusting diseases.[1]

The following year Wakefield reiterated his plea with a reprint of Sir G.O. Paul's letter of 1806 calling for county asylums.[2] Nothing came of these proposals, but in April 1814 Wakefield visited Bethlem Hospital. What he saw there has since become one of the legends in the history of the treatment of the insane, and there is no need to repeat yet again the accounts we have of the neglect and cruelty that confronted Wakefield and the 1815 Select Committee that was set up, partly to investigate his allegations.[3]

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1 Wakefield, 1812, p. 227. Samuel Tuke also wrote to The Philanthropist calling for more public asylums (S. Tuke, 1811).

2 In loc.cit., vol. 3 (1813), pp. 214-27. See also above, p.170 note 1.

3 On this see the evidence given by Wakefield to the 1815 SC (1st Report, pp. 11-4).

What is not so well known is that what he saw at Bethlem inspired Wakefield to do something more than writing articles for other like-minded philanthropists to read. Specifically, he formed a committee to investigate the possibilities of establishing a "London Asylum". The original Proposal for the London Asylum pointed out the inadequacy of existing provision in London for the insane, and then pointed to the shining example of the Retreat. Nearly half of the Proposal consisted of quotations from the Description. According to the Committee,

> The Retreat at York, has given the world such an example of practical wisdom and humanity, and affords such admirable illustrations of the successful application of the mild treatment for upwards of seventeen years, as to justify an extensive diffusion of its benefits--by establishing a LONDON ASYLUM, for the care and cure of the INSANE, on an IMPROVED SYSTEM OF MANAGEMENT.[1]

The London Asylum was seen to be a direct descendant of the Retreat. This point must be kept in mind in the following discussion of its features, as they might appear at first sight to involve a radical change from those in favour at the Retreat.

The general intentions of the Proposal were ratified by Wakefield into specific suggestions as to the possible size and shape of the proposed asylum.[2] The asylum was to be a large one: an initial figure of 400 patients was given although this was later changed to 250 to 300. Finance was appealed for with the understanding that the investment would provide "a proper remuneration on the Capital advanced". Running costs were to come from the weekly income of the patients themselves. But far more important than the financial return was the philanthropic pay-off, the feeling the investors would get from knowing they had advanced

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1 London Asylum, 1814, no pagination. Emphasis in the original.

2 Wakefield, 1814.

the cause of "humanity".[1]

This was all in 1814. In the following year Wakefield gave details to the 1815 Select Committee on the specifications that he was proposing the new asylum should incorporate.[2] But 1815 was the year that the new Bethlem was built, and it is likely that the erection of this enlarged institution did much to take away the impetus for a "London Asylum".[3] The latter was never built, but the details of it that Wakefield made public are sufficient to provide a better understanding of what was considered progressive in asylum construction in the 1810s.

The plan of the proposed London Asylum in shown in Figure 3. It can be seen immediately that this was no simple gallery model, such as Bethlem was about to incorporate in its new building (see Figure 2). The model for the London Asylum, as for that of the West Riding of

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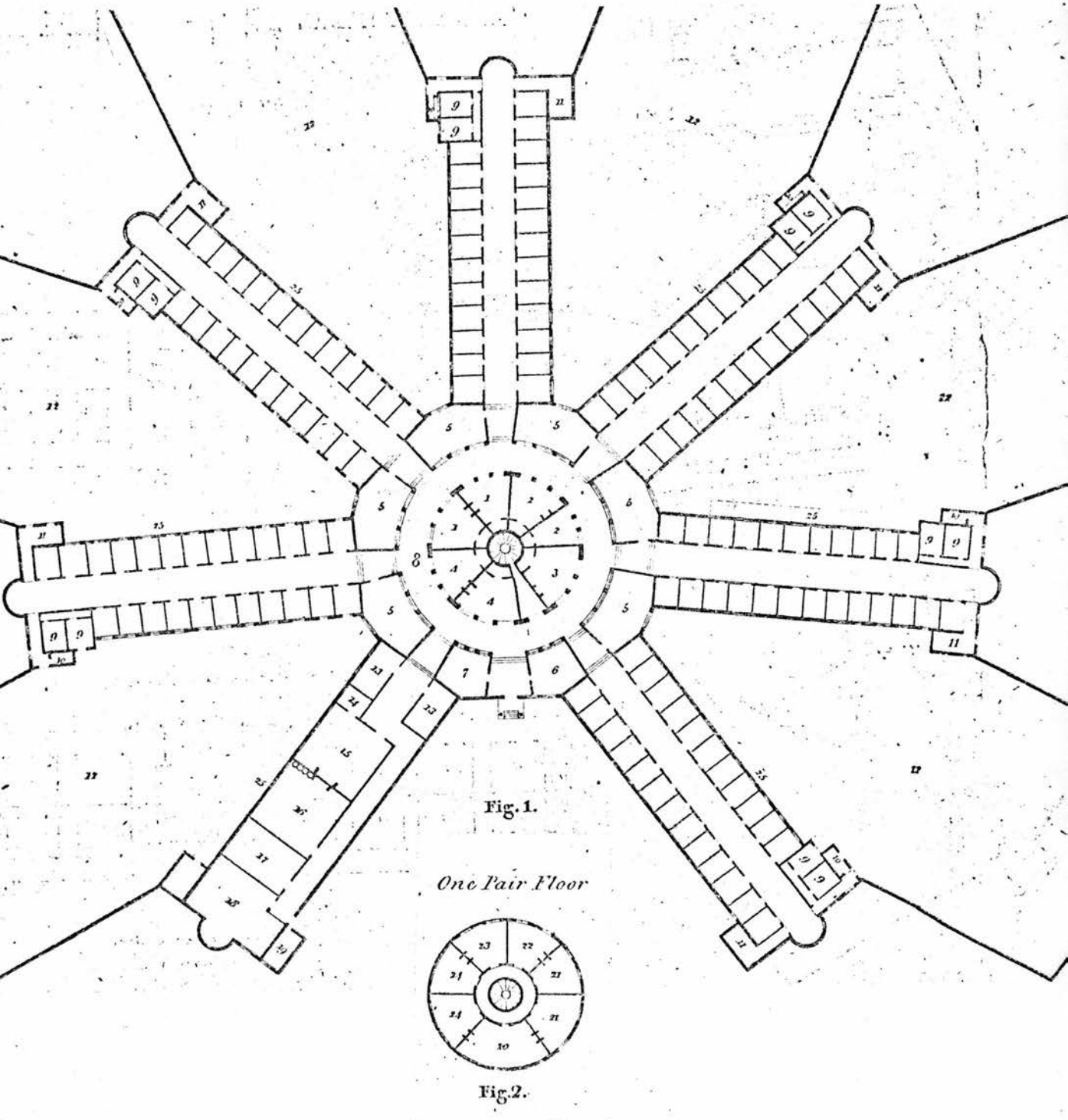
1 London Asylum, 1814.

2 See 1815 SC, 4th Report, pp. 185-6.

3 The new Bethlem was built for 192 patients compared with the 119 which was all the old and by then dilapidated building could contain in 1814. The new Bethlem was erected not without the criticism that it reproduced the old, outdated, approach to insanity. John Haslam, the apothecary to Bethlem, who was hardly in the avant-garde of contemporary opinion, advertised in 1810 for a forthcoming work by him entitled "Hints on the Construction, Internal Economy, and Moral Management of an Hospital for the Insane; pointing out the existing Defects in such Institutions, and proposed means For Ameliorating the Condition of Maniacs"(in the flyleaf to Haslam, 1810). Unfortunately for historians, this book was never published but Haslam does give some hints in his book of 1818 of what he envisaged. His aim, he said, was that the "new hospital might proudly exemplify the science and display the enlightened humanity of the nineteenth century" (Haslam, 1818, p. 51). More specifically, he went on, "Its ample dome might have been omitted, and its stately columns sacrificed to the conveniences of internal construction" (ibid., p. 52). But it was not, and what still stands today as an imposing landmark in Lambeth proudly proclaimed its allegiance to what Haslam graphically summed up as "an invidious aristocracy in the heart of a charitable commonwealth" (ibid.). For discussion and illustration of plans submitted to the competition for a new Bethlem see Rosenau 1970, pp. 69-70.

Figure 3

Plan of the proposed London Asylum



"1) Stewards Apartments 2) Matrons Apartments 3) Surgery 4) Apothecarys Apartments 5) Day Rooms 6) Porters Room 7) Visitors Room 8) Inspection Gallery 9) Rooms for Noisy Patients 10) Patients Water Closets 11) Warm Baths 12) Airing Grounds 13) Store Room 14) Pantry 15) Kitchen 16) Wash-house 17) Drying Room 18) Straw Room 19) Servants Water Closet One Pair Floor 20) Committee Room 21) Women Servants Bed Rooms 22) Matrons Bed Room 23) Stewards Bed Room 24) Men Servants Bed Rooms 25) Covered Walks"

Source: 1815 SC, Report, plate 2.

Yorkshire and some other asylums, was not derived from medical precedent at all but from another area of social control--that of the penitentiary or penal reformatory. To understand the full implications of what Wakefield and his philanthropic colleagues were proposing, it is necessary to turn for a moment from the history of the insane to that of their colleagues in deviance--those who had broken the law.

As was seen in Chapter One, the change from local ad hoc and private provision for the pauper lunatic to specialist and public facilities took place over a long period of time. The first specialist workhouse existed in the seventeenth century and the first specialist hospitals began to appear in the first half of the eighteenth. But in the provision of facilities for the criminally deviant it was not until much later that reforms were initiated. As has already been mentioned in passing, eighteenth-century gaols were privately run for financial profit, with every incident of prison life being charged for by the gaolers, from making an arrest to the provision of bedclothes and the arrangements for discharge. It is true that there were many insane kept in privately-run custodial madhouses whose only rationale was profit, but the patients often had fond relatives who were concerned with their welfare, or at least a parish which was concerned with the money being spent on its dependents. For those who had broken the law, on the other hand, the predominant concern of most authorities appears to have been one of simply wanting to get rid of its nuisances. Most people were quite happy to leave the responsibility of looking after the gaoled to those who were prepared to do so. The gaolers were subjected to no central control; they provided custodial facilities according to the ability of their charges to pay for them. As the Webbs have pointed out, as long as individual profit was the basis of custody there could be no attempt to

secure healthy conditions for prisoners as a group, "let alone uniformity or reformative treatment".[1] But these latter values were what an increasing number of people were looking for in all aspects of deviance control.[2]

The dominant figure in the history of penal reform is undoubtedly John Howard. Howard, like a number of philanthropists in this period, started life as a modest entrepreneur (in his case he was apprenticed to a wholesale grocer) who, on his father's death or at marriage, inherited a large sum of money. These philanthropists did not use this money for straightforward investment in capital: rather they used it to support their ideological investment in the social relations required by capital.[3] Their financial inheritance, a direct result of the growing profitability

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1 S. and B. Webb, 1922, p. 18.

2 As well as the change in values caused by the need to ideologise the changing social relations of production, mention must be made of the growth of the prison population. Itself a function of the urbanisation of poverty and the consequent need of the poor to support themselves without traditional family or social ties, the large increase in the number of prisoners (as of lunatics) made the need for a solution to deviance more pressing than it would otherwise have been.

3 Howard's father was a wealthy upholsterer who died when John was 16, leaving his son with enough inheritance so that he would no longer have to work for his living. (On Howard's career see Baumgartner and Muirhead, 1939.) Another example of this pattern is the career of J.C. Lettsom, who started as a surgeon's dresser, but with the aid of the sale of the family estate in Jamaica and the fortune supplied by his wife, a tin producer's heiress, was able to move into "high society". He gave much money to charities and visited prisons with Howard, as well as taking part in other philanthropic activities. But, as one biographer has commented, "Lettsom's philanthropy shows too much of a tendency to cure immediate and obvious evils without seeking out and attacking the economic sources of such evils" (Trent, 1948, p. 537). Another philanthropist who inherited "a considerable estate" (DNB) on his father's death was Godfrey Higgins. Higgins was Justice of the Peace for the West Riding of Yorkshire, and in today's terms would be described as a "liberal activist". He was influential in exposing the mismanagement at York Lunatic Asylum and in founding the County Asylum at Wakefield. He was also involved in the movements for the abolition of the Corn Laws and the disestablishment of the Irish Church.

of the capitalist means of production, was transformed through their ideological work into institutions which were designed to make more efficient, and hence even more profitable, the exploitation of labour which was one of the bases of the whole system.

In other words, argued Howard, what the criminals of society needed was not exclusion, but rehabilitation, to make them more productive. Howard first noticed the condition of prisons and Houses of Correction in the course of his duties as High Sheriff for Bedford. He was appointed to this position in 1773 and four years later he published his State of the Prisons in England and Wales.[1] This was followed in 1798 with his Account of the Principal Lazarettos in Europe,[2] the result of his extensive research into hospitals for the poor all over the Continent. Howard's works contained not only a detailed account of what he saw, but proposals for model penal institutions based on what he considered to be important in the confinement of those who had broken the law. He made four main proposals for penal reform: (1) the necessity for structurally secure and sanitary buildings in which to house prisoners; (2) subjection of all prisoners to a reformatory programme; (3) transformation of the gaoler from independent profit-maker to salaried servant of a public authority; and (4) systematic inspection by an outside authority.

An aspect of proposals (1) and (2) was the need for an appropriately-shaped building in which the prisoners could most efficiently (that is, with least expense) be reformed. Practically all the writers on penal reform at this time pointed out the dangers of the old mixed gaols in

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1 Reprinted as J. Howard, 1973, vol. 1.

2 Reprinted as J. Howard, 1973, vol. 2. Useful discussions of Howard's ideas appear in S. and B. Webb, 1922, pp. 37ff. and Rosenau, 1970, chap. 4.

which there existed a community of thieves and from which "the novice will depart an adept",[1] as one of them put it. This writer continued,

> This surely is a most unjust, as well as impolitic, mode of treating those, who by a separation from evil companions should be preserved from farther corruption, who should be taught good habits by the discipline of labour, and be admonished by the friendly voice of instruction.[2]

But while the writer here was praising the positive virtues of being a member of society, rather than being permanently excluded from it, we must not let the rhetoric conceal from us exactly what resocialisation was being planned for these deviants from normality.

According to the logic of the reformers, if mixed gaols encouraged crime the prisoners must be separated. Howard was the first in this country to popularise the principle of solitary confinement, a principle that was to be developed far beyond what Howard personally intended. It was also the principle that was to dominate much of the discussion about suitable facilities for the insane. As a direct result of Howard's work, an act was passed in 1779 which stated the principle that

> if many Offenders, convicted of Crimes for which Transportation hath been usually inflicted, were ordered to

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1 Bowen, 1797, p. 9 (see also Aikin, 1792, p. 172; Wedderburn, 1793, p. 13). This sort of remark is very similar to that made by Samuel Tuke and others, criticising the way in which large custodial madhouses socialised their inmates into norms of insane behaviour. As Tuke put it, writing about one such institution he had visited, "In the midst of society, every one seemed in solitude; conversation or amusement was rarely to be observed--employment never. Each individual appeared to be pursuing his own busy cogitations; pacing with restless step from one end of the enclosure to the other, or lolling in slothful apathy upon the benches. It was evident that society could not exist in such a crowd" (S. Tuke, 1815, pp. 14-5).

2 Bowen, op.cit., pp. 9-10. Bowen was the Chaplain to Bridewell Hospital and also to Bethlem, about which he had already written a descriptive account (Bowen, 1784).

> solitary Imprisonment, accompanied by well-regulated Labour, and religious Instruction, it might be the Means, under Providence, not only of deterring others from the Commission of like Crimes, but also of reforming the Individuals, and inuring them to Habits of Industry.[1]

"Well-regulated Labour" which would inure the prisoners to "Habits of Industry", and solitary confinement: two principles so new (in this context) and so strongly believed in that a new term was devised to describe the institution in which they were to be embodied--the Penitentiary.

The principle of work as an instrument of reform was not new, as the discussion on the workhouses has shown, but some of the early reformed gaols carried its practice to new extremes. The House of Correction built at Preston in Lancashire in 1790 was run, as near as possible, on the lines of a cotton-weaving factory, employing 150 men on handlooms and the rest working at tailoring, shoemaking or cotton-picking, and other simple occupations. But almost as soon as institutions like this became operational, there was criticism that they were not indoctrinating their inmates into the right sort of labour. It was an argument that was later to be applied to the lunatic asylums, and it centred around the different conceptions of the end product that were expected from the reformative process. In the minds of many administrators and reformers, a prison which allowed skilled artisans to engage in their trades which, because of the nature of the productive processes, required association of the prisoners; and which would even teach some prisoners a trade: such a prison was not the terrible place it should be. From this point of view the emphasis that some prisons laid on output of production was ill-conceived. Although, argued many reformers, the work done had to be useful, it was the principle that was more important. As one of them

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1 19 Geo III, chap. 74, quoted in Rosenau, 1970, p. 94.

put it,

> neither the absolute value of the work produced, nor the proportion it bears to the maintenance of the workman, is the principle object; the point is, that he should be EMPLOYED; whether more or less usefully, depends on the ingenuity of those who let him to work, and the profit of it is a local concern; but it imports the publick that he should WORK, let the value be ever so trifling.[1]

In other words, what was needed was the inculcation of work habits into the prisoners' very nature so that when they were released they would no longer turn to crime but to the factory for profitable employment.

The other principle that the Penitentiary was to embody, and which was intended to complement that of habits of industry, was solitary confinement. All reformers at that time expressed a commitment to the principle of segregation, but there was a continual debate as to the length of time a prisoner should be kept in isolation. One extreme was that of Philadelphia Prison, founded by the Quakers in 1790. Here the prisoners were kept in their cells 24 hours a day, the aim being, according to the Webbs, "the religious and moral regeneration of the prisoner, which, it was supposed, would be promoted by uninterrupted introspection".[2] This introspection or reflection is the sort of quality we might expect the Quakers to value, given their commitment to each man becoming conscious of his place in a world that was dominated by the moral relationship of man to God. For most prison administrators, confinement to the cells was used as punishment[3] or because separate confinement made the admin-

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1 Wedderburn, 1793, p. 17, emphasis in the original.

2 S. and B. Webb, 1922, p. 116. "Alone in his cell, the convict is handed over to himself; in the silence of his passions and of the world that surrounds him, he descends into his own conscience, he questions it and feels awakening within him the moral feeling that never entirely perishes in the heart of man "(Journal des economistes, 1842, quoted in Foucault, 1977, p. 238).

3 The Webbs give an example of an inmate sentenced to two years' solitary confinement for "uttering seditious words" (S. and B. Webb, op.cit., p. 91).

istration of labour easier, as when individual treadmills were installed in each cell. The lack of association with other prisoners and the constant labour were obviously meant to have some effect on the inmates' minds, but it was intended to be more along the lines of instilling habits of industry rather than of creating in the prisoners' minds a conscious recognition that hard work could lead to social mobility or the attainment of other social values.[1]

In the years following the publication of Howard's State of the Prisons, numerous plans were published and buildings erected in attempts to express these penitentiary principles. Although Howard also produced plans to show what he envisaged as an ideal basis of confinement, he was, as a recent commentator has pointed out, "not remarkable for his architectural vision".[2] His plan for a penitentiary is shown in Figure 4. This plan allowed for work, segregation, and inspection to be enforced on the prisoners, but it hardly did so in the most efficient way. A number of architects and reformers argued that if these were the principles on which the penitentiary was to be based, what was needed was a building that incorporated the maximum of each of these principles within it.

This line of thinking reached its apotheosis in the concept developed and made famous by Jeremy Bentham: the Panopticon.[3] Figure 5 shows

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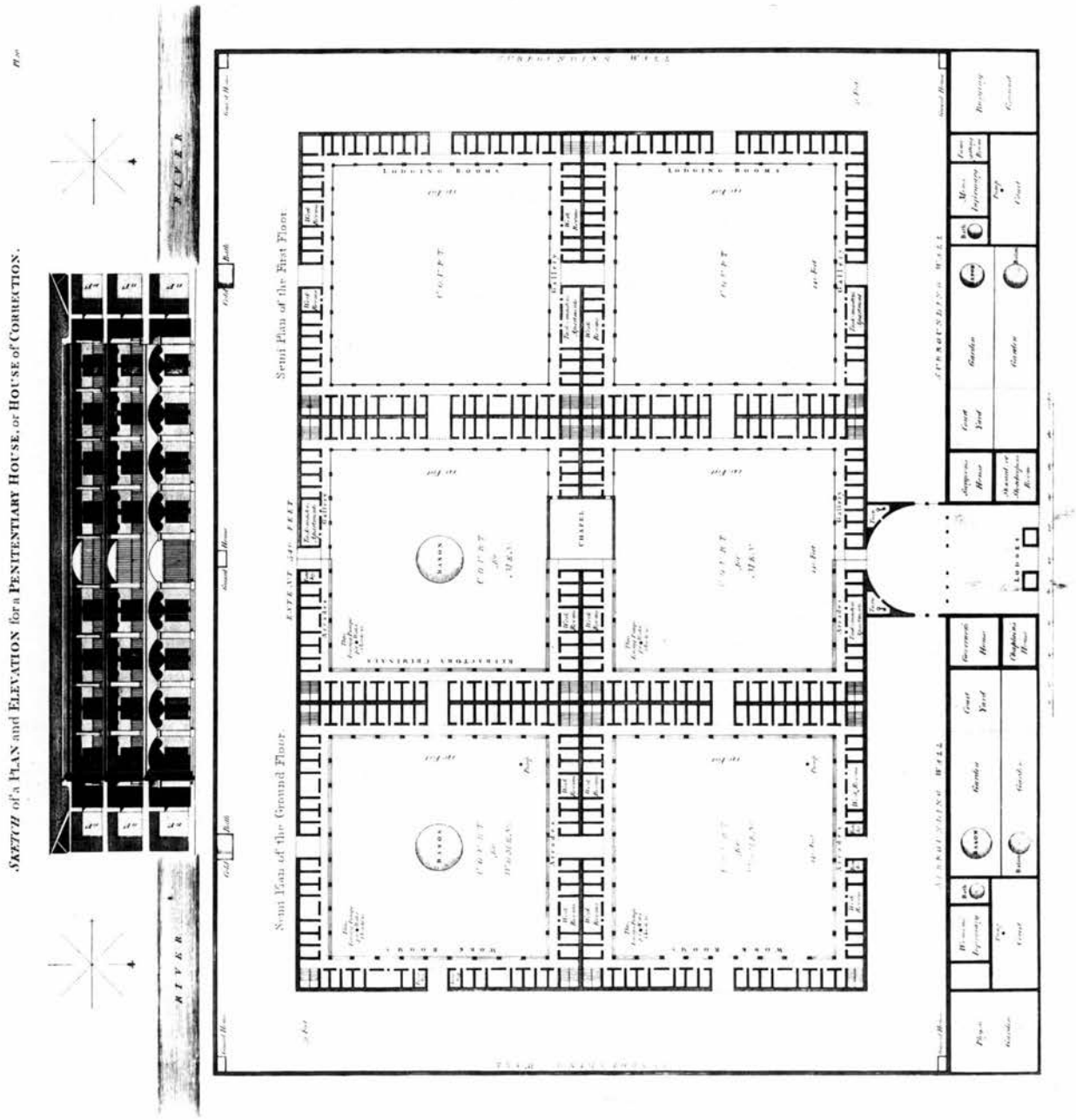
1 There was a long-standing debate between the advocates of the Philadelphia model, in which the ideal was the confrontation of each man with his own conscience (the Quaker "Spirit of God"); and the advocates of the Auburn model, in which the aim was a replication of an ideal world, a "microcosm of a perfect society in which individuals are isolated in their moral existence, but in which they come together in a strict hierarchical framework, with no lateral relation, communication being possible only in a vertical direction" (Foucault, 1977, p. 238).

2 Rosenau, 1970, p. 82.

3 Bentham, 1791. The full title of this work makes clear the meaning of

Figure 4

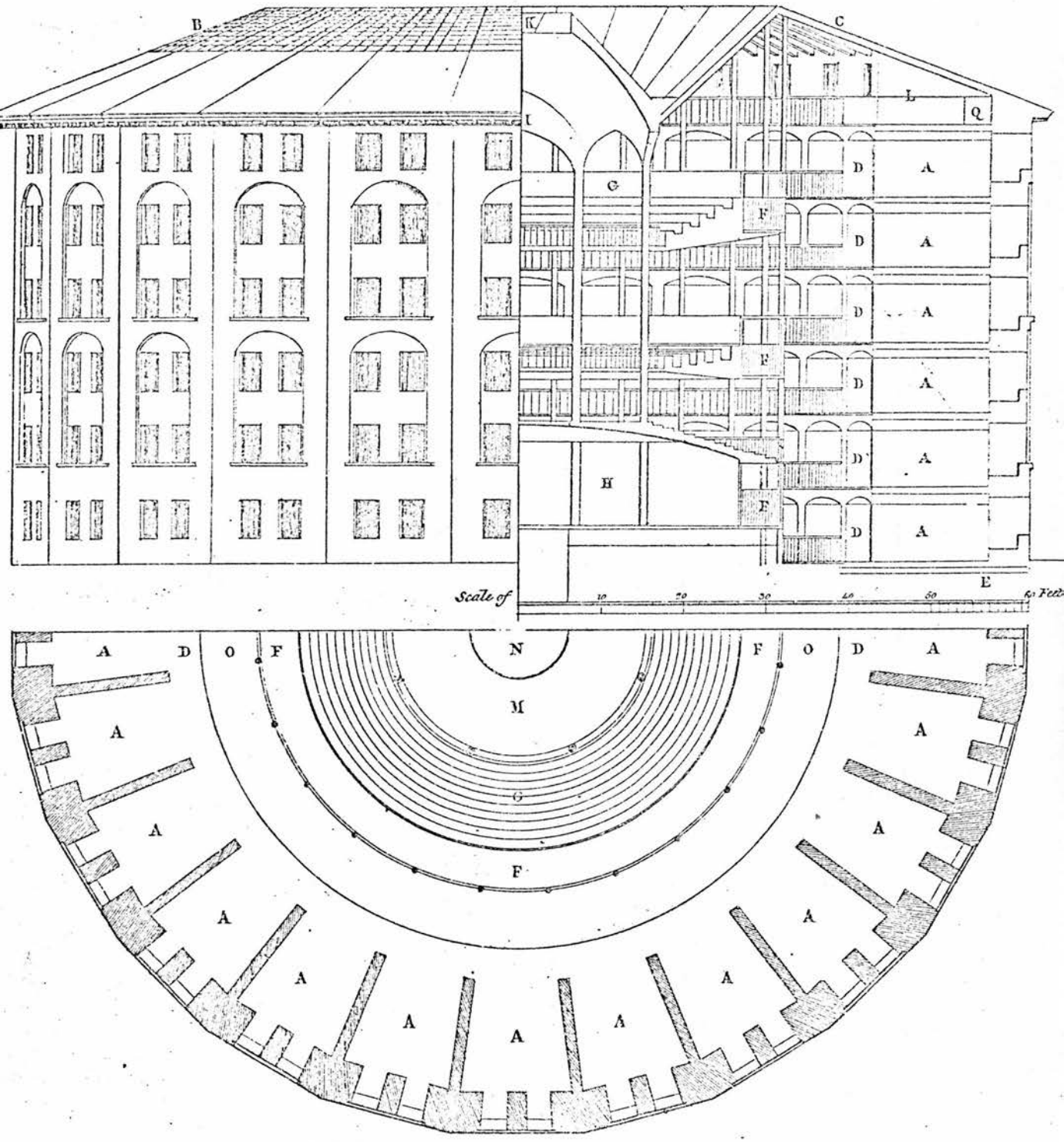
Howard's plan for a penitentiary



Source: Howard, 1973, vol. 1, facing p. 229.

Figure 5

Bentham's design for a Panopticon



"Explanation: A. Cells B to C. Great Annular Sky Light D. Cell Galleries E. Entrance F. Inspection Galleries G. Chapel Gallerics H. Inspector's Lodge I. Dome of the Chapel K. Sky Light to D° L. Store Rooms &c. with their Galleries; immediately within the outer wall all round place for an annular Cistern Q M. Floor of the Chapel N. Circular Opening in d° (open except at Church times), to light the Inspector's Lodge O. Annular Wall from top to bottom, for light, air, and separation."

Source: Bentham, 1843, vol. 4, facing p. 172.

the Panopticon as Bentham conceived it. He meant it as a general plan, to be applied not only to penal institutions, but

> it will be found applicable, I think, without exception to all establishments whatsoever, in which within a space not too large to be covered or commanded by buildings, a number of persons are meant to be kept under inspection. No matter how different, or even opposite the purpose: whether it be, that of punishing the incorrigible, guarding the insane, reforming the vicious, confining the suspected, employing the idle, maintaining the helpless, curing the sick, instructing the willing in any branch of industry, or training the rising race in the path of education. . .[1]

Each inmate was to be confined to his individual cell, there to work, sleep, eat, and reflect on his condition, all under the omnipotent eye of his keeper. It was this latter function that was so distinctive about the Panopticon: it allowed total surveillance of its inmates. In practice, as Bentham and all who accepted this principle realised, to do this would be impossible without a staff numbering nearly as many as those they were watching. The alternative, which was the whole point of the Panopticon, was "to make them not only suspect, but be assured, that whatever they do is known, even though that should not be the case".[2] This would be particularly applicable to the control of lunatics, argued Bentham, in that it would establish an invisible restraint, the

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the unfamiliar term: Panopticon, or The Inspection House. Bentham published a second defence of his ideas on the subject in 1802 (see Bentham, 1843, vol. 4, pp. 174-248).

[1] Bentham, 1791, vol. 1, p. 2, emphasis in the original. Or, as he put it later in the book, "What would you say, if by the gradual adoption and diversified application of this single principle, you should see a new scene of things spread itself over the face of civilised society? - Morals reformed, health preserved, industry invigorated, instruction diffused, public burthens lightened, economy seated as it were upon a rock, the Gordian knot of the Poor-laws not cut but untied--all by a simple idea in architecture?" (ibid., pp. 139-40).

[2] Ibid., p. 137.

gaze of the keeper, which "would render the use of chains and other modes of corporeal sufference as unnecessary in this case as any".[1]

There is a strong echo here of Francis Willis' "piercing eye" which could "read their hearts and divine their thoughts as they formed" in his patients, and which technique he used to control the mad King George III.[2] But the "eye" technique was labour-intensive and was also more appropriate to the individual patron-client relationship that aristocratic patients would expect. For paupers and criminals, the aim was maximum control which at the same time established the subject as one of the many who had to be made conscious of their communal impotence under the authority of the ruling class.

> The essence of it [the Panopticon] consists then, in the centrality of the Inspector's situation, combined with the well known and most effectual contrivances for seeing without being seen.[3]

Through a system of spy holes and strategically placed windows, the confined were to be given the impression of being continually under surveillance. Control was to be established, not through crude mechanical restraint, nor through a reliance on total internalisation, but through something which utilised aspects of both: the suggestion of an authority that, like God himself, could see all and from whom one's only defence was total conformity. The principle was established. Within these rigid and massive structures of order the deviant was to be reclaimed to society,

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1 Bentham, 1791, vol. 1, p. 111.

2 Anon, 1796, p. 764. (See above, p. 68, note 3.)

3 Bentham, op. cit., p. 23, emphasis in the original. As well as the brilliance of fulfilling so many functions which Bentham was always maintaining for his invention, we must not forget his trump card, economy. The Panopticon, argued Bentham, would be cheaper than transportation, cheaper indeed than any method which did not effectively reform its charges. (See Bentham, 1843, vol. 4, p. 174.)

through reflection and through work.

Not everyone agreed with Bentham as to the necessity for prisons to be built entirely on the cellular principle. For one thing, it was expensive; and for another, continual isolation bore no relationship to the social structure of the world to which the prisoner was supposed to be returning. One cogent criticism of Pentonville, built on the Panopticon principle, was that its cells were the equivalent of the lunatics' straitjacket:

> In order to teach the untamed criminal to restrain the violence of his passions, [Pentonville] isolates him from his fellows, and proposes to give him the power of overcoming temptation by removing him out of its reach! Of all questionable means to effect a given end, this seems to me the most questionable. In the name of reason, what discipline can the cell afford to the uneducated? . . . We have lunatics in strait-jackets, very quiet and very harmless, who, if out of them, would be very violent. But is this a good argument for putting all lunatics, without exception, into strait-jackets? The cell is, in fact, the criminal's strait-jacket. It keeps him very quiet and makes him very obedient; but the question nevertheless, remains open--Does it make him a better man? What we want are sound minds, not quiet men in strait-jackets; good citizens, not submissive criminals in silent cells.[1]

Everyone agreed with the principle of segregation. What was needed was a model which could incorporate it along lines which reproduced the structure of society, and not the extreme individualist dreams of Bentham. Bentham reduced all social and psychological values to the production of pleasure and the avoidance of pain, as they were created by individual actions. "The interest of the community then is what? - the sum of the interests of the members who compose it."[2] So, argued Bentham, make the individual members of a community happy[3] and all society will experience

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1 Hepworth Dixon, quoted in D.L. Howard, 1960, pp. 66-7.

2 Bentham, 1843, vol. 1, p. 2.

3 Bentham used the term "happiness" to refer to such disparate achieve-

the same state of happiness. Thus the Panopticon was devised to transform each individual on an individual basis because, for Bentham, society was no more than the sum of its individuals.

Compared to many of his colleagues in the reform movement, Bentham was ahead of his time. He was a truly bourgeois ideologist who saw all social relations in terms of a simple profit-and-loss account, such as a small shopkeeper might use. He attempted to transform deviance within the logic of purely bourgeois values. But many of the people associated with penal and lunacy reform, and especially the magistracy and representatives of the Church, were committed more to traditional values. According to them, the planning of institutions for the reformation of deviants should be made subordinate to the reproduction of the correct relationship between classes, specifically that between the "lower" classes and their "betters".[1]

It was pressure from these quarters, notably from Sir G.O. Paul and the Reverend J.T. Becher, that led to the Panopticon not being recommended by the 1811 Select Committee on Penitentiaries. They favoured a model which still allowed for inspection, segregation, and employment,

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ments as "advantage", "good", "benefit", and "pleasure" (see Bentham, 1843, vol. 1, p. 2). This idiosyncratic usage must be kept in mind when reading such phrases as the following, in which he extolled the virtues of the Panopticon: "Would happiness be most likely to be increased or diminished by this discipline? - Call them soldiers, call them monks, call them machines, so long they were but happy ones, I should not care" (Bentham, 1791, vol. 1, p. 128).

[1] In many ways my analysis here parallels that of Foucault in his Discipline and Punish (Foucault, 1977, especially part 3), which appeared after I had completed the draft of this thesis. As Foucault points out, the opposition between the advocates of alternative models of reform was based on many arguments--economic, religious, administrative, and medical, "But at the heart of the debate, and making it possible, was this primary objective of carceral action: coercive individualisation, by the termination of any relation that is not supervised by authority or arranged according to hierarchy" (ibid., p. 239).

but within structures of order that did not reduce all inmates to an identical atomistic status. In place of the totally impersonal and battery type of accommodation that the Panopticon entailed, the 1811 Select Committee decided to recommend reformative institutions that relied on some degree of segregation, but which also allowed resocialisation within groups that bore a resemblance to the outside world as the Committee saw it. They looked favourably on the House of Correction at Southwell on the grounds that

> It is there supposed that the vigilance of those who have the care of the prisoners will be able to prevent any mischief that might result from the communication of a few individuals with each other; and that in the small circle in which the offender is allowed to move, he may be expected under proper management to form habits of industry and self-restraint, which he will be likely to practise on his return to society.[1]

This ideal, based primarily on the Auburn model of penal reform, was expressed in the plans for Ipswich Gaol and in the plan for a penitentiary that Sir John Soane drew up.[2] It was also expressed in the plan for the proposed London Asylum (Figure 3). As can be seen from that plan, in the centre are the representatives of order, who would patrol the inspection galleries, inspecting the day rooms where homogeneous groups of inmates would congregate. At night the patients would return to their single cells. The totally insensible or "noisy" patients, those on whom order had proved to be redundant, were relegated to the furthest reaches of the asylum. For them confinement only was required.

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1 1811 SC, 1st Report, p. 20. This Report contains evidence by Bentham, Becher (a founder of Nottingham Asylum), and Paul (a founder of Gloucester Asylum) showing the various arguments presented for and against the Panopticon design. The Panopticon principle did experience a revival of interest in the 1820s. (See Society for the Improvement of Prison Discipline, 1826.)

2 Illustrated in Rosenau, 1970, pp. 84-5.

Here, apparently, was the model that had been looked for throughout the eighteenth century, and that neither the workhouse nor the specialist hospitals had been able to provide. At last deviance of all kinds was to be abolished, to be made to wither under the penetrating gaze of authority. This was an authority which now had the self-confidence to confront its deviants rather than to transport them to distant countries or to herd them unclassified into centres purely for confinement; but it was also an authority which realised that the cosy family control of institutions like the Retreat could hardly work with the majority of those who did not conform. Internalisation of control was still the long-term aim, but the type and methods of control had to be made appropriate to those who needed it. Segregation, inspection, employment: three principles by which deviance was to be coerced back to normality; three principles which did not originate with the penal reform movement but which were developed by that movement into specific practices which could be used by others interested in deviance control.

As already stated, the London Asylum was not built, but others on the same model were, and in them can be seen the same structure of order. One of these was the Glasgow Asylum. According to H.G. Bennet, a member of the 1816 Select Committee on madhouses, "I have no hesitation in saying this is the best Lunatic Asylum I have ever seen". The reason, he concluded, was that

> its principle merit consists in the great classification of the patients, and in the separating them into small families, there being a great number of galleries, and only seven or eight cells in each gallery, with a common room belonging to each, with a window at the end commanding a lawn, with a very gay and chearful prospect.[1]

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[1] 1816 SC, 3rd Report, p. 7. That Glasgow Asylum was the best in Britain was a sentiment reiterated by the Edinburgh Review (Fitton, 1817, p. 460).

Figure 6 shows the plan of Glasgow Asylum as drawn by its architect, William Stark. As can be seen, classification was effected not only by state of illness or convalescence, but by sex and "rank". In other words, 16 different sections were needed to encompass all the different classifications. A three-storey building was erected (Figure 7) and was divided for use according to the principles laid out in Table 4.

Stark aknowledged the value of having been able to communicate with John Ferriar, physician at Manchester Lunatic Hospital, whose own attempts at management had been hampered by the physical shape of his building. Ferriar, it will be remembered, was one of the first amongst the medical profession to state what the penal reformers were beginning to realise with lawbreakers. As Ferriar, writing of the insane, put it,

> in the cure of diseases of this nature, the patient must "minister" to himself; medicine may restore him more early and more completely to the command of his intellectual operations; discipline must direct him in their exertion.[1]

This recognition must be seen as a progressive move because it exchanged an absolutist punishment, which saw deviance purely as a symbol of moral disorder, with an attempt to communicate with deviance on naturalistic terms. Deviants were merely human, like everyone else: therefore, argued the reformers, they must be subjected to the same processes of social control as everyone else. Although as far as Stark's own model of an ideal asylum was concerned, it must be said that in attempting to replicate what he saw as the natural divisions of society, he let the principle of classification blind him to the realities of administering an institution. Samuel Tuke, for one, criticised Stark's design on the grounds that he overdid the degree of classification. According to Tuke, Stark's plan was based too much on

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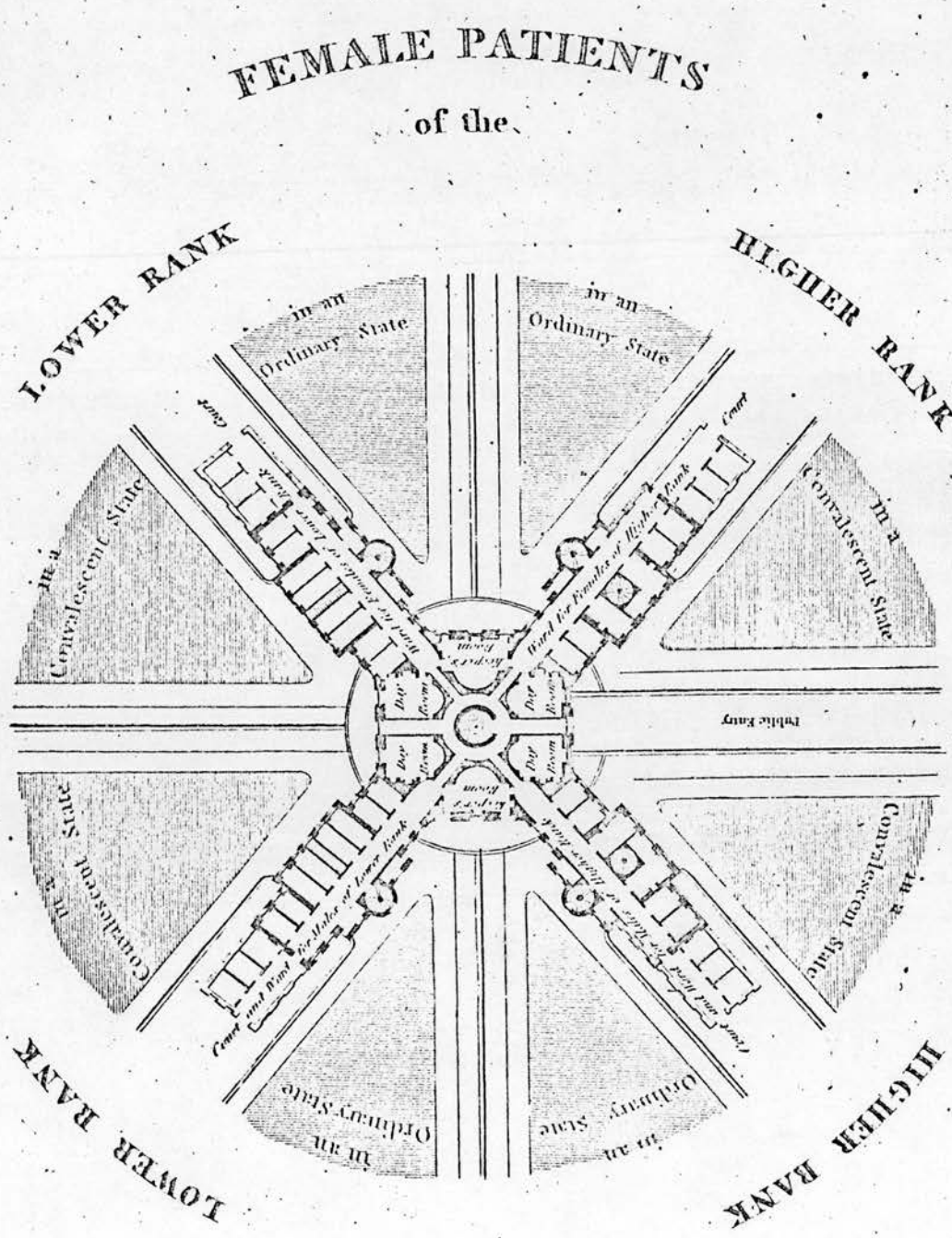
1 Ferriar, 1792-1798, vol. 2, p. 112.

Figure 6

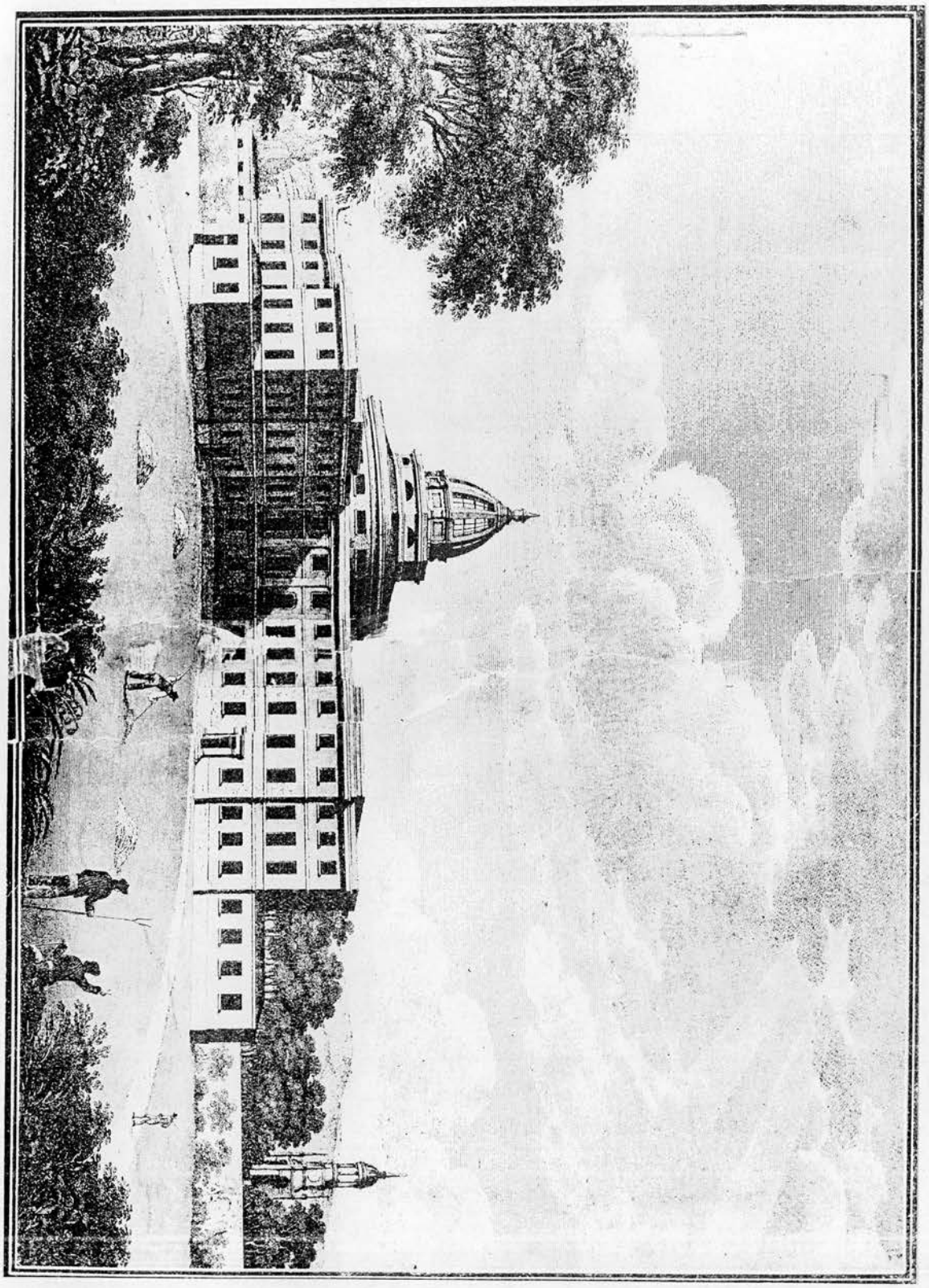
Plan of Glasgow Asylum



Source: Stark, 1807.

Figure 7

Elevation of Glasgow Asylum



Source: Glasgow Herald, 19th December, 1914.

Table 4

"General View of the Plan of Classification, and of the Distribution of Classes in the

GLASGOW LUNATIC ASYLUM[1]

MALE PATIENTS	of the Higher Rank.	Frantic,.....Ground story--remote ward	of the Front Wing,	Right Hand.
		Incurable,.....Ditto, nearest the centre		
		Convalescent,.....Principal story.....		
		In an ordinary state,..Second story.....		
	of the Lower Rank.	Frantic,.....Ground story, remote ward	of the Back Wing,	
		Incurable,.....Ditto, nearest the centre		
		Convalescent,.....Principal story.....		
		In an ordinary state,..Second story.....		
FEMALE PATIENTS	of the Higher Rank.	Frantic,.....Ground story--remote ward	of the Front Wing,	Left Hand."
		Incurable,.....Ditto, nearest the centre		
		Convalescent,.....Principal story.....		
		In an ordinary state,..Second story.....		
	of the Lower Rank.	Frantic,.....Ground story, remote ward	of the Back Wing,	
		Incurable,.....Ditto, nearest the centre		
		Convalescent,.....Principal story.....		
		In an ordinary state,..Second story.....		

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[1] Reproduced from Stark, 1807. (Built for a maximum of 120 patients, ten patients per wing, four wings per storey on three storeys.)

prison design. It did not allow sufficiently for the "facility of interchange"[1] which lunatics required but prisoners did not. As Table 4 shows, some classifications (for example, the male higher-rank frantic) had an allocation of only about five beds out of 120. This might have reflected an ideal conception of the world held by Stark, and it certainly made for a beautifully symmetrical architectural design. But it was extremely impractical and can never have been adhered to except in the early years when the asylum was less than half full.[2]

Although Stark's design was undoubtedly an extreme one, the principle of classification based on the patients' discipline or conformity to norms of correct behaviour was accepted by all as correct.[3] When Tuke was able to exert some of his own influence on asylum design, he put forward suggestions that owed much to Stark's model.

At the end of 1814 advertisements began to appear in the Wakefield and Halifax Journal and other newspapers, inviting designs for a public lunatic asylum to be built at Wakefield.[4] A first prize of one hundred guineas was offered. James Bevans, the architect of the proposed London Asylum, submitted plans, as well as extensive details of his design, to the 1815 Select Committee.[5] But Bevans was only one of 40 entrants, and the winners of the competition were to be Watson and Pritchett of York,

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1 S. Tuke, 1815, p. 24.

2 According to evidence given to the 1816 SC, there were only 56 patients in the asylum at that time (3rd Report, pp. 7-8).

3 A fuller discussion of the role of classification in moral treatment appears below, in Chapter Four.

4 Broadbent, 1956.

5 See 1815 SC, 3rd Report, pp. 160-1.

friends of Samuel Tuke, who had based their design on his suggestions.[1]

Building was begun in February 1816, and the asylum opened in November 1818. It was built, on Tuke's recommendation, for 150 patients, 75 of each sex. Figures 8 and 9 show, respectively, the plans of the ground and first floors of the asylum as it was built. Tuke favoured the "H" shaped design as it allowed for the maximum separation of male and female patients, as at Glasgow; but unlike Glasgow, allowed more mixing of the patients under suitable supervision.[2] "Supervision" was still the operative word. Tuke criticised the Panopticon design as not allowing sufficient supervision or surveillance, not of the inmates but of the staff themselves. Like Bentham, Tuke agreed that inspection was the major principle of care. Everything had to be made subordinate to inspection of the patients. In designing an asylum, argued Tuke, whatever the other principles to be taken into account,

> some sacrifice in regard to easy inspection, an object to which even cheerfulness is but secondary, must probably be made.[3]

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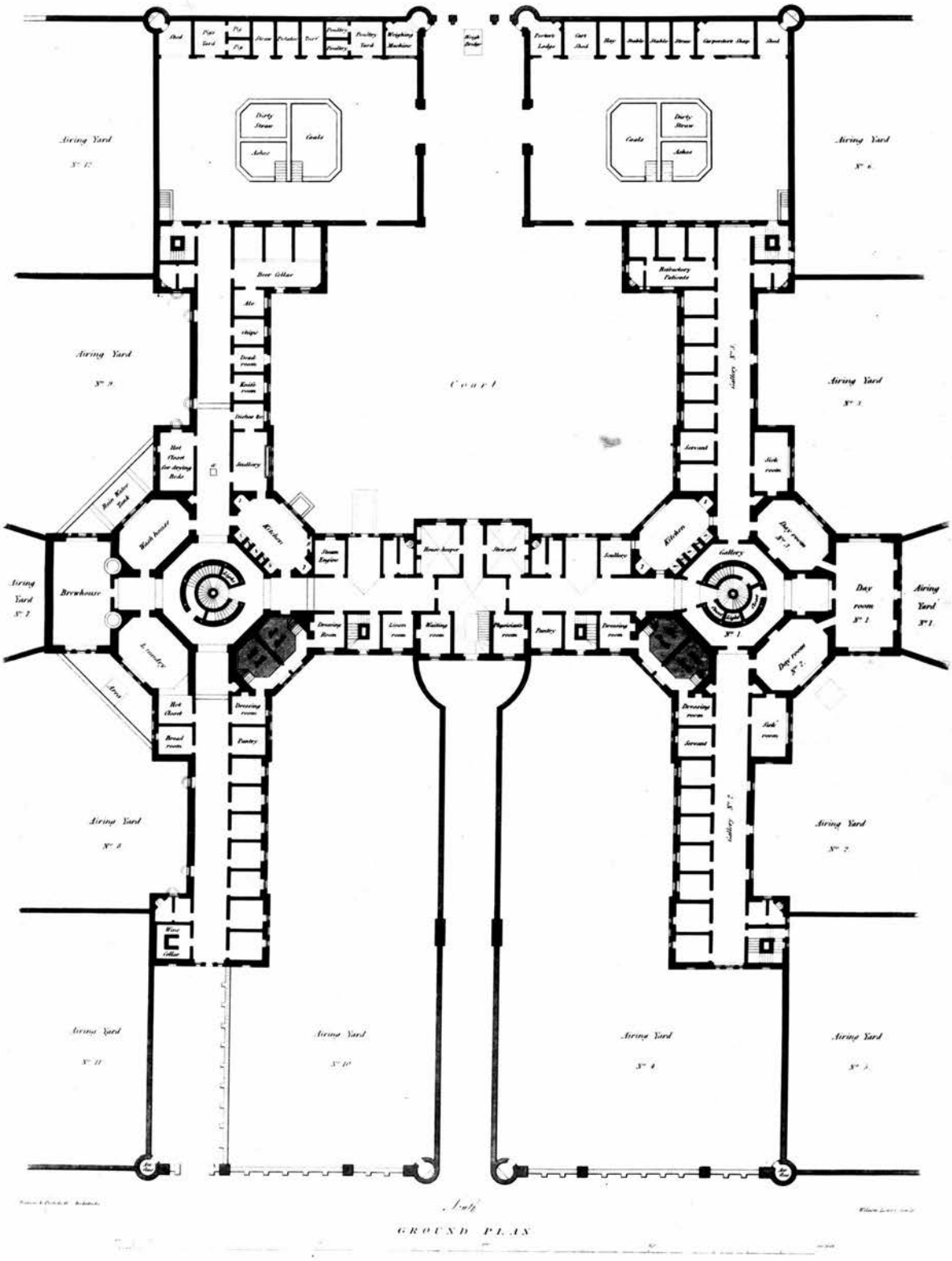
1 S. Tuke, 1815, 1819; Watson and Pritchett, 1819.

2 Note that the category of patients consigned to the most distant cells are no longer described by the medical category of "frantic" as at Glasgow Asylum, but under the reformatory category of "refractory", that is, "stubborn" or "unmanageable" (OED).

3 S. Tuke, 1815, p. 40. Bevan's unsuccessful design also accepted the necessity for inspection or, as he put it, "With regard to Inspection, the object is one of such importance, that of itself it would have been sufficient to have induced me to have placed all the Patients as nearly as possible on one floor" 1815 SC, 3rd Report, p. 162). Bevan did incorporate the principle of inspection into his design by providing "sash-doors" so that the Superintendent and Matron could see the patient without themselves being seen. This was apparently not recognised as being as efficient a method of surveillance as that submitted by the winners of the competition.

Figure 8

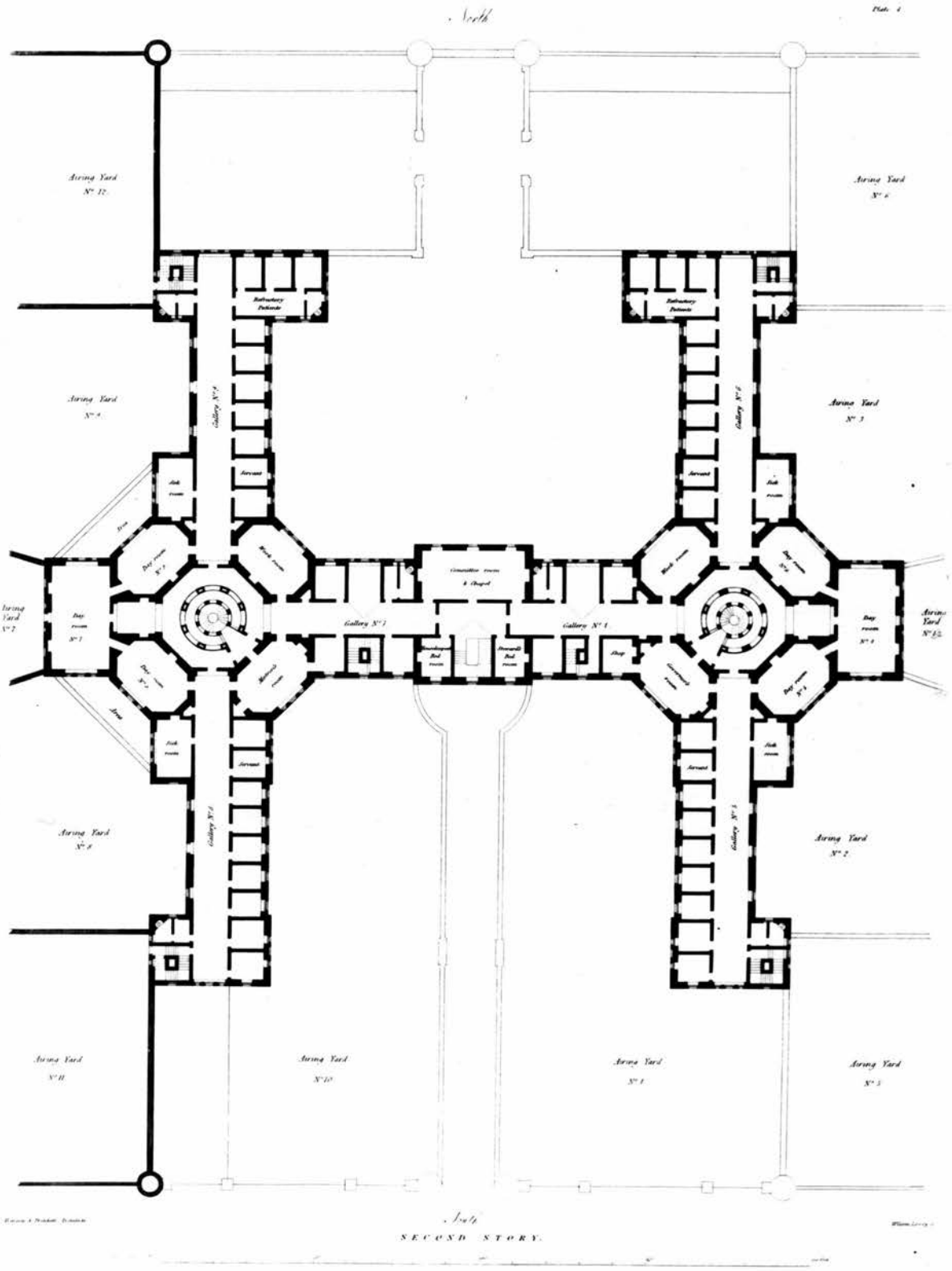
Plan of ground floor, Wakefield Asylum



Source: Watson and Pritchett, 1819, plate 3.

Figure 9

Plan of first floor, Wakefield Asylum



Source: Watson and Pritchett, 1819, plate 4.

Out of this principle of inspection Tuke proposed the first step to an institutionalised bureaucracy of control:

> The regulations of an Asylum should establish a species of espionage, terminating in the public: this cannot be effected in an ill constructed building. One servant and one officer should be so placed as to watch over another. All should be vigilantly observed by well selected and interested visiters; and these should be stimulated to attention, by the greatest facilities being afforded to persons who, from motives of rational, not idle, curiosity, are desirous of inspecting such establishments.[1]

Some idea of how this principle of espionage was built into the physical fabric of Wakefield Asylum can be seen from Figures 10, 11, and 12. Figure 10, as its label indicates, shows a section through a staircase (of a plan of the asylum). Figures 11 and 12 show more clearly the actual spyhole through which the "espionage" was to take place, and which was in existence until the 1950s. These stairwells were made accessible only to staff. The senior staff would be able to look from the top platform at the keepers, who would in turn be inspecting the patients in the day rooms. And at night, or whenever the keepers were patrolling the galleries, the superintendent could check the keepers' progress through the spyholes to the galleries.

Here was a vision far removed from the comparative disorder of the Retreat; but at that institution all were agreed on their place in the social and natural order as defined by God.[2] In the pauper asylum the

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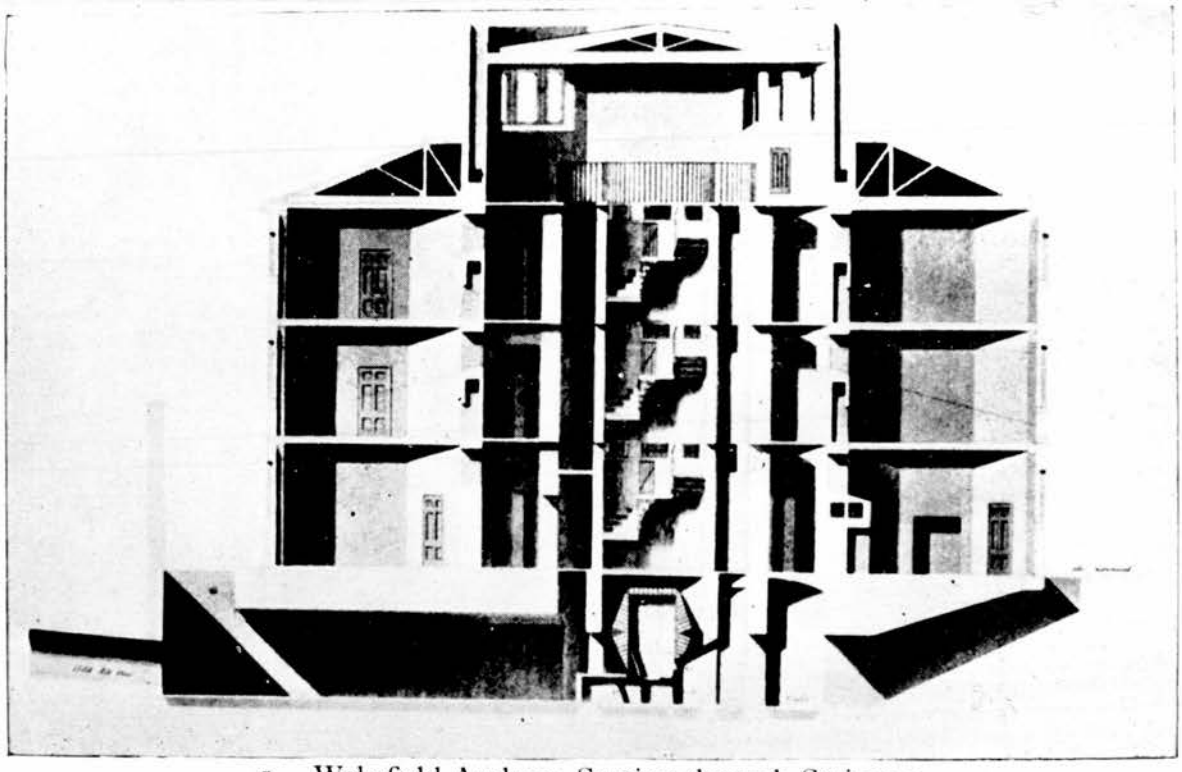
1 S. Tuke, 1815, p. 28, emphasis in the original. For a recent commentary on this principle, see Foucault, 1977, pp. 170-7.

2 Samuel Tuke did acknowledge that the Retreat was not architecturally perfect as an asylum (see Description, pp. 104-7), but unfortunately he left no precise details as to how he would have liked to see the Retreat improved, except to state that he would have liked more window space in some "rather gloomy" rooms. More interesting is the fact that Tuke put a lot of effort into trying to prevent national statutory inspection of asylums being extended to private institutions like the Retreat. In an "Observations" on a Bill of 1814, Tuke accepted the need for "independent

Figure 10

Section through staircase, Wakefield Asylum



5. Wakefield Asylum: Section through Staircase.

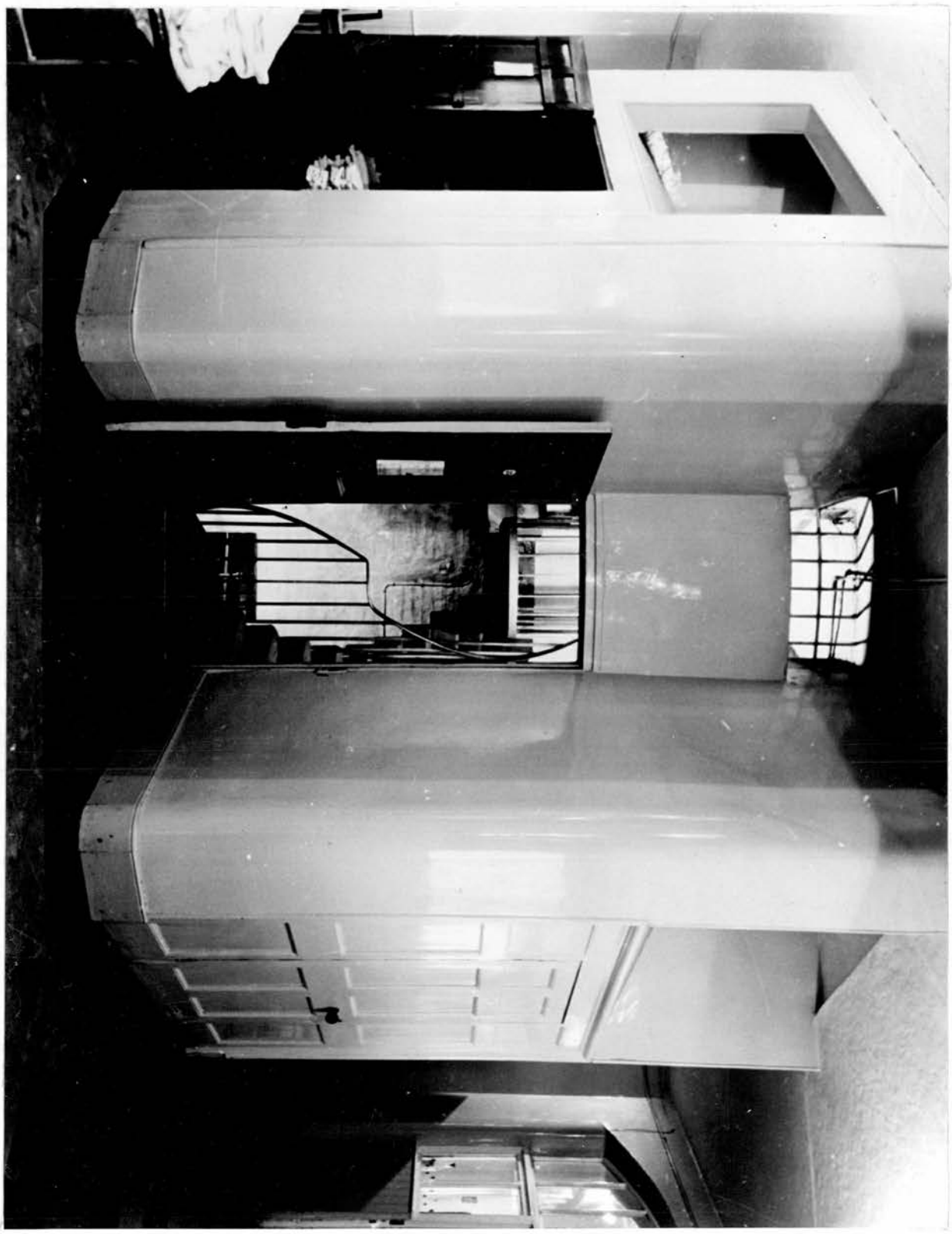
Source: Broadbent, 1956, facing p. 107.

Figure 11

Spyhole through staircase, Wakefield Asylum

Figure 12

Spyhole from ward, Wakefield Asylum



order had to be established in bricks and mortar. This principle of surveillance or espionage, which Pinel had come to see as the most important aspect of "traitement moral", was now in Britain the dominant theme on which progressive asylum architecture was based. Within the spaces formed by this new physical structure of order, the practice of moral treatment continued its emergence into the world.

In terms of the history of moral treatment, the architectural principle of espionage or surveillance can hardly be said to mark an advance on moral treatment as it was practised at the Retreat. It was, after all, the primary aim of moral treatment there to provide "means [by which] the power of the patient to control his disorder, is strengthened and assisted".[1] Self-restraint, in other words, rather than the harsh coercive restraint of chains and whips. From that standpoint, the emphasis on constantly watching the inmates of an asylum was a retrograde step; it seemed to admit that for many self-restraint could never be achieved, that it remained an ideal but one that had to be reinforced by the invisible restraints of surveillance. This type of approach may have been partly due to the influence of the penal reform movement (specifically the Auburn model of reform), and it may have been partly due to the conservatism of reformers like Samuel Tuke who never really trusted the ability of the (non-Quaker) members of the working class to

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public visitors" of lunatic asylums but maintained that the introduction of National Commissioners to inspect all asylums "would tend to diminish the interest of the local Committees now entrusted with their management, and repress, rather than stimulate, the right zeal and energy of their principle officers" (S. Tuke, [1814a], p. 1). See also S. Tuke, [1814b], for a similar statement, this time within the stronger format of a petition to the House of Commons.

1 Description, p. 138.

control themselves. As will be seen, this attitude diminished in strength when a new generation of reformers emerged.

Before moving on to another fragment of moral treatment, a word should be said about one idea dominating all discussion on asylum architecture: economy. A member of the 1816 Select Committee had commented on what he saw as a defect of the otherwise excellent design of Glasgow Asylum:

> I feel it, however, necessary to add, that for general adoption I should think the external decoration of the building much too costly, as undoubtedly the architect who built it had in view no less the convenience of the unhappy maniacs confined in it, than the ornament of the great capital of the western part of Scotland.[1]

As can be seen from Figure 7, the building is impressive, but hardly in the grand manner of Bethlem (Figure 2). A further distinction which Bennet did not mention was that Glasgow Asylum, like the English subscription hospitals and like Nottingham and Stafford County Asylums, was not built solely for paupers. The patients of "higher rank" at Glasgow paid from 15 shillings to £1.11s.6d. per week, whereas the paupers were paid for by their parishes at the rate of eight shillings to 10s.6d. per week.

Stark, like Robert Owen, saw no contradiction in trying to establish a moral community in which rich and poor were to share at least the same building. The only necessity was that the rich should not be <u>physically</u> mixed with the lower classes. As Stark pointed out, writing of mixed madhouses,

> In such abodes persons of liberal education, and of respectable rank in society, are unavoidably mixed with those of lowest rank, of the most brutal manners, and of the most profligate habits; almost every possible state of the disease, is, in like manner, exhibited in the same ward, as if mental derangement, like the hand of death, levelled all

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1 H.G. Bennet, 1816 SC, 3rd <u>Report</u>, p. 8.

distinctions.[1]

But even to mix the classes to the extent of confining them within the same building was too much for Tuke and most of the English reformers. It might work for Scotland, where an organic paternalism still seemed to hold the "ranks" of society together in a symbiotic relationship;[2] but in England by this time most reformers were beginning to acknowledge the class basis of society. The point has already been made that moral paternalism did not disappear with the rise to political and economic power of the manufacturing class. What is noteworthy from the point of view of the self-image of that class is that it has, in spite of its material dominance, remained ideologically content to see itself as a "middle" class. An aspect of this is that the moralistic attentions of the middle class have seldom been directed "upwards". Samuel Tuke maintained, in relation to the insane rich, that

> It is not very likely that County Asylums will ever be made acceptable to the highest class of society. . . .I am inclined to think, that in regard to the most wealthy class of insane persons, all that can be done for them is, through legislative means, to provide for the careful and efficient inspection of the establishments appropriated to their use.[3]

What these "highest class establishments" were like will be examined below.[4] But at Wakefield, in an asylum built solely for paupers, everything was made subordinate to the strongest possible commitment to economy. As the architects themselves pointed out,

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1 Stark, 1807, p. 10.

2 This point is made by J.F.C. Harrison (1969) in relation to Robert Owen's ambiguous attitude to the 1834 Poor Law.

3 S. Tuke, 1841, p. xiv. Even today, the Retreat remains a select private asylum for those who wish to locate themselves outside the ideological hegemony of the Welfare State.

4 See pp. 247ff.

> No attempt has been made in these elevations at architectural display. Neither magistrates nor architects forgot that this was a Pauper Lunatic Asylum. . . .Even the cornice is not solely for ornament, gutters for the water being hollowed out of it.[1]

This was an aspect of the construction of this asylum that Tuke himself was very conscious of: that its capital cost was to come from a County rate, and therefore it should cost no more than the absolute minimum required to produce its effect.

This was a perfectly realistic consideration: it was always a complaint of asylum administrators that the Overseers of the Poor were reluctant to release their insane charges from the workhouses as long as the asylums were more expensive. At Wakefield, for instance, in spite of all the attempts to reduce costs, the rate of maintenance charged to Overseers was initially 10s.6d. per week, or over three times the cost of keeping a pauper in a workhouse.[2] To justify this expense, the asylums had to proclaim loudly their added advantages over other forms of confinement. To remove from public view the offensive spectacle of undisciplined behaviour was certainly one function of the asylums; more important, though, was their commitment to rehabilitation, their proclaimed ability to return useful members of society to active functioning. This is why the architecture of the asylum was so important--it had to incorporate not only a means of inspection, but also a system whereby the reformative process could most efficiently be put into action.

The ideal model for the reformation of deviants was thus slowly taking shape. On the one hand was the paternalistic attempt to create

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1 Watson and Pritchett, 1819, p. 30.

2 Personal communication from Mr A.L. Ashworth, Archivist at the Stanley Royd Hospital in Wakefield. On the continuing imbalance between asylum and workhouse charges see K. Jones, 1972, pp. 129-30.

a moral community, non-punitive, yet almost totalitarian in its implications. And on the other stood the model of the prisons and the physical constraints that could be brought to the aid of inculcating the right habits. There is one further theme which runs through both these approaches, which was common to all reformative ideologies of the time, and which was one of the core features of moral treatment. This is the incorporation of productive work into therapeutic programmes, an incorporation which was seen as so vital to the whole enterprise that it might justly be said to be the glue which held the whole edifice together.

3. The Imperative to Work

Scattered throughout all the pronouncements on the aims of therapy examined up to now have been repeated references to the value of work, and to the general need to create "habits of industry" in all paupers. The Edinburgh Review summed up the prevailing attitude in 1817:

> For the lower classes, laborious occupation is the best form of exercise, and is well described by the master of St Luke's [Lunatic Hospital] "as the best doctor they have".[1]

The principle was clear but, before examining the precise meaning of this ideological proclamation, it is worth asking to what extent "laborious occupation" was actually engaged upon in the early asylums. Did it remain an ideology, or were any creative attempts made to reproduce the working part of patients' lives in the asylum?

As was made clear in Chapter Two, Samuel Tuke was convinced of the centrality of work in the treatment of the insane. He never lost his belief that, as he put it,

> Of all the modes by which patients may be induced to restrain themselves, regular employment is perhaps the most generally efficacious.[2]

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1 Fitton, 1817, p. 453.

2 Description, p. 156.

In his instructions to the architects of the West Riding of York Asylum at Wakefield, Tuke insisted that "A work room, where from 20 to 30 patients may be employed in weaving &.c. must be provided".[1] As was usual with Tuke, the reason he put forward for this was one based on custom and not on commitment to a theory. In his words,

> It has, as may be supposed, been found most easy to induce the patient to engage in pursuits, to which he has been previously accustomed; and it is probable, that a considerable proportion of the West-Riding pauper patients, will have been engaged in weaving.[2]

Tuke's commitment to incorporating work into the daily life at the Wakefield Asylum was also stated by the asylum's first superintendent, William Ellis, in 1815. Ellis had been working in a private madhouse in Hull. The high cure rate that the house had achieved was attributed by Ellis almost entirely to the patients' "being kept almost constantly employed in the gardens".[3] The types of work recommended by Ellis were, as with Tuke's suggestions, dependent on the patients' own past experiences.

> As a general rule, work of all kinds in the open air, when the weather will permit; in the house, for mechanics in the various kinds of handycraft business, with which they are acquainted, as they will turn their attention more readily to what they know, than to that of which they are ignorant, because it requires much less exertion, and the mind being in a state of debility is easily fatigued.[4]

When he took up the post of superintendent at Wakefield, Ellis lost no

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1 "Instructions drawn up by Mr Samuel Tuke for the Architects who prepared designs for the West-Riding Asylum" in Watson and Pritchett, 1819, p. 2. Tuke's "Instructions" were incorporated into the official requirements for the plans of the asylum, as can be seen from the Competition requirements given in the 1815 SC, 3rd Report, pp. 160-1.

2 S. Tuke, 1815, p. 43.

3 W.C. Ellis, 1815, p. 23.

4 Ibid., pp. 11-12.

time in putting his beliefs into practice. From the beginning, all the manual work was done by the patients. No aspect of asylum life was exempt, from the brewing of the asylum beer to the gardening and engineering tasks that had to be done. The head of each department--kitchen, garden, etc.--was a member of staff, but beyond that all the asylum work was done by the patients. Here indeed was a glue by which the moral community of the asylum could really be held together.

A year after the asylum was opened, Ellis was able to announce that

> Within doors, as far as is possible, every patient is regularly set to work, and in time, it is probable, that the principle part of the clothing for the Patients will be manufactured in the Asylum.[1]

The following year self-sufficiency had almost been achieved, as Ellis was able to report at the end of 1820:

> The employment in some way or other, of every Patient capable of it has been constantly persevered in, during the year and this has been attended with the best effects. Almost the whole of the clothing has been manufactured by the persons under confinement. All the shoes and the clothes, both for the males and the females have been entirely made by the patients.[2]

This was with an asylum population of 125, but the employment did not cease as the asylum got larger. In 1833, when its population was over 250, and when Ellis had been two years out of office, the new director was able to report that

> A considerable reduction has been made in the expense of clothing the patients, by the profits arising from the sale of cloth made by them.[3]

Similar profits were reported by Ellis at Hanwell where he was superintendent from 1831 to 1838. In 1834 when the asylum there was at bursting

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1 West Riding of Yorkshire Pauper Lunatic Asylum, Annual Report, 1819.

2 Ibid., Annual Report, 1820.

3 Ibid., Annual Report, 1833.

point with 558 patients, he was able to announce that the average number of patients employed at any one time was 320. These patients were not only the recently invalided, but included many who must have spent years confined in workhouse or madhouse cells. Ellis attempted to find employment for all. In 1836, he wrote how

> Within the year, a species of employment has also been discovered for the imbecile, and even the mischievous Patient. It is that of picking in pieces the fibres of the outer husk of the Cocoa-nut, which is becoming generally used for the same purpose as horse-hair. Six pounds ten shillings a ton is received for the work; and the employment saves more than the sum paid for the labour in keeping the Patients from destroying their clothes, and it also renders personal confinement less necessary.[1]

The enormous extent of this change of attitude towards the insane can hardly be overemphasized.[2] When Wakefield Asylum was first opened, detractors of Ellis' plans had argued that no patient should be allowed to work in the asylum grounds unless chained to a keeper. It was also proposed

> that a corner of the garden should be allotted for their labour, and that they should dig it over and over again all the year round.[3]

This attitude was one that still considered the insane as a category different from normal people. On the contrary, argued Ellis,

> One great error in dealing with the insane is in treating them as if they were differently constituted from the sane.[4]

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1 Quoted in Hunter and Macalpine's introduction to Conolly, 1968, p. 18.

2 Ellis' contribution was certainly recognised by Samuel Tuke. Later in his life Tuke honoured the memory of William Ellis because "to him we are indebted for the first extensive and successful experiment to introduce labour systematically into our public asylums" (S. Tuke, 1841, p. xxvii).

3 W.C. Ellis, 1838, p. 8.

4 Quoted in [H.W. Ellis,] 1868, p. 60.

This is of course the argument implicit in all moral treatment: that the insane, given the opportunity, can develop their capabilities just like anybody else. What was distinctive about Wakefield Asylum was that the precept was put into practice there more rigorously than at any other asylum. But, while it was one of the earliest and most extensive examples of industrial therapy, it was by no means the only one in existence at this time. At Glasgow, that other asylum of which Samuel Tuke and the Edinburgh Review spoke so highly,

> Every encouragement. . .is given to the exertions of industry, because nothing contributes so much to promote a cure, and prevent a relapse.[1]

Glasgow Asylum was opened in December 1814, and two years later had two looms installed plus a number of spinning wheels. As the asylum had been built close to the centre of the city and at a time when the city was growing fast, it was not able to engage its patients in agriculture, as were the more rural asylums. But large amounts of stone-breaking were done for the new building taking place in Glasgow, as well as rope-making for the ships that used the Glasgow docks.

W.A.F. Browne was another enthusiast of the value of work, and his comments on the subject are perhaps the most imaginative of all the moral therapists'. As he showed in his What Asylums are. . ., he was well aware of the healing effect of taking part in normal purposive activity. Here, for instance, are his comments on the value of work:

> If a man, who imagines himself an outcast from society, the object of contempt and scorn, be placed at a loom, and induced to produce ten or fifteen yards of cloth per day, it is quite clear, that during the execution of his task, if it be done well, he is forced to exert his whole attention and no little ingenuity and manual dexterity upon the management of the shuttle, bean, & c., that while his mind is so directed, it cannot be under the dominion of morbid sorrows. . .[2]

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1 Glasgow Lunatic Asylum, Annual Report, 1817, p. 9.

2 Browne, 1837, pp. 93-4.

Browne did not only present this as a theoretical principle. As he pointed out, productive labour had been engaged in for years at Montrose Asylum:

> Weavers, shoemakers, tailors, gardeners, carpenters, watch-makers, have all been tried for years, and found to work as diligently, and to produce as good articles when confined as when at liberty.[1]

Other writers had already pointed out the value of letting the patients practice the crafts and trades at which they were already competent. Browne went one step further and asked, in relation to laying turf, masonry, and other tasks, why "should not lunatics be taught to do these and many other things"?[2] The essential thing to keep in mind, argued Browne, was that the patient could see the point of the work he or she was given to do. In work

> which is evidently prescribed as an occupation, and of no utility either to himself or others, his pride is offended . . .and the moral effect is lost.[3]

This may appear a truism to us, but the realisation by physicians and reformers of the value of this principle was not the same thing as the acceptance by the patients that work was good for them. As William Drury, the superintendent at Glasgow Asylum, remarked,

> several of the Patients refuse to labour, some from laziness, others from an opinion that they ought not to do any thing beneficial to a house fully paid for their support.[4]

It is not unlikely that it was the nature of the work (stone-breaking)

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1 Browne, 1837, p. 96. The extent to which Browne trusted his patients can be seen by the fact that he allowed one patient to transcribe the text of his 1837 book, and another to proofread it.

2 Ibid., p. 191, emphasis in the original.

3 Ibid., p. 192. See also pp. 94 and 196.

4 Glasgow Lunatic Asylum, Annual Report, 1817, p. 9.

engaged in at Glasgow that made it unpopular with the patient. At about the same time the physician at Cork Public Lunatic Asylum, W.S. Hallaran, was able to report that

> The easy labour of the garden, in which force is never employed, becomes at once a recreation and an amusement; to be permitted the indulgence is generally the reward of previous good conduct.[1]

But this was unusual and, since Hallaran went on to argue that the amount of work produced by his patients "is seldom inferior to four times as much"[2] as was usually done by ordinary labourers, we are justified in taking his whole account with more than a pinch of salt.

A slightly different approach to motivation on the part of his patients is expressed in Ellis' remark that

> If the patients are in good health, and in a proper state to work, they are allowed no beer, and every little indulgence is withheld, so long as they are idle. They soon find out that employment tends to their comfort.[3]

All the moral therapists appeared to have tried the carrot approach as well as the stick. Both Ellis and Browne mentioned the importance of rewarding the patients with extra tea or tobacco if they would agree to work.[4] Only if this failed were the sanctions to be applied. Browne's argument on the importance of rewards is down-to-earth and clear:

> Could we act upon all lunatics through higher motives than by wages or bribes or commands, it would be well, but the great majority of the worst cases, at least, are ceasing to be lunatics, becoming convalescent, before you can do so. As the minds of the lower orders are at present constituted, the most powerful stimulus is gain, and if by

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1 Hallaran, 1818, p. 173. Cork was another large asylum by contemporary standards, with 251 patients in 1818.

2 Ibid., p. 174.

3 W.C. Ellis, 1838, p. 311.

4 Browne, 1837, p. 197; W.C. Ellis, op.cit., p. 308.

> addressing ourselves to the propensity to acquire, we can subdue more violent propensities, or still the agitation of disease, it would be imprudent and unphilosphical to reject the aid of such an agent.[1]

Note that Browne saw no distinction between the "minds of the lower orders" outside of the asylum and those invalided by disease within its walls. And yet he did not consider the idea of paying the patients for the work they did as an appropriate one, although on occasion necessary to gain their confidence. He preferred instead to reward the workers with commodities such as tobacco, extra clothes, and food; items that their fellow patients would also want to acquire. It is this action of rewarding the patients like good children, instead of paying them as the workers they were (in that they enabled many of the asylums to be nearly self-sufficient) that makes "moral treatment" such an appropriate term to describe this process. Work was not recognised as the productive activity that in fact it was. Its meaning was constantly mediated through the authority relationship of the physician or asylum superintendent to his patients.

Whatever the particular characteristics of moral therapists like Browne and Ellis, productive employment was one form of moral treatment that caught on fast in the county asylums. In 1826, out of the nine asylums surveyed by Sir Andrew Halliday, the patients were regularly employed in six of them.[2] Halliday pointed out that it was not so much a disinterest in employment that prevented its greater application but the

> want of space for different workshops, and of a sufficient quantity of ground on which the patients can be employed in agricultural labour.[3]

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1 Browne, 1837, p. 197.

2 Halliday, 1828, pp. 19-23.

3 Ibid.

The amount of ground available for cultivation by the patients varied from 30 acres for 155 patients at Stafford to 3 acres for 52 patients at Bedford. At Lancaster, a large asylum of over 280 patients,

> all who are in a fit situation, are employed in such occupations as are adapted to their abilities and previous habits: some in husbandry and gardening, getting stones, and making roads upon the waste ground adjoining the house, under the superintendence of the keepers; but as yet no manufactory is carried out in this asylum.[1]

Ten acres were cultivated as a dairy farm and there were plans to increase this acreage to 30. At Lancaster Asylum the superintendent believed that the best occupation for his patients was for them to push wheelbarrows, if necessary with their hands tied to the barrow handles. By engaging up to six patients at a time, all pushing their wheelbarrows in a neat row, Knight, the superintendent, maintained that he was able to demonstrate to his patients in a very practical way the usefulness of their actions.[2]

Ten years later employment in asylums was recognised to be so important that a Parliamentary Return on the numbers of patients in the asylums included a question on the modes of occupation and numbers of patients employed.[3] There was great variety in the extent to which the asylum authorities bothered to answer the question. Some ignored it altogether or dismissed it in one line (Cornwall, Norfolk) while Ellis at Hanwell littered references to work throughout his eight foolscap pages of report. According to the Return, the numbers regularly employed in the various asylums ranged from 360 plus out of 580 at Hanwell to 15 out of 425 at Lancaster.[4] The West Riding of Yorks Asylum, then under the superintendence

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1 Quoted in Halliday, 1828, p. 20.

2 P.S. Knight, 1827, pp. 85-90.

3 Parliamentary Return, 1836

4 Note the drop at Lancaster from its high level in the previous decade,

of Dr Corsellis, provided a complete breakdown of its workforce of 194 regularly employed out of some 300 patients. This division of labour is shown in Table 5. It provides a fairly typical picture of the kinds

Table 5

Patients regularly employed in the West Riding of Yorks Asylum, 1836[1]

Occupation	Male	Female
Agriculture	33	—
Garden	10	—
Shoemakers	7	—
Weavers	5	—
Cleaning wards	24	26
Painters	2	—
Turner	1	—
Glazer	1	—
Cooper	1	—
Engineer	1	—
Baking	1	2
Brewer	1	—
Laundry	4	18
House (Servants)	3	3
Clerk	1	—
Whitewashers	4	—
Kitchen & Dairy	—	4
Sewing	—	30
Knitting	—	12

of labour engaged in by inmates of pauper lunatic asylums at the time and throughout most of the nineteenth century.[2] Productive manual labour had

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a change that was directly due to the change in superintendence. Knight was sacked from his post in 1824, and it was not until 1841 that the asylum again became a centre for progressive methods. (On the conditions facing the reformers in 1841 see Lancaster Moor Hospital, 1966, pp. 4-5).

1 Source: Parliamentary Return, 1836, p. 30.

2 For a recent and detailed account of the place of productive employment in one particular county asylum (Colney Hatch) in the second half of the nineteenth century see Hunter and Macalpine, 1974, pp. 125-33.

thus become an integral part of the county asylum regime by the second quarter of the nineteenth century. It had been agreed that not only was work good for pauper lunatics, but that the county asylum was the appropriate place in which the work should be done. What must now be established is why work was good for the insane, or at least, what were the reasons given for holding that belief at the time.

First of all, there were vaguely medical reasons based on the idea that work, like diet or ventilation, was a branch of physical hygiene.[1] Work, maintained Ellis, "occupies their minds and prevents the intrusion of many painful thoughts and musings".[2] Browne drew an analogy with the treatment of a wounded limb. We do not use it, but allow it to rest by employing the others. So also with

> prescribing occupation then to the insane, it is proposed to engage the healthy, the unwounded powers and thereby to save those which are pained or diseased, and would be injured by exertion.[3]

Alongside these reasons, which were concerned with the individual benefit of the patient,[4] were the more moral ones which applied to the maintenance of moral community in the asylum. This was the aspect of life at Hanwell Asylum that Harriet Martineau noticed there in 1834: its non-conflict-ridden atmosphere with everyone busy at his or her allotted task.[5]

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1 In Thurnam's Observations on. . .Insanity (1845a) the then superintendent of the Retreat listed the importance of employment under the heading of "General hygienic conditions", although this did not stop him discussing it again under the heading of "Moral treatment".

2 Quoted in Ashworth, 1975, p. 21.

3 Browne, 1837, p. 93.

4 These vaguely medical reasons will be examined in more detail in the next chapter, which is about the epistemological bases of moral treatment.

5 Martineau, 1834, especially pp. 305-7

The theme of moral community has already been discussed above and the use of work as a contribution to the idea of community added nothing to the points that have already been made. Where the idea of employment does stand out as a distinctive element is in its general quality of uniting all the reformers together, whatever their other assumptions about moral treatment. On this they were all agreed: that the insane could be made to work and that it was to their advantage as convalescent invalids to do so.

To return for a moment to the Retreat, it was pointed out in the discussion of the place of work in moral treatment at that institution that it always involved a conceptual ambiguity. The value of employment, as of all moral treatment, rested on a concealment of its joint meaning as at one and the same time a reflection of the patients' praxis, and as a coercive attempt by the therapist to reproduce his ideas of what that praxis ought to be. Sometimes the coercive element appeared to be very small because the therapist's understanding of improvement coincided with that of the patient. In the work of William Ellis and his wife, for example, there occasionally appear glimpses of a compassion that was linked only to the needs of the patient. Ellis' grand-daughter gave an example of one case where a patient was asked to make a dress, but refused on the grounds that no-one would wear it. "Oh yes," replied Lady Ellis, "I will wear it," and she did.[1] It is this sort of example that provides the grounds for those historians who wish to see moral treatment as an essentially humanitarian activity, unconnected with ulterior motives except a concern for the patient as a human being.

Another area in which Ellis is said to have made an innovation is

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[1] [H.W. Ellis,] 1868, p. 46.

in providing financial assistance for cases of hardship. Some of the profits from the work done by the patients at Wakefield went to a "general fund" which was established to help in cases of need. One case that Ellis recorded was of a patient whose insanity was brought on by "hard work, scanty fare, and anxiety (over children's illness)"[1] The patient was admitted but his daughter could not afford to pay the rent. In order to avoid further distress to the patient or to his family the rent was paid out of this general fund.

These attempts to help the patients certainly existed and in many cases provided a foundation for attitudes and approaches that are still with us. On the other hand, what needs to be emphasized again and again is the precise extent of this concern. The county asylums were built with the greatest economy, and were meant to be run with the same concern for this economy before the individual needs of the patients were even considered. At Hanwell, Ellis was able to reduce the cost of maintenance of the patients from nine shillings per week in 1831 to 5s.10d. in 1836, solely from the profits of the patients' labour. The visiting justices pointed out the saving of £650 per annum on the cost of milk alone because of the asylum's farm.[2] John Conolly, resident physician at Hanwell after Ellis, was later to comment on this aspect of Ellis' moral treatment. As he put it,

> The employment of the patients. . .was put too prominently forward as a source of pecuniary profit, whilst every item of expenditure was kept as low as practicable, to avoid the charge of unnecessary extravagance.[3]

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1 Case cited in [H.W. Ellis,] 1868, p. 21. On the growth of funds of this nature under Ellis' superintendence see Hunter and Macalpine's introduction to Conolly, 1968, p. 17.

2 Hunter and Macalpine, loc.cit.

3 Conolly, 1973, p. 181.

It was also realised that as well as producing marketable commodities, when the patients were working they were not causing trouble or needing as much supervision as they would need if they were merely confined. This allowed a saving on asylum staff, as Ellis was well aware:

> Once take away the inducement for them to employ themselves, and you must immediately increase by far the most expensive part of the establishment, the servants; and there would be no little addition to the expense in the injuries that would be done by the patients, by their applying, to mischievous purposes, that muscular or nervous energy, which is now profitably spent in useful labour.[1]

These are realistic concerns, and to raise the issue here is not to imply criticism. Ellis and the other asylum superintendents had to compete for their charges with the workhouses and the private madhouses, institutions which could always cut their costs as long as their aim was solely to provide a physical confinement for the insane. To use asylum patients as laundry maids, floor scrubbers, or in any other cleaning positions was, it seemed, a natural way of avoiding the expense of employing outside staff to do the same thing.

The introduction of work into the asylum had then two major functions: individual therapy, and the maintenance of the social system of the asylum. It was because these functions were never clearly separated that employment therapy was allowed to degenerate into nothing other than a means of economising on the running costs. Especially as the asylums grew larger, it was less easy to devise employment facilities matched to individual needs or skills. A major textbook on lunatic asylums published in 1894 made this point, its author complaining that the use made of employment in the treatment of the insane did not take into account the patients' own motivations for working.[2] One of the reasons for the decline in the

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1 W.C. Ellis, 1838, p. 313.

2 Mercier, 1894, chap. 14.

use made of work in the asylums was the conflict between the medical profession, who increasingly saw work therapy as irrelevant to the physical forms of treatment they came to believe in, and the lay authorities who were financing the asylum service and who wanted to run the asylums as efficient workhouses. As Scull has shown,[1] the medical profession gradually won the struggle for ideological control of the asylums, and it was not until the 1950s that work therapy appeared to regain any attraction for psychiatrists.[2]

In a very real sense the conflicts within the asylum stand as a representation of the conflict between the functions of work in the outside society. For many of the patients in the asylums, engaged in their skilled trades and occupations which had been interrupted by their illness, it would be easy to agree with Paul Slade Knight, the superintendent at Lancaster Asylum, that

> It is. . .of the utmost importance for the care of the insane, that ample means be provided for every gradation of exercise and labour; because, superadded to mere exercise, the contemplation of our labour when we see it is useful,

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1 See especially his 1976.

2 In the mid-1950s work was reintroduced in this country as an active means of therapy for individual patients (Carstairs et.al., 1956), but it has never become generally accepted as a necessary basis of rehabilitation. A survey in 1967 found that 33% of all male and 21% of all female patients were engaged in some form of industrial therapy, but these figures conceal a wide range of opportunities (Wansborough, 1970). One of the most imaginative of modern industrial therapists is Roger Morgan, who has pointed out the needs of working patients to strike and to be paid a living wage out of which they can be charged for board and lodging (R. Morgan, 1970: on the lack of official support for Morgan's ideas see Sedgwick, 1977). The material reasons for these changing vicissitudes of work therapy are complex and unlikely to be located in any "decline of a work ethic". One possible reason is the continuing conflict in the minds of psychiatrists regarding their commitment to the mentally ill. On the one side is their image of therapy based on professional knowledge and norms of behaviour, and on the other is the nexus of social, political, moral and ideological beliefs that psychiatrists may share with other groups in society. At any given time there are always likely to be some psychiatrists who feel more influenced by non-professional beliefs than they do by the norms of their profession.

> is pleasing and healthful to the mind; it never fails to produce a certain degree of gratification and content; whereas the contemplation of a mere idle use of time is unpleasing, and tends to relax and enervate the mind.[1]

In other words, the act of engaging in useful, subjectively meaningful labour creates a consciousness that can at least aid in the creation of self-respect. Consciousness, as was shown in the Introduction, is itself a step in the dialectical construction of human nature. Created out of labour, it is the basis for the further expression of labour.

It was this aspect of the value of work that was emphasized by the moral therapists as confirming that the bourgeois way of life was intrinsically more healthy than that of the indolent gentry. This was the point that had been made by Pinel, and it was one that was emphasized by other authors. According to the phrenologist, Spurzheim,

> It has been observed that, in all institutions for insane, the male patients who assist in cutting wood, making fire, and digging in the garden, and the females who are employed in washing, ironing, and scrubbing floors often recover; while persons, whose rank exempts them from performing such services, languish away their life within the walls.[2]

This idea that work provided a meaningful <u>rite de passage</u> back into the real world is an attractive one that had its roots deep in the bourgeois consciousness; but how many of the patients were offered this as a real possibility? When the asylum superintendents were not merely using them as cheap labour, their aims were more often to create just enough consciousness in their patients' minds to inculcate "habits of industry".[3] Or, perhaps even more likely, once the imperative to work

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1 P.S. Knight, 1827, p. 90.

2 Spurzheim, 1817, p. 254. Spurzheim's contribution to moral treatment will be examined in the next chapter. The physician John Reid also reaffirmed Pinel's point that in Spain "the poorer classes are made to work and are generally cured", whereas the aristocratic patients were not (J. Reid, 1821, p. 400).

3 A comment made in the Report of the Select Committee on Labourers'

had been established as a normative aspect of asylum life, superintendents merely followed the trend without really considering what they were doing. According to Conolly in 1846,

> as regards county asylums, there is now a great disposition in the officers to set every patient to work as soon as admitted; sometimes very improperly, and when, perhaps, work has made the poor creature mad. A man just admitted is perhaps sent off to the shoemaker's shop before his case can have been considered by the physician; and a poor melancholy woman, or a frightened, agitated girl is set to work immediately with a needle and thread, to pursue, as if in a mere workhouse, the same sedentary occupation which has already destroyed her health.[1]

John Conolly, as will be shown in the next chapter, was one of the most perceptive and creative of all the moral therapists. He always retained his vision of the real potential for growth that moral treatment implied. For most reformers though, a commitment to the potential of work was merely an ideological commitment. It proclaimed their humanity and it proclaimed the democratic basis of the society of which they were enthusiastic members.

In concluding this assessment of the place of work in the asylums, it may be said that it affirmed a central belief of all moral treatment: the recognition of the possibility that the insane could take an active and conscious part in the life of their society. As a practical accomplishment in the county asylums, the meaning of employment was very

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Wages in 1824 summed up this aspect of the imperative to work: "There are but two motives by which men are induced to work: the one, the hope of improving the condition of themselves and their families; the other, the fear of punishment. The one is the principle of free labour, the other the principle of slave labour" (quoted in Poynter, 1969, p. xvii). It was this commitmant to "free labour", a commitment whose whole point was to inculcate an unthinking conformity in the minds of the working class, that provided one of the central tenets of all moral treatment in the public asylums. On this aspect of work in the penal reform movement, see Foucault, 1977, pp. 239-44.

1 Conolly, 1968, p. 78.

different. By narrowly circumscribing the range of activities it offered its recipients it reveals to us the limits of its initiators' horizons, themselves circumscribed within narrow assumptions about the nature of their society and the place of men within it. This antagonism between theory and practice was not unique to the asylum: it is a description of daily life in a capitalist society. It is a necessary product of a system in which the necessity to sell one's labour power is not equally distributed. As Sartre has pointed out, "Absolute respect for the freedom of the propertyless is the best way of leaving him at the mercy of material constraints".[1] The county asylums attempted to abolish the old constraints of chains and depletions and replace them with the far more effective forces of the market.

It must be emphasized that there was nothing intrinsic in moral treatment which located it so exactly as the ideology of a specific class. To accept that would be to accept an idealistic definition of what was a very material practice. The notion of moral treatment had merely raised the possibility of treating the insane like other members of the human race. It was the application of this idea by a particular group of people that made moral treatment into the force for social control of the working class that it became. Even Samuel Tuke, who had done so much to increase the opportunities for the insane, had no

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[1] Sartre, 1976, p. 110. To appreciate the full significance of employment under capitalism it is necessary to compare it with conditions in other social systems based on the exploitation of surplus value, namely socialist societies. Unfortunately such a comparison is outside the scope of this thesis; but it must be emphasized that it is not employment *per se* that is being discussed, but the specific manifestation of it in the conditions of early industrial capitalism. Under that system the meaning of labour was defined, not by the owners of that labour, but by a class who depended for their very existence upon the exploitation of that labour. In a society where the meaning of labour is defined by those who own it, the place of employment as a rehabilitative function of psychiatric therapy will be directly dependent on that definition and on the interests of that class.

wish to go further than the reproduction of society as he saw it. In 1841 he wrote the following passage, which attempted to reconcile his religious beliefs with what he saw as the state of the world. "It appears to be a providential ordination", Tuke wrote,

> that our healthy and most agreeable feelings are connected with the employment of our time in the moderately active pursuit of some apparently useful object.

Given Tuke's religious commitments, this must stand as an honest appraisal of his material life. But, he continued,

> even if this were not the constitution of our nature, the habits of that class of person, which mainly supplies our public asylums, would point out the importance of keeping up that association between the enjoyment of health and labour which their circumstances have induced.[1]

In other words, even if the natural order of the world is not as we perceive it, we must still accept the social order just because it is there.

To appreciate the narrowness of this application we may turn now to the administration of moral treatment outside of the pauper asylums. It was only here that other possibilities for its practice could be envisaged.

4. Moral Treatment as Commodity[2]

Up to now this chapter has dealt almost exclusively with the version of moral treatment received by the majority of the insane in the early

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1 S. Tuke, 1841, p. xxix.

2 The term "commodity" is used in this section merely to refer to something which has the capacity of being bought or sold; it is not used in the wider, more theoretically informed sense in which it was discussed in the Introduction. That definition of a commodity includes the ability of a product to be bought or sold, but also refers to the wider frame of reference of the society in which commodity production is the dominant rationale underlying all communication and discourse. That definition of commodity pervades every page of this analysis of moral treatment, whereas the explicit presentation of moral treatment as a marketable commodity was a special case, applicable only to the moral treatment of those who paid for it with money.

Table 6

Numbers of private and pauper patients in the public hospitals and asylums in England and Wales in 1844[1]

Asylum	Original Source of Funding*	Private Patients	Pauper Patients	Private Patients as a Percentage of the Total
Bedfordshire	CR	0	139	nil
Cheshire	CR + Sub	9	155	5.5
Cornwall	CR + Sub	20	133	13.1
Dorset	CR + Sub	0	107	nil
Gloucestershire	CR + Sub	68	189	26.5
Kent	CR	0	249	nil
Lancashire	CR	0	611	nil
Leicestershire	CR + Sub	27	104	20.6
Middlesex (Hanwell)	CR	0	975	nil
Norfolk	CR	0	164	nil
Nottinghamshire	CR + Sub	52	125	29.4
Staffordshire	CR + Sub	62	183	25.3
Suffolk	CR + Sub	7	206	3.3
Surrey	CR	0	382	nil
West Riding of Yorks	CR	0	433	nil
Guy's Hospital	End	25	0	100.0
Lincoln	Sub	30	73	29.1
Liverpool Hospital	Sub	37	36	50.7
Manchester Hospital	Sub	36	0	100.0
Northampton Hospital	Sub	50	181	21.6
York Lunatic Asylum	Sub	105	52	66.9

*CR = County Rate; Sub = Subscription; End = Endowment

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county asylums. This version drew much of its inspiration from the example of the Retreat, but it applied what it saw as the lessons of the Retreat in such a way that was only appropriate to the lowest class of society. This should hardly surprise us, given the class-ridden nature of early Victorian society. But not all the insane were paupers, and not all moral treatment was confined to the county asylums.

It has already been mentioned that some of the early public asylums were not only for pauper lunatics, but were funded partly by subscriptions and donations, and, in Scotland, by endowment. These institutions

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1 Source: Parliamentary Returns, 1844.

were meant for the insane from all classes of society, from the paupers paid for by their parishes at the absolute minimum possible, to the private patients with unlimited financial resources. Table 6 shows the relative numbers of private and pauper patients in the public asylums in 1844. As can be see from that table the percentage of private patients in these asylums ranged from nil to nearly 30% at Nottingham.

The definition of "private" is necessarily a crude one which conceals the variety of rates that were offered to the prospective patients. At Gloucester Asylum, for instance, it was proposed that the scale of rates should extend from the paupers who would pay 12 shillings per week to the "opulent" patients at three guineas.[1] An extreme example, but one which clearly illustrates the types of facilities that the different rates paid for, is shown in Table 7. This table is of the rates of board at the Crichton Royal Institution in Dumfries, one of the centres of excellence of moral treatment, according to contemporary opinion, but one at which the practice of moral treatment was carefully measured according to the patient's finances.

Browne was quite clear as to the justification for this. He wanted the insane restored to their rightful place in society. He drew an analogy with the status of the blacks in the United States of America, who were not permitted to worship in the same church pews as the whites. Similarly, in regard to Hanwell, Browne pointed out that a proposal to let the patients go out in a pony chaise was objected to by the local inhabitants on the grounds that it was an invasion of <u>their</u> rights.[2] These were the sort of attitudes he wanted to over-

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1 Bailey, 1971, p. 187.

2 Browne, 1837, pp. 172-3.

Table 7

Rates of board at the Crichton Royal Institution in 1839[1]

Class of Patient	Annual Charge	Accommodation	Size of Staff	Privileges
I	£15[a] £18[b]	Public room for 10, private sleeping room	1 attendant to 10 patients	"Tobacco and beer to the industrious males"
II	£30-£100	Public room for 5, private sleeping room with carpet	1 attendant to 10 patients	"Wine to the industrious; piano, billiards, and society to the well behaved"
III	£100	Parlour and bedroom for each furnished of "American Birch"	1 attendant to 4 patients	"Use of a carriage as an indulgence, and a piano, & c. as a right"
IV	£200	Parlour and bedroom furnished in Mahogany	1 attendant to 2 patients	"Use of a carriage three times a week or use of a horse"
V	£350	Parlour, bedroom and bathroom	1 attendant to 1 patient	Carriage or horse every day

[a] for Paupers from Dumfries and Wigtown only

[b] for all other Paupers

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come. But, if the insane were to receive the same rights as the sane, they must also reflect the same distinctions as the sane. Browne believed that

> In a country where the distinctions of rank and riches are so broad and practical as in this, it is absolutely necessary that the first principle of arrangement of the inhabitants of an Asylum should be founded upon the amount of board paid. . . .It separates those who could have no thought or occupation or feeling in common, and groups together those who are similar in station, and whose language, sympathies, and sentiments are alike, or closely assimilated.[2]

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[1] Source: Information extracted from a leaflet entitled "Crichton Royal Institution Rates of Board" in Crichton Royal Archives.

[2] Crichton Royal Institution, 6th Annual Report, 1845, p. 20. In a

It was within this structure of "rank" that Browne put into practice all his ideas on the rehabilitation of patients. Within each of the fee-paying sections all patients were divided into three (for the females) or four (for the males) smaller groups depending on their degree of convalescence or conformity to the rules. All, that is, except the paupers, who were lumped together into two great divisions, the "industrious" and the "idle". One powerful reason Browne could afford to be imaginative in the practice of moral treatment at Crichton Royal was precisely because he was dealing there with members of his own class. His "language, sympathies, and sentiments" were the same as those of his patients. Crichton Royal was never predominantly a pauper institution, with all that meant in terms of economy and overall policy. In the first ten years of its existence the average number of paupers staying at Crichton Royal was 45.6, and that of private patients 76.4.[1] The paupers were to receive "the minimum amount of board" and the rich "every luxury which the present state of society has rendered necessary".[2] In 1850, a separate building

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similar way the proposed London Asylum was also adjusted to the realities of the social structure in spite of its commitment to a firm philosophy (in its case, that of the Panopticon principle of order). The main Panopticon-shaped building was never intended to be "for Patients of Superior Rank" as Edward Wakefield put it in 1815 (1815 SC, 4th Report, p. 186). For them there was to be a separate building which "will not in any respect have the appearance of a place of confinement" (ibid.). This other building was to have "proper water-closets", not privies, and was to include the novel feature of a "coffee-room".

1 Figures extracted from the tables in Easterbrook, 1940. The number of private patients as a percentage of the whole was 62.6%, a greater proportion than all but one of the English asylums. Neither does there appear to have been much room for cases of financial hardship. The second patient admitted to Crichton Royal, a farmer, was transferred six years later to Glasgow Asylum "to be placed upon the Pauper Rate" as his friends could not afford to pay for him any longer (Crichton Royal Institution, Case Book I).

2 Crichton Royal Institution, 1st Annual Report, 1840, pp. 5-6.

was opened to house the paupers.

In other words, Browne's clientele was exceptional for a public asylum, and this must be taken into account when assessing the "progressive" nature of his contribution to the development of moral treatment. In 1851, for instance, Browne was proclaiming that

> Patients are participators in every arrangement. . .They are led to understand that each progressive step is not merely for them but by them. They are their own gardeners, labourers, players, musicians, precentors, librarians, and under certain restrictions, their own police.[1]

At a first reading this might appear to mark a dramatic improvement over the moral treatment at Wakefield or other public asylums. On the other hand, if this is seen in the context of the 98 private patients who were the sole occupants of Crichton Royal at the time it was written, it is little different to what had been practised at many of the private madhouses that had been operating in the previous half century, where the patients had always taken an active part in the running of their own asylum regimes.

Where it may be said to mark an advance is in the public sector, in that all the patients at Crichton Royal received some moral treatment, however tailored to their position within the class structure. The opposite end of the spectrum is portrayed at the socially mixed asylums like Gloucester where, in 1841, a Belgian physician was told by the founder that "a fifth of my patients are under no restriction whatever";[2] yet, when the visitor examined the conditions, he found the contrast between the private patients and the paupers "so great and so revolting as to produce the most painful impressions on anyone with human feelings".[3]

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1 Crichton Royal Institution, Annual Report, 1851, p. 23.

2 Dr C. Crommelinck, quoted in Walk, 1954, p. 832.

3 Crommelinck, quoted in Walk and Walker, 1961, p. 615.

That, of course, was only one observer's opinion of one asylum, but it was hardly a surprising one given, apart from anything else, the enormous differences in charges for what was essentially the same thing--a cure. It was precisely because this cure involved a return to an unequal world that so much effort had to be put into making the route to it so similarly unequal.

The alternative form of care for those who lived far from the catchment area of a reputable asylum, or for those who wished to evade what appeared to them as the stigma of the public asylum, was the private madhouse, or "private asylum" as it was coming to be known in the 1830s. This alternative remained a very real one throughout the nineteenth century. In 1844, for instance, there were 2399 privately paying patients in private asylums (compared to 2774 paid for by their parishes). By 1874 the number had risen to 3122 (with only 1394 paupers).[1] Not that this was accepted as a satisfactory state of affairs: public condemnation throughout this period continued to look down upon the madhouse proprietors, those "wholesale dealers and traffickers in this species of human misery", as one well-known writer on the subject put it.[2]

But, just as not all county asylums were models of enlightenment, not all the private asylums were dungeons of despair. Doctors such as William Ellis realised, once they had made their reputations in the public asylums, that there was a lot of money to be made by going private, as well as the more pleasant conditions of working

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1 Report of the Metropolitan Commissioners in Lunacy, 1844; D.H. Tuke, 1882, p. 252.

2 Sir Andrew Halliday, writing in 1826, quoted in Scull, 1974, p. 120. On the variety of madhouse provision at this time see Parry-Jones, 1972, pp. 77-90.

among the "refined" sections of society. There was as much money and certainly more status to be gained from running a private asylum on respectable and rehabilitative lines as there was from cramming large numbers of pauper patients into what was purely a centre of confinement.

If the pauper asylums were able to rehabilitate their patients, the solution of the needs of patients from other classes must be sought with the same methods. In the words of Harriet Martineau,

> Circumstances will be, must be overruled, so that the rich shall be raised to an equality of advantage with the poor, in the single instance in which they are at present sunk below their pauper fellow sufferers.[1]

This was said after a visit to Ellis at Hanwell in 1834 and, as will be seen, Ellis thought the same way--although what was meant by "equality of advantage" was certainly not similarity of conditions. This was not purely an ideological defence of the interests of the middle class. Few patients from any class received the "best" moral treatment as it has been described here, but the county asylums did at least exist, which was more than could be said for an organised movement for the middle-class insane. Some years later there was an attempt to found a public middle-class asylum in London, financed by subscriptions and donations, but it was not successful.[2]

It has been argued so far that moral treatment developed as a

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1 Quoted in [H.W. Ellis,] 1868, p. 57.

2 See Asylum for. . .[1849?]. The copy of this prospectus in the British Library contains, on the front cover, the words "Patrons" and "Committee of Management" with a space underneath but without names. If this is a typical copy it suggests that the prospectus was never actually issued. Hunter and Macalpine have pointed out that the idea of a public middle-class asylum was dear to John Conolly, and that he made a number of attempts in the 1840s to raise an appeal for one (introduction to Conolly, 1973, pp. xli-xlii, especially note 132).

means by which the social relations of production could be reproduced; the creation of the willing worker. In the Retreat there was a degree of consensus, caused by an overall commitment to Quaker social philosophy, that allowed this means to be moulded into a full scale therapeutic programme. In the county asylums it was possible to exercise a degree of coercion over the patients in order to achieve the same thing, through a system of espionage, through withdrawal of privileges if behaviour did not "improve", and through other means of intimidation. But with the wealthy, non-religious lunatic these methods were no longer applicable. For this sort of patient moral treatment had to be modified yet again.

It had to retain its essential feature of the inculcation of self-control over unwanted behaviour, but it had to appear as a means of doing this which was entirely within the values and interests of those who were paying for it.[1] In moral treatment for the poor, the main direction of the ideology was towards other reformers and especially the progressively-minded magistrates who decided on the allocation of public funds. In moral treatment for those who were paying for it directly out of their, or their relatives', pockets, the aim of the ideology was itself more direct. It was no longer to get public administrators to spend public money on a branch of social

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[1] There is no doubt that the advertised picture was often far distant from the realities of day-to-day practice. The pronouncements still have value as ideology in that they disclose the values and assumptions of the moral therapists, but it must be remembered that they often had no other substance. Unfortunately there are very few first-hand accounts of those who were held in the respectable asylums, but those that do exist conflict with the image presented by the asylum proprietors. For Brislington House in 1831-1832 there is J.T. Perceval's vivid account of restraints and punishments (Bateson, 1962); and for Matthew Allen's High Beech in 1837-1841 there is the experience of John Clare who found the conditions oppressive and eventually escaped (on this see Barnet, 1965).

control; it was to get the wealthy to spend their money on themselves while at the same time acknowledging the humanitarian nature of the therapists' intentions. As such, the ideology had to appeal to the luxurious yet virtuous benefits of moral treatment rather than to its ability to produce subservience or any other working-class traits which might be required. It had, in short, to be presented as a commodity which could be purchased like any other.

An insight into this appeal can be gained by comparing the changing function of therapies for the insane with the changing function of music. In the eighteenth century, musical works were commissioned by individual patrons, much as Jewson has demonstrated that medical therapies were produced for those individuals who paid for them.[1] Bourgeois demands were different, in music as in medicine. A greater number of people wanted to benefit from new ideas, although any one of them had less money than the old aristocratic and ecclesiastical patrons. A free market was established in which the musical productions, or psychiatric therapies, or whatever, were presented as commodities available to all. An essential characteristic of these commodities was their apparent universality: they could be partaken of by all, provided of course that their prospective purchasers had enough money. At the same time the existence of the market meant that all the therapies (and musical productions) had to compete with each other. They had to appear, simultaneously, as available to all yet appreciable only to those with discretion.[2]

Of course, not all the recipients of private moral treatment

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1 Jewson, 1974.

2 On the changing social function of music at this time see Hauser, 1962, vol. 3, pp. 73-7.

were very wealthy. It was a continual complaint of many who dealt with the middle-class insane that a long illness could financially destroy those who had done most to create their own wealth. Pauperization was not simply a condition of poverty; it involved a recognition of class membership--the lowest, most degraded class in a society that was obsessed with maintaining its inequalities of opportunity and reward. Above all, the private asylums had to advertise their distance from pauper life. At one madhouse in Kensington, for instance, with fees of from one to five guineas per week, the prospectus proclaimed one of the virtues of the house to be the "absolute exclusion of pauper patients".[1]

An obvious model for the small private asylums was the Retreat, and a number of houses borrowed directly from its inspiration. Its name was used by many madhouse proprietors, thus enabling them to proclaim where their intentions lay.[2] Some of the Retreat's minor innovations, such as the way it disguised the iron window bars to make them look like ordinary wooden sashes, were also borrowed without acknowledgement.[3] The private asylums could not compete with the

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[1] [Finch], 1830, p. 11, emphasis in the original. This proprietor had previously been in charge of Laverstock House, of which Edward Wakefield had said, "In this establishment I saw all that Tuke has written realized; and no words in which I can describe it. . .can characterize it in too high terms" (1815 SC, 1st Report, p. 48). But Wakefield had also said that the paupers at this madhouse were kept separately "in a building at a distance from the house", and when he was asked, "Do you know whether each of the male pauper patients has a bed to himself?" he had to answer, "I cannot speak to that" (1816 SC, 1st Report, p. 37).

[2] There were six private madhouses named "The Retreat" in the East Riding of Yorkshire before 1850 (J.A.R and M.E. Bickford, 1976). Other "Retreats" existed near Leeds (The Scotsman, 15th September, 1838) and in London ([Finch], 1830).

[3] M. Allen, 1829, [p. 1.] For this practice at the Retreat, see the Description, pp. 98-100. Although Allen cited Tuke enthusiastically in his 1837, he maintained four years later that "I was the first who

public ones in terms of the amount of capital they could invest in purpose-built accommodation or in agricultural land for the patients to work on. Instead, like the Retreat, they advertised a small, family-type atmosphere with a high proportion of staff to patients. At Ticehurst, for instance, an asylum of which many of its 50 patients "spoke with pleasure of their residence. . .and expressed unwillingness to quit it", there were 36 members of staff.[1]

In William Ellis' asylum at Southall Park, which he ran for the last year of his life, "his great principle was that of family association".[2] At 8.30 a.m. all staff and patients attended family worship, and from then until breakfast the time was spent by Ellis in "kind and genial converse with each inmate".[3] At dinner time all who were well enough ate at the same table "where they were frequently joined by Sir William's personal friends and the relatives of the inmates."[4] According to one madhouse proprietor, even the principle of sex segregation, strictly adhered to in most asylums, could be

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carried out a system of kindness and liberality about which others who have been to imitate it, have made so much puff and fuss in puffing themselves off" (letter to Cyrus Redding, 21st April 1841, quoted in Parry-Jones, 1972, p. 94).

1 Comment of official visitors, 24th November 1827, quoted in Scull, 1974, p. 115.

2 [H.W. Ellis,] 1868, p. 66. Other examples of commitment to this principle include Matthew Allen, who advertised his asylum at High Beech on the grounds that "everything resembles a family house" (M. Allen, 1829, [p. 1]). Arthur Stilwell, who kept the Moorcroft private asylum in Hillingdon, was praised in an obituary letter to The Lancet because of the family lines on which he had conducted his asylum over the previous 30 years (The Lancet, 1840-1, 1, 23rd January 1841, p. 631).

3 [H.W. Ellis,] loc.cit.

4 Ibid., p. 67.

broken in the interests of the right sort of rehabilitation.

> The seperation [sic] of the sexes is complete at Leopards Hill Lodge, where most of the cases are of a decided nature, but at Fair Mead where they are more correct, the occasional intercourse (especially at meals and some amusements--music--Lectures--cards &c.) is highly advantageous, it preserves that mutual restraint and softening influence which the sexes so powerfully exercise on each other.[1]

As can be seen, there was little difference in principle between this sort of moral treatment and that reserved for the paupers. The principle remained tha same; the difference was in its application. William Ellis had pointed out that

> The great means of. . .influencing the conduct of the patients in any. . .respect, is by ascertaining what they particularly like and dislike, and then granting or withholding the indulgence, according to their behaviour. . .These preferences are the lever, and frequently the only lever, by which the moral man can be moved.[2]

In the pauper asylums this had meant bribes of alcohol, tobacco, extra food, and even money to achieve the desired effect. Whereas the moral affectations that motivated the working class were held to be of greed or simple self-interest, with the upper and middle classes there were more noble appeals that could be made. According

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1 M. Allen, 1829, [p. 2.] Mixing of the sexes in order to help with rehabilitation was not unheard of before this, but it was rarely practised as a matter of course in the pauper asylum. In his recommendations for such asylums Samuel Tuke had insisted upon the complete separation of the male and female patients, but had then modified the rule for those patients who could be trusted to behave themselves. In his words, "where the judgement and moral feelings, are in great measure restored, benefit appears to arise from their [that is, the male and female patients] occasionally meeting together. It is far indeed from occurring, in all instances of insanity, that the passions are strong, and the moral feelings obliterated; and no disadvantage has been found, at the Retreat, from a majority of the patients being assembled in the same room, for the purposes of reading or devotion" (S. Tuke, 1815, p. 12).

2 W.C. Ellis, 1838, p. 194.

to Ellis,

> An appeal to the moral and benevolent feelings will arouse a patient to action, when a merely intellectual inducement is ineffectual. Point out the sufferings of the poor. . .and many will cheerfully exert themselves whom no other inducement could influence.[1]

Similarly, Allen pointed out that "it is not known. . .how powerful with the higher class of patients is the principle of honour".[2] These imputations of motivation were not carefully matched to the individual desire of each patient, but were attributed to them on the grounds of their class membership. The rewards were defined by the therapist according to his perception of how his patients ought to live.

One interesting point is that none of the moral therapists came from anything except a lower middle-class background, and many of them, like Ellis and Allen, appear to be examples of people with few qualifications and many aspirations.[3] In other words, it does not seem

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1 Quoted in [H.W. Ellis], 1868, p. 60.

2 M. Allen, 1837, p. 66.

3 On Ellis' career, see above, p.187, note 1. Matthew Allen's biography is an especially interesting one from the point of view of seeking the class motivations of the moral therapists. Allen was born in 1783, the youngest son of a dissenting minister. He began his medical career as an apprentice to his brother, an apothecary, but gave it up in favour of itinerant preaching and shop-keeping. He was a poor entrepreneur, being imprisoned for debt and for trading without paying stamp-duty. His brother helped him out and secured for him the post of apothecary at York Lunatic Asylum, a position from which he was sacked in 1824. The following year his entrepreneurial ambition surfaced again, and he borrowed some money to finance High Beech Asylum. Here he settled for the rest of his life (that is, until 1845), although he never stopped thinking up new ways of making money. In 1837 the Tennyson family moved near High Beech and Allen persuaded Alfred Tennyson to lend him a large sum of money to finance "a patented process for carving wood by machinery". The money was lent and the scheme failed. (On Allen's career see Barnet, 1965, and Allen's preface to his 1837.) Although Allem cannot be said to be a "typical" member of any class, many of his inspirations were clearly those of the self-made businessman who was such a model for the Victorian bourgeoisie.

unfair to describe some of the ideal asylums as portrayed by men like Allen and Ellis as examples of a status in society to which they personally would have liked to belong.[1] "For persons in the higher rank of society", wrote Ellis in 1838,

> a mansion should be provided, with park, woods, lawns, hot-houses, gardens, and green houses. It should be fitted, internally, with every convenience and luxury for the gratification of the taste. Science and the fine arts ought to be pressed into the service of stimulating the dormant faculties to healthy exercise. . . and one evening per week should be specially devoted to a dress concert or oratorio, to which all, in a fit state to attend, should be invited.[2]

This image of a perfect way of life was written at the end of a career which Ellis had begun as a surgeon's apprentice, in which he had been honoured with a knighthood, and in which he had finally acquired a private asylum of his own.

Allen's understanding of non-working-class needs was more intellectual and psychological, but no less clearly stated:

> . . .a person of high moral and intellectual endowments, possessing the most ardent desires for the joys of moral and intellectual friendship, but who, instead of receiving appropriate and healthy food for these desires, is confined to such as have nothing in common with him. . .then these desires are not satisfied; on the contrary they are all disagreeably affected. . . . This disagreeable excitement may amount to pain, aversion, hatred, contempt, and fury!. . .and throws the mind open to all the spirits of vice and misery, which torture and distract, irritate and inflame, paralyse and derange, all the physical functions of body and mind, and destroy all that for which existence was given us.[3]

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1 The patients at Allen's High Beech Asylum consisted of people with such occupations as gentlemen, merchants, solicitors, surveyors, shoemakers, surgeons, and innkeepers (Barnet, 1965, p. 23).

2 W.C. Ellis, 1838, p. 201

3 M. Allen, 1831, pp. 44-5.

Allen's language is so strong, his belief so fiercely argued, that it is reasonable to suppose that he had had a personal experience of non-discriminatory confinement. Perhaps it was the fact that he had been in prison at least twice that had helped him form his belief in the need to maintain class distinctions. But whether or not Allen had a personal reason for his belief does not detract from the main point: moral treatment for the rich and the middle class was as much dependent on a social definition of normality as it was for those patients who were to return to the cotton mill.

One aspect of moral treatment that was not so easy to establish amongst those who were paying for the service was the idea that employment was good for them. All the moral therapists mention this problem, and attempted to adapt the imperative to work to what they saw as the interests of their paying clientele. Ellis pointed out the problem as he saw it:

> As might reasonably be expected, from their previous habits, a much greater difficulty exists in inducing persons of higher rank to employ themselves in bodily labour, than those of the lower classes.[1]

The generally accepted solution was not even to try. Bodily exercise was achieved through such suitably refined pursuits as "bowls in the garden", "coursing. . .daily on the downs", "a carriage in which the ladies ride out".[2] The ruling class was intended to think, not to

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[1] W.C. Ellis, 1838, p. 198. E.L. Fox also pointed out how at Brislington House "The greatest difficulty has been experienced in finding employment for Gentlemen" (letter to Lord Seymour, in Fox, [1809]).

[2] Edward Wakefield, referring to Dr Finch's madhouse at Laverstock (1816 SC, 1st Report, p. 36). See also Fox, op.cit.; [Finch], 1830; [Bradbury], 1836. This latter publication was an advertising leaflet for a private asylum in Kensington described by Sir Henry Halford, President of the Royal College of Physicians, as "the very best establishment for the reception of insane patients which I have ever seen" (p. 6). At the back of the leaflet are a number of engravings of ladies doing genteel "calisthenic exercises" in the grounds of the house.

get its hands dirty, and so it was not bodily labour it was given to do, but mental. For them there should be "lectures on chemistry", "botany ought to be sedulously cultivated", and other intellectual pursuits should be encouraged.[1]

Perhaps the only exception to this rule that the upper-class patients should not engage in manual labour appears to have occurred at Francis Willis' private madhouse in Lincolnshire. Willis was the idiosyncratic physician who was able to control the mad King George III by the use of his (Willis') "eye", and his methods of caring for the patients at his private madhouse appear to be no less original. A contemporary observer reported that

> As the unprepared traveller approached the town, he was astonished to find almost all the surrounding ploughmen, gardeners, threshers, thatchers and other labourers attired in black coats, white waistcoats, black silk breeches and stockings, and the head of each 'bien poudre, frise, et arrange'. These were the doctor's patients. . .[2]

But this was unusual, and in 1846, John Conolly, who probably knew more about the subject than anyone else, had to conclude his survey of the different means of employment used in the treatment of the insane with the comment,

> I do not know that any systematic attempts have been made to introduce work among patients in England of a higher class than mechanics.[3]

Again, like many others, this fragment of moral treatment reflected a practice begun at the Retreat. But what had been merely

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1 W.C. Ellis, 1838, p. 203. At Crichton Royal the first theatrical production put on by asylum patients anywhere received its premiere on 9th January 1843. The following year a highly erudite literary magazine began monthly publication, produced entirely by the patients.

2 The Life and Times of Frederick Reynolds, quoted in Parry-Jones, 1972, p. 183. See also Anon, 1796. Parry-Jones provides a discussion of the extent to which work was encouraged in private madhouses (ibid., pp. 182-4).

3 Conolly, 1968, p. 82.

one aspect of Retreat life, heavily mediated through Quaker ideology, was presented here, in isolation, as a purchasable commodity. And, like all commodities, the living praxis which had given it its meaning was concealed and presented as something with no value other than that which the exchange of money gave to it. The inequalities of daily life, which the Retreat had demonstrated could be changed, were once again petrified, and by the very practice which had revealed their possibility of change.

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Such was moral treatment in the 20 or so years after the Description of the Retreat was published. The initial vision was fragmented into a hundred parts, each to express in its own way the different values and interests of those who practised it. As we have seen, these fragments drew their inspiration from a number of social movements and ideologies. It might appear that too much emphasis has been placed on too few people: after all, it may be argued that there were only 1100 insane persons held in public asylums and at least another 4000 outside in 1826. Any one moral therapist could only deal with a very small number of these people. In particular, it might seem that too much has been made of William Ellis and his version of moral treatment.

Briefly, two points may be made in support of the approach followed here. One way of assessing Ellis' importance is to cover the subsequent history of the treatment of the insane, and to show the extent to which his work was seen as important by later practitioners. This will be done in Chapter 5. On the other hand, this in itself is not enough. There is always a danger of writing history with too much hindsight, which in this case means assuming that as moral treatment did become generally diffused, it was always going

to be accepted as necessary. Nothing was further from the truth, at least in the minds of the moral therapists. They were constantly aware of the struggle involved in gaining acceptance of their new ideas. The success of moral treatment was always problematic: in a very real sense it could be said that it never was a success. Its general acceptance marked an institutional diffusion which, like the aftermath of all too many political revolutions, killed off all that was dynamic in its inspiration. But all that was a long way in the future. In the 1820s and early 1830s the outcome was far from settled.

An alternative way of assessing Ellis' practice and demonstrating the significance of his work is to describe the material configuration out of which his practice emerged. Exceptional ideas derive from exceptional circumstances: what has to be determined is whether this exceptionality is a fluke with no significance beyond its own appearance, or whether it is the circumstances that are themselves significant and which by a chance combination allow what is normally found in moderation to be expressed in acute form. Only by answering this sort of material question is it ever possible to discover the extent to which "social being determines consciousness".

One overridingly important factor in the successful application of moral treatment was an institutional environment in which it was allowed to dominate all aspects of the life of the asylum. It was only when such conditions had existed at the Retreat that moral treatment emerged as a distinct practice at all, separate from isolated attempts at physical and psychical management. This, aside from any ideological reasons, was a major determining factor in the emergence of moral treatment as a viable practice. As public opinion

changed these experimental conditions became less necessary but, at a time when moral treatment represented something new and untried, it was only possible to introduce it when the innovator had complete control over his asylum or institution.

As far as Ellis was concerned, there are two main reasons he should have satisfied these conditions. One was his own personality and the other was the social context of his appointment as superintendent to the West Riding of Yorks Asylum. Ellis had always had what could be called an authoritarian attitude towards the management of the insane. As early as 1815, before he was appointed to Wakefield, he had written,

> It is absolutely necessary, that to manage such a house [as a lunatic asylum], and such inhabitants, the heads of it ought to possess the most sovereign authority over all the rest; and consequently to be accountable for everything.[1]

When appointed as superintendent (or Director, as he was usually called) to Wakefield Asylum Ellis, with his wife, was given complete control to run the institution as he liked. If we are to believe the visiting physician, Caleb Crowther, Ellis ran the asylum with a complete disregard for all those who might legitimately have viewed themselves as his colleagues. "I have been opposed and thwarted", wrote Crowther in 1828 to a visiting magistrate, "by a Director, whose object it has been to become the Autocrat of the Asylum, to govern me and govern you."[2]

While we may accept that this accusation of being an "Autocrat

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[1] W.C. Ellis, 1815, p. 17. Another moral therapist with similar views on asylum managament was W.A.F. Browne. In 1864, he argued that the organisation in the asylum should mirror that of the society outside it, "The power or government by which such communities are ruled should be monarchical. The details, as well as the principle, should emanate from one central will. . .[and] subordinates should be chosen, their views and acts should be influenced, their whole bearing determined by the supreme official".

[2] Letter to G. Higgins, 16th February 1828, in C. Crowther, 1830, p. 7.

of the Asylum" says something about Ellis' personality, it also says a lot about the authority relationships in existence at Wakefield Asylum. It is this that leads on to the other aspect of Ellis' work--the social context and significance of his appointment as Director.

It was pointed out at the beginning of this chapter how the 1815 Select Committee exposed the appalling conditions under which the insane were kept all over the country. Legislation had been passed in 1808 allowing the local authorities to establish public asylums. The Description of the Retreat had been published in 1813. And yet there was no organised movement to build asylums or to implement Tuke's proposals. Only six asylums were built in the 10 years after 1815. Wakefield Asylum was an exception, rather than the rule. What were the reasons for this lack of interest? One important factor was that the small group of reformers who had been largely responsible for the enquiries of 1807 and 1815 had begun to break up. Whitbread, Romilly and Rose died between 1815 and 1818, and Seymour retired from active life.[1] All attempts at further national reform were blocked by the House of Lords for another decade.[2]

The changes that did take place were initiated not at national level but locally, by magistrates such as Godfrey Higgins in York, the man who had exposed the conditions at York Lunatic Asylum and who was partly responsible for appointing Ellis as superintendent at Wakefield. Because of the lack of a national policy it was up to the Asylum Committee in each county to decide on the administration

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1 K. Jones, 1972, pp. 86-7.

2 Halliday, 1828, p. 12.

of its asylum. At Wakefield, there were men on the committee with a general interest in the reformative possibilities of pauper care as well as specific knowledge of what was possible with the insane.[1] In other towns, the Asylum Committee turned to more traditional areas for its inspiration. Samuel Whitbread, founder of Bedford Asylum, was a friend of Thomas Dunston, the head keeper at St Luke's Lunatic Hospital, and Whitbread had asked Dunston's advice on suitable methods of controlling the patients. Dunston replied,

> A Chain for Arm and Leglocks to be fixed to, by a Staple in the Bedstead, the Wall or Floor as may be required.[2]

Because Whitbread's conception of the function of the asylum was mainly a custodial one, he was not concerned to employ a superintendent with therapeutic ambitions. Instead, the Committee appointed as the asylum's first "Governor" a William Pither, a house painter by trade who, together with his wife, was employed more in the capacity of workhouse master and mistress than as superintendent and matron of a medical establishment. This leads on to a vital factor which underlies this whole discussion: the medical status of the person in charge of the asylum.

As Scull has pointed out in his detailed paper on the medicalisation of insanity control, Pither was eventually forced to resign as a result of pressure from medically qualified critics of his regime.[3] At Wakefield, Ellis was able to withstand medical criticism

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1 The first Chairman of the West Riding of Yorkshire Asylum Committee was J.P. Heywood, a magistrate with experience of running the Wakefield Lancastrian School and the town Dispensary. Godfrey Higgins was also a member of this Committee. He was a close friend of Samuel Tuke and had worked with him in the attempt to expose the conditions at York Lunatic Asylum.

2 Letter to Whitbread, 23rd April 1812 (in Beds. C.R.O., LBP/1).

3 Scull, 1975a, pp. 247-50. Scull emphasizes the fact that Pither

of his work because he did have at least a minimal medical training. Scull presents the conflict as a fairly straightforward one between the lay reformers and the medical profession, but it was a conflict exacerbated by the divisions in the medical profession itself. The three strata of the profession--apothecaries, surgeons, and physicians--did not make up a unified whole. Their members came from different sections of the population, received different forms of training, and practised on widely different groups. After the establishment of the College of Surgeons in 1800 it was common for apothecaries to take the licence of the College as an additional qualification, but there still remained a social and professional gulf between these medical practitioners and the physicians.[1]

Mad-doctors came from all three strata, and Bedford Asylum was unusual in that its superintendent was wholly medically unqualified. It was far more usual for the superintendent to be trained as an apothecary or surgeon. At Nottingham Asylum from 1812 to 1844 the superintendent's post was held by Thomas Powell, a surgeon (with his wife as matron). At Lancaster, Paul Slade Knight held the posts of manager, treasurer, medical superintendent and surgeon from 1816

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was not medically qualified while his opponents were. Scull uses this to make his point about the growing medicalisation of the treatment of insanity. A less didactic explanation is simply that Pither was not very good at his job of governing a large institution. He was criticised repeatedly by the Visiting Justices for such matters as keeping pigs and for excessive expenditure (Beds. C.R.O., correspondence relating to Bedfordshire County Asylum, WI/136-180). It is significant that Pither's replacement, John Harris (whose medical training was only to the level of apothecary), was a keen moral therapist. Harris demanded a major change in the asylum regime, incorporating such features as that every patient "should have some occupation suited to his former habits" (letter to Visiting Magistrates, 2nd March 1829, in Beds. C.R.O., L.B. 1/2).

1 Holloway, 1966, especially pp. 107-9.

until he was sacked in 1824. Although trained initially as a surgeon, Knight, like Ellis, had upgraded his status to that of physician by qualifying as an MD from St Andrews University--a title which could be bought without further training as long as the application was countersigned by two other physicians. It was a very similar course to this which marked Ellis' own career. Ellis, it will be remembered, began as a surgeon's apprentice and only obtained his MD from St Andrews after he had accepted the post of director at the West Riding of Yorks Asylum.

What is significant about all this is that as long as the superintendent was not himself a physician, his authority was likely to be severely curtailed by the instructions of the visiting physician, who was appointed on a consultancy basis to look after the medical interests of the patients. As has already been seen, Ellis had to cope with a great deal of sniping from Crowther, the visiting physician at Wakefield Asylum. Crowther attacked Ellis, not only for his "autocracy", but also on the grounds that his medical training was insufficient: "he [Ellis] never had received any regular education for the profession; of course, his medical knowledge, when he came to Wakefield, was scanty".[1] Maybe it was, but Ellis' qualifications (especially once he had received his knighthood) were quite sufficient for the majority of the medical profession to accept his position at Wakefield as one of medical directorship. Ellis thus incorporated into his reputation the acceptance of the lay reformers who saw moral treatment as essentially a social movement, plus that of

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[1] C. Crowther, 1838, p. 50. Little is known about Crowther's own medical career. He was a GP in Wakefield for 20 years, as well as being physician to the Dispensary there. However, he was not a member of any of the medical societies or Colleges, which is surprising if his apparent professional pride is taken as a real reflection of his status in the profession.

being in the top stratum of the medical profession. As such, his career must be seen as highly significant; occurring as it did in a period when the administration of asylums was changing from a predominantly lay to a medical one, he was respected and respectable.[1]

Confirmation of Ellis' status, if such is still needed, can be seen in the very large salary he was making as an asylum superintendent. Together with his wife, he received £550 per annum, plus another £400 per annum in kind (services, provisions, accommodation, and servants). As Jones has pointed out, "He was thus in receipt of a gross wage of nearly £1000 per annum at a time when a living wage was well under £1 per week".[2]

In Ellis' career, as in the Tukes' before him, it is possible to see in action many of the social forces of his day. At the same time it is possible to see, and this chapter has been written to show, that moral treatment was not necessarily tied to the praxis of any

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[1] This of course is a recognition of Ellis' ideological significance, not a description of what his moral treatment was "really" like. To search for that is a harder task, especially when most of his critics were other professionals who saw him as a threat to their status. Apart from Crowther's complaints, there is an interesting comment made by Sir Alexander Morison (later to be visiting physician at Hanwell) when he visited Wakefield in 1823. Morison noted that on Thursdays (the day on which patients were received) and Fridays (the day on which patients' friends were allowed to visit), Ellis was "always at home on these days", as though he was not around for the rest of the week (Morison, diary entry for 2nd June 1823). That Ellis was not present every day was something firmly stated by Crowther. "Require him," wrote Crowther of Ellis, "daily to superintend the convalescent insane, in the field and in the garden, during the hours of labour; and you will secure to him better health than by permitting him to go out with the fox-hounds and to visit watering places" (C. Crowther, 1838, p. 104).

[2] K. Jones, 1972, p. 121. Ellis was also the highest paid of the county asylum superintendents of the time. In the Cornwall Asylum the joint salary for the superintendent and matron was £200, and at Stafford the superintendent received £200 and the matron an additional £40 (ibid., pp. 91-2).

one individual or class. It was simultaneously a basis for psychological development and an instrument of social control. Ellis' fragment of moral treatment reflected the various interests of certain sections of the bourgeois class. This ability to reflect such a breadth of interests was a powerful force in maintaining moral treatment as an active ideology.

And yet, as the picture has been portrayed so far, moral treatment appears as peculiarly lifeless, as little more than a vehicle for the ambitions of aspirants to the ruling class. In short, this past chapter has examined moral treatment from an external perspective and has ignored the internal dimension of its dynamic. It has been a necessary perspective, in that to locate any social phenomenon in the history of its time it is essential to provide this external view of its existence, fashioned as it must be out of the hopes and dreams of men who lived in that external world. But that is only half the picture. A major part of the strength of moral treatment was that it appeared as an autonomous reality, an ideology with a life of its own. It had an internal history--with of course a social significance--but with an immediate meaning that derived from medical and other forms of knowledge. It is only now, with the social dimensions of moral treatment having been firmly established, that we may enter its internal, epistemological, history.

CHAPTER FOUR

Moral Treatment as Knowledge

Bourgeois ideology continuously transforms the products of history into essential types. Just as the cuttlefish squirts its ink in order to protect itself, it cannot rest until it has obscured the ceaseless making of the world, fixated this world into an object which can be for ever possessed, catalogued its riches, embalmed it, and injected into reality some purifying essence which will stop its transformation, its flight towards other forms of existence.

--Roland Barthes, 1972

. . .residing amidst six hundred lunatics, no day passes over in which the truth of Phrenology is not exemplified.

--W.C. Ellis, 1836

By the 1820s, moral treatment was an established fact confronting the medical profession. As social practice it was apparently successful, and certainly as ideology it proved an adequate vehicle for a number of contemporary opinions. But medicine is not only the reflection of social fashions, however closely they may be tied to the realities of class struggle. Its rationale is the production and application of specialised knowledge. What was the relationship of moral treatment to medical knowledge? It is this question that the present chapter will attempt to answer.

As we have seen, neither Pinel nor the Tukes attempted to tie their moral therapies to a precise medical theory. The idea of manipulating the passions had a long history of medical associations, but it was never presented by Pinel as an advance in medical knowledge. Indeed, as modern commentators have pointed out,[1] moral treatment appeared to present the medical profession with something of an anomaly. There they were, overwhelmingly committed to a somatic or physicalist theory of disease, and moral treatment, the new wonder therapy, appeared to work upon their patients' minds.[2]

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[1] See for instance Bynum, 1974, pp. 329-31; Cooter, 1976, 135-6; Scull, 1975a, 250-4.

[2] Very few physicians at the time held the view that insanity was simply a disease of the mind involving no degeneration of the physical structure of the brain. Perhaps the strongest commitment to the idea of a sick mind that was held by a practising mad-doctor was that of W.S. Hallaran, physician at Cork Lunatic Asylum. Hallaran defended his concept of "mental insanity" with a quotation from the Bible: "The Spirit of man will sustain his infirmity; but a wounded Spirit who can bear?" (Proverbs XVIII, verse 14, quoted in Hallaran, 1818, p. 22). Not that Hallaran entirely rejected the need for somatic treatment, but he saw insanity as a disease having physical and mental properties in a far more distinct way than most writers on the subject. (See also ibid., pp. 64, 150.)

One extreme, and not very commonly held, position was to argue that moral treatment could have no value in dealing with the physical disease of insanity. A clear statement of this position was put by the visiting physician to Wakefield Asylum in 1827:

> From morbid anatomy we learn that in ninety-five cases out of a hundred of the deranged patients examined after death, the structure of thebrain is materially injured by chronic inflammation of its investing membranes, or by an effusion of water into its ventricles. It must be evident to every individual possessing common sense, that water in the ventricles and chronic inflammation of its membranes, can neither be obviated nor cured by moral treatment.[1]

Crowther maintained that he did not devalue the possible contribution of moral treatment in helping the insane, but he emphasized that this must remain secondary to the medical help the physician could provide. According to a petition he submitted to Parliament in 1834,

> after curing the bodily disease incident upon the first attack of insanity, nothing contributes more towards removing the mental alienation, than employment suited to the circumstances and habits of the patient.[2]

But the curing comes first, insisted Crowther, and it is only physicians who were competent to handle this aspect of treatment. This distinction between curing the illness and restoring the patient to full mental health is similar to the one that the private asylum owner, George Man Burrows, made in writing of Abercrombie's comments on insanity. John Abercrombie was physician to the Edinburgh Public Dispensary, and had a considerable reputation as a Society physician. The significance of his written work lies in the fact that he was a

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1 Caleb Crowther, letter to Visiting Magistrates of West Riding of Yorkshire Pauper Lunatic Asylum, 26th December 1827, in C. Crowther, 1830, pp. 16-7.

2 7th February 1834, in C. Crowther, 1838, p. 144.

follower of the Scottish "Philosophy of Mind" school developed by Thomas Reid and John Gregory, and this made his theories too mentalistic for most English physicians. Abercrombie was unconcerned with somatic bases of insanity: what he saw as important was the inculcation of "mental discipline".[1] Burrows' point was that this was all very well "for purposes of instruction, to guide the impressions and associations of early life",[2] but that as far as insanity was concerned the mental functions were too badly damaged for this sort of approach. The physician, according to Burrows, had to use methods that were more drastic and more fundamental than those which involved a mere exercise of mind.

Although this argument could be seen to possess (and still does) a great deal of theoretical attractiveness to physicians holding a somatic theory of insanity, in practice most doctors actually working with the insane recognised that such a distinction was untenable. The doctors had to deal with their patients as whole people; the restoration of health was as much an essential part of treatment as the destruction of disease. This was an old established truth that the moral therapists had rediscovered for themselves; although,

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1 For Abercrombie on the treatment of insanity see his 1832, pp. 306-49; and for his general attitude towards "mental discipline", his 1837, pp. 13-21. John Gregory had published a book as early as 1765 arguing for the inseparable effect of the mind on the body and vice versa (Gregory, 1765). That Gregory's work was not recognised as important by reformers of the treatment of the insane is perhaps to be located in the reasons that Shapin gives (Shapin, 1975) for the unpopularity of the "philosophy of mind" outside of the Scottish universities generally. Shapin argues that it was the contingent elitist associations of this philosophy, as propagated by the professors of philosophy in Scottish universities, that made it uncongenial to the democratic aspirations of middle-class intellectuals. There was certainly nothing intrinsically elitist or obscure about its intellectual content; indeed it was a psychological approach which would seem, on the face of it, to be very congenial to the moral therapists.

2 Burrows, 1828, p. 5.

for reasons which have already been discussed, this initiative for a new approach to mental health did not come predominantly from within the medical profession. But once that initiative existed, the medical profession had to come to terms with it. This was especially so in view of the association that many people made between the primarily medical institutions like Bethlem, and neglect, and lay-administered asylums like the Retreat, and compassionate concern.

One solution, and this was the one most popular with many of the less well-qualified mad-doctors in charge of private asylums, was merely to pragmatically accept moral treatment as something which worked. It was practised alongside medical treatment and defended on practical, not theoretical, grounds--just as had been done at the Retreat. A vivid example which illustrates this eclectic approach to therapy is the use made of the swing or the "rotatory machine" in the treatment of insanity.

The idea of swinging a patient to induce sedation mechanically goes back to Greek medicine, but it was reintroduced by J.C. Smyth who recommended it in 1787 for reducing fever and promoting expectoration in consumptive patients.[1] Whatever the original theoretical justification for the swing, Smyth's (and subsequent) recommendations of its values were based purely on a supposedly empirical observation that it caused a lessening of the symptoms of consumption, fever, mania, or whatever. Its value was that it could be defended on purely pragmatic grounds: that it worked, whatever the conflicting medical theories exhorting physicians to use one

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1 Smyth, 1787, p. 47.

method rather than another. Smyth had erected a swing in the grounds of the Middlesex Hospital, and from his account it appears to have been an ordinary garden swing. The idea was taken up by Erasmus Darwin who recommended the principle of swinging to reduce fever, only in Darwin's case his rationale was based on how a mill-wright

> told me, that he had more than once seen the experiment of a man extending himself across the large stone of a corn-mill, and that by gradually letting the stone whirl, the man fell asleep.[1]

Smyth had based his reasoning on the observation that sea voyages were good for consumption and that, according to Smyth, neither sea air, exercise, nor vomiting on its own had any effect. What was common to Smyth's and Darwin's suggestions was the belief, based on observation, that a regular swinging motion reduced fever. Since the symptoms of fever appeared to have many similarities with those of mania, it is not surprising that the principle of swinging was adapted for use on the insane. Joseph Mason Cox, a mad-house proprietor in Bristol, was the first to popularise the swing in this way in 1804, and 20 years later G.M. Burrows maintained that most British asylums were then using the swing.[2]

The patient was strapped into a chair and rotated by means of a windlass mechanism.[3] Both the horizontal and vertical positions were used, at speeds of up to 100 revolutions a minute.[4] Burrows also recounted the necessity of changing direction every six to eight minutes. The physical results of all this were understandably

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1 Darwin, 1794-1796, vol. 1, p. 218. See also vol. 2, pp. 608-9.

2 Cox, 1804, pp. 102-12; Burrows, 1828, p. 601.

3 For illustrations of swinging machines, see HMA, pp. 601, 650.

4 Hallaran, 1818, p. 95.

dramatic. "The consequence is, an instant discharge of the contents of the stomach, bowels, and bladder, in quick succession."[1] It also had an immediate and powerful effect on "lowering the circulation, and the general temperature of the body".[2]

All the writers on the subject advised caution; these were powerful results and, as Burrows pointed out, mad-doctors already had a bad enough reputation--what would be the consequences for the profession if a fatal accident were to occur?[3] What is interesting in the context of the present discussion is that, as Cox put it, swinging "is both a moral and medical mean in the treatment of maniacs".[4] He explained why: once it had been used on a patient

> the physician will often only have to threaten its employment to secure compliance with his wishes, while no species of punishment is more harmless or efficacious.[5]

He gave a case history to show the success of this principle. One patient was repeatedly treated with the swing. He made a partial recovery

> but his former mental peculiarities soon after returning, the swing was prepared. . .but rather than repeat the ride in the whirlygig, as he termed it, he submitted entirely to my wishes and with some occasional returns of obstinacy. . .I had the pleasure to see him gradually improve and advance to perfect reason.[6]

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1 Burrows, 1828, p. 601.

2 Hallaran, 1818, p. 94.

3 Burrows, op.cit., p. 605. For an example of contemporary opinion against the swing, see the letter to The Times, 18th August 1827.

4 Cox, 1804, p. 102.

5 Ibid., p. 109.

6 Ibid., p. 112. This moral advantage of the swing was reiterated by Burrows (op.cit., pp. 601,602); W.C. Ellis (1838, p. 228); Prichard (1835, pp. 216ff).

The swing thus worked on the body and the mind. It is perhaps more correct to say that the swing worked on the body and the thought of being strapped into it worked on the mind, but the two aspects were necessarily joined as far as both the patients and their doctors were concerned.[1] The point about the example of the swing is that it illustrates the pragmatic way that methods of treatment were accepted as having an effect on their patients' minds as well as their bodies. In view of the apparent belief by some present-day historians that late-eighteenth-century mad-doctors had some difficulty in reconciling physical and mental modes of therapy, it is worth emphasizing this point by reference to two more examples.

Bringing the patient into contact with water had been a perennially used method of treating the insane. Its justification had varied depending on the intellectual fashions of the times. In the eighteenth century it was still possible to point to examples of the use of water as a means of driving out spirits,[2] but its most frequent justification at that time depended on a pragmatic recognition that the mind and the body did "interact" and that what was done to one affected the other.

James Currie, physician at Liverpool Lunatic Asylum, gave a vivid example of a case of "furious insanity" admitted there in

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[1] Although at least one physician (Sir Alexander Morison) saw a direct "moral effect" created by being on the swing itself because, as he put it, "the disagreeable sensations produced by it tend to excite fear, and to rouse the indolent insane; the former effect may sometimes divert the mind from the train of ideas impelling to suicide" (Morison, 1828, p. 50).

[2] D.H. Tuke, 1882, pp. 11-23; B. Clarke, 1975, pp. 127-33; and for a commentary on the diverse justifications of the use of water, see Foucault, 1971, pp. 166-72.

1796. The patient

> was thrown headlong into a cold bath - He came out calm, and nearly rational. . .[When his calm state wore off two days later] he was again thrown into the cold bath in the height of his fury, as before. As he came out, he was thrown in again, and this was repeated five different times, till he could not leave the bath without assistance. He became perfectly calm and rational in the bath, and has remained so ever since.[1]

Such examples do not appear to have been exceptional. Perhaps the most frightening story of all is that of the woman patient who eventually agreed to "become a Loving obedient and dutifull Wife for ever thereafter" as a result of having 15 tons of water dropped on her in the space of 90 minutes.[2]

Sometimes the proponents of these schemes looked for theoretical justification of their therapies in terms of contemporary knowledge, but more often they were likely to advertise them on the grounds that they worked--for whatever reason. A second example of a therapeutic means coming into popularity at this time was a machine for administering electric shocks. The treatment was so common for a variety of ills that few writers bothered to comment on it. The London Electric Dispensary was founded in 1793 "with a view to afford a new benefit to the lower orders of mankind".[3] In the first nine years of its existence the Dispensary treated 3274 and "cured" 1401, including such cases as

> Hannah Atherway, for several years. . .subject to Hysteric Fits, so as to render her incapable of service; she was Electrified once a day for two months,

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1 J. Currie, 1805, vol. 1, p. 185.

2 Patrick Blair, Some observations on the cure of mad persons by the fall of water, 1725, quoted in HMA, pp. 326-9.

3 Highmore, 1810, p. 348.

which entirely removed her complaint.[1]

An electrical machine was bought for Bethlem in 1796[2] and for the Retreat in 1798.[3] William Ellis compared the values of the "electrifying-machine" to those of the swing in that "patients soon learn to put themselves under that discipline which will exempt them from such uncomfortable circumstances".[4]

These were therapies which were popular because they appeared to work. There is no doubt about their popularity, but where there was some doubt was in the extent to which they relied on esoteric knowledge to which only those in the medical profession had access. To some there seemed a danger that once the principle of "anything that works" was accepted, the medical profession would be made redundant in the treatment of the insane. This could, after all, be construed as the lesson of the Retreat. Medicine had not been outlawed from that institution, but it could be argued that the status of the medical profession had been severely compromised by the pragmatic attitude of the Tukes' approach to therapy.[5] To combat this, the profession had to demonstrate why it should necessarily be in charge of the treatment of the insane. To do this, it had to show that not only could physicians practice moral treatment, but that what they were doing could only be fully appreciated by another

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1 Bemrose, 1794, p. 10.

2 Bethlem Hospital, Committee Books, 7th June 1796.

3 Retreat Archives, Cash Book, entry for 12th October 1798.

4 W.C. Ellis, 1838, p. 228.

5 See for instance Scull, 1975a, pp. 250ff; Bynum, 1974, pp. 324-5.

member of the medical profession. In other words, moral treatment had to be incorporated not only into medical practice but into whatever it was that gave that practice its validity as medicine. The medical profession thus felt the need to demonstrate, to themselves and their critics, that moral treatment worked because it was merely exploiting in practical terms what the profession knew already in theoretical terms. This was something the Tukes had attempted to do for the religion of the Society of Friends. How could medicine assert <u>its</u> authority in this area?

One possible inspiration for the theoretical work that had to be done was of course the French tradition propounded by Cabanis and Pinel: that it was only the physician who understood the physical nature of man, so it was only the physician who could appreciate man's moral nature. A similar point was made by Thomas Percival in his influential work on medical ethics published in 1803. According to Percival, only the physician could

> unite an intimate knowledge with the laws of association; the controul of fancy over judgement; the force of habit; the direction and comparative strength of opposing passions; and the reciprocal dependencies and relations of the moral and intellectual powers of man.[1]

What Percival was saying, as Cabanis, Pinel, and many others had said before him, was that there were indissoluble links between man's mind and his body. What worked on one had an effect on the other. The point is a trivial one only if we ignore the enormous weight of the Christian tradition, which had in effect appropriated the spiritual aspect of human nature for so long. As the importance of this authority waned--as concepts like "Reason", for instance--became

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[1] Percival, 1803, p. 27.

increasingly secularised--so the medical profession attempted to include man's mind as well as his body within its province. Numerous medical texts around the end of the eighteenth century pointed out the interrelation of the mind and the body and the unique position of medicine in being able to appreciate the full subtleties of this phenomenon.[1]

There were two conclusions that physicians drew from this interrelation. One of these, as the visiting physician for Bedford Asylum argued in his attempt to get a medical superintendent for that insititution, was the need for physical medicine for disorders of the mind:

> Daily experience teaches me that a costive state of the Body, a Disordered State of the Stomach, and a pregnant condition of the Womb are capable of inducing temporary Melancholy, and great irregularity of moral action; and little difference is, I think, to be observed between the Ravings of the Drunkard, and the Paroxysms of the Maniac, beyond the length of their Duration. The influence of these circumstances upon the Mind prove its dependence and subjection to Physical Agents; and if Physical Agents can thus induce Moral Disorder, it is reasonable to presume that Moral Disorder may be corrected by Physical Agents. . . .great encouragement is I think held out for placing a Lunatic Asylum on the footing of a Medical Institution.[2]

The other conclusion was simply the obverse: disorders of the body could be affected by approaches to the mind. Pinel and Esquirol had done much to reawaken the profession's awareness of the role of the passions in this process, and a few English physicians reasserted their value in mad-doctoring. Thomas Young, reviewer of Pinel's Treatise for the Quarterly Review, gave a clear account of their

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[1] See for example J. Gregory, 1765, p. 6; Beddoes, 1802-1803, vol 3, frontispiece; S. Walker, 1796, pp. 212-24; J. Reid, 1816, p. 15.

[2] Joseph Thackeray, letter to Lord St John, 4th September 1815, (Beds. C.R.O., LBP/1).

function:

> the passions may be expected to be extremely active in exciting and not wholly ineffectual in curing the disease: since the violent passions appear to increase and the depressing passions to diminish the powers of the circulation in general, and both to affect particularly the state of the blood-vessels in the head. Passion, in a physiological sense, may be defined an affection of the nervous system, communicated from the brain to the sympathetic or visceral nerves, which govern the involuntary motions; and indicated in general by the acceleration or retardation of the heart.[1]

William Ellis was one moral therapist who recognised that much of his moral treatment consisted in manipulating his patients' passions. According to Ellis,

> In the moral treatment of cases of insanity, it is of great importance to ascertain the ruling passion of the patient: an appeal to this will frequently divert the attention, and obviate the necessity of having recourse to violent measures.[2]

This was a theoretical principle. In practice Ellis appeared to believe that one of the most useful passions was that of fear. He described the case of one patient who he frightened by threatening her with removal from her ward if she did not stop moaning at night.

> From fear of the consequences, she refrained from making the noise and laid still in bed. In a few nights the restraint she imposed upon herself produced sleep.[3]

Similarly, to threaten a patient with a session on the swinging machine was, in theoretical terms, merely to invoke the passion of fear.

The theory of the passions did then provide an intellectual basis for psychical intervention in cases of physical disease. On

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1 T. Young, 1809, p. 158.

2 W.C. Ellis, 1838, p. 220.

3 Ibid., p. 226.

the other hand it would not be fair to say that it was widely proclaimed as such: it was perhaps so much a part of "common sense" that to have announced it as a new discovery would have made the medical profession susceptible to ridicule. How could something which had been known for centuries involve an advance in science? What the medical profession, and especially that section of it connected with the treatment of the insane, needed at this time was esoteric, not taken-for-granted, knowledge.[1]

If nothing else had appeared, presumably sensationalism or the doctrine of the association of ideas would have been developed to fit the bill. But, as research of the last few years has demonstrated in detail, a particularly appropriate "scientific" theory did appear. This new "knowledge" of human nature was phrenology.

* * *

The contemporary importance of phrenology for the branch of the medical profession connected with the treatment of the insane can no longer be doubted following the meticulous and extensive work by Roger Cooter on the subject.[2] Cooter has described in detail the scientific and social significance of phrenology to the asylum physicians, and other writers have pointed out its more general social implications.[3] There is no need to repeat any of the excellent work that has been done, and much of what follows is

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1 It is perhaps this aspect of passion theory which leads both Scull (1975a) and Bynum (1974) to ignore it altogether in their accounts of the theoretical bases of moral treatment.

2 Cooter's long article of 1976 is based on part of the research undertaken by him for a Cambridge University PhD thesis.

3 DeGiustino, 1975; Maclaren, 1974; Shapin, 1975.

dependent on these secondary accounts, at least for its inspiration. The following account may be seen as complementary to this other work in that it does not intend to replace it, but to add to it by approaching the significance of phrenology from the standpoint of the specific concerns of this thesis.

Phrenology was a doctrine, originating in the work of Franz Joseph Gall, which located the faculties of the mind in the organs of the brain. Some of the early works on phrenology use the term "organology" to refer to this new description of the brain.[1] The mind, it was argued, occupied a series of organs, much as the ability to digest depended on the functioning of a number of physical digestive organs in the body. Gall attributed his original theoretical inspiration to his observation when he was a schoolboy "that fellow pupils with excellent memories had prominent eyes".[2] Gall later became the physician to a lunatic asylum in Vienna and his observations there and in schools and prisons convinced him that men's characters could be deduced from their physiognomy. Gall divided the brain into 27 organs, each one supposedly representing a discrete mental function. His pupil and colleague, J.G. Spurzheim, soon increased this number to 35. Figure 13 shows a typical popular illustration of a phrenological head, indicating the location of the various faculties.

All the boundaries of human nature, its attributes and functions, were redefined at a stroke. Morality was no longer to be a function of man's purpose in the world according to a metaphysics

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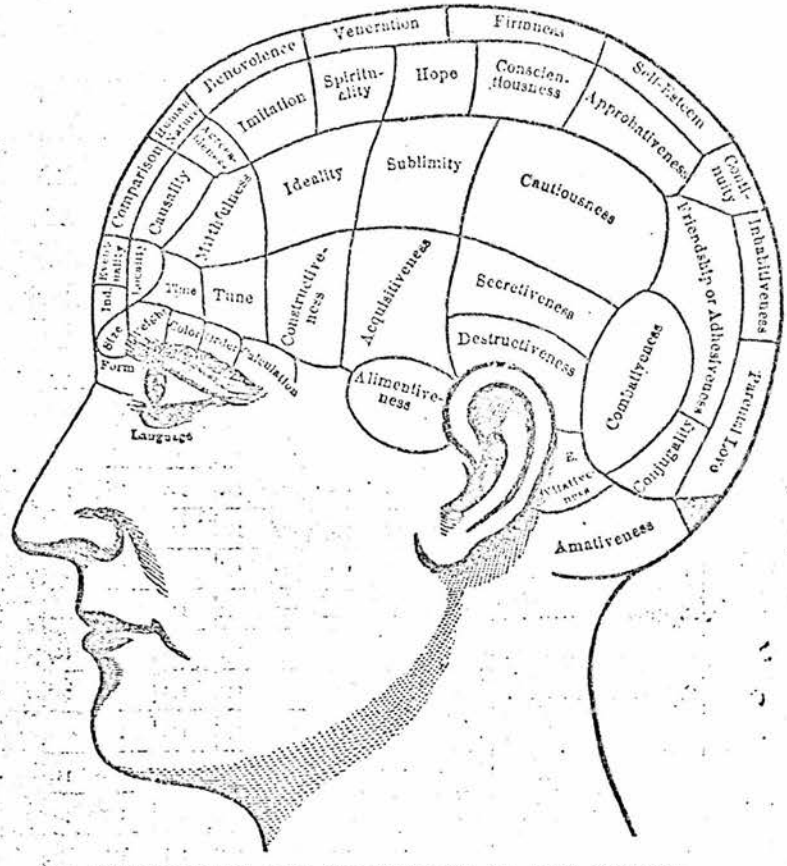
1 See for instance Forster, 1815a.

2 HMA, p. 712. Gall lived from 1758 to 1828. For a summary of his career see Temkin, 1947.

Figure 13

A phrenological head



NUMBERING AND DEFINITION OF THE ORGANS.

1. AMATIVENESS, Love between the sexes.
A. CONJUGALITY, Matrimony—love of one. [etc.
2. PARENTAL LOVE, Regard for offspring, pets,
3. FRIENDSHIP, Adhesiveness—sociability.
4. INHABITIVENESS, Love of home
5. CONTINUITY, One thing at a time.
E. VITATIVENESS, Love of life.
6. COMBATIVENESS, Resistance—defense.
7. DESTRUCTIVENESS, Executiveness—force.
8. ALIMENTIVENESS, Appetite—hunger.
9. ACQUISITIVENESS, Accumulation.
10. SECRETIVENESS, Policy—management.
11. CAUTIOUSNESS, Prudence—provision.
12. APPROBATIVENESS, Ambition—display.
13. SELF-ESTEEM, Self-respect—dignity.
14. FIRMNESS, Decision—perseverance.
15. CONSCIENTIOUSNESS, Justice, equity.
16. HOPE, Expectation—enterprise.
17. SPIRITUALITY, Intuition—faith—credulity.
18. VENERATION, Devotion—respect.
19. BENEVOLENCE, Kindness—goodness.
20. CONSTRUCTIVENESS, Mechanical ingenuity
21. IDEALITY, Refinement—taste—purity.
B. SUBLIMITY, Love of grandeur—infinitude.
22. IMITATION, Copying—patterning.
23. MIRTHFULNESS, Jocoseness—wit—fun.
24. INDIVIDUALITY, Observation.
25. FORM, Recollection of shape.
26. SIZE, Measuring by the eye.
27. WEIGHT, Balancing—climbing.
28. COLOR, Judgment of colors.
29. ORDER, Method—system—arrangement.
30. CALCULATION, Mental arithmetic.
31. LOCALITY, Recollection of places.
32. EVENTUALITY, Memory of facts.
33. TIME, Cognizance of duration.
34. TUNE, Sense of harmony and melody.
35. LANGUAGE, Expression of ideas.
36. CAUSALITY, Applying causes to effect. [tion.
37. COMPARISON, Inductive reasoning—illustra-
C. HUMAN NATURE, Perception of motives.
D. AGREEABLENESS, Pleasantness—suavity.

Source: O.S. and L.N. Fowler, no date, p. vi.

of being; morality henceforth was to become a function of the natural properties of human nature, as they were given and could be observed by scientific methods. This emphasis on naturalistic observations, on human nature as a product of "the independent operation of the natural laws",[1] was to have a profound effect on the future of the treatment of the insane. And yet this was not a totally original idea: it was after all in 1804 that the French physician, P.G. Cabanis, wrote that

> it is now beginning to be perceived, that medicine and moral philosophy form but two branches of the same science.[2]

Cabanis had in his turn formed his ideas partly out of the physiognomical theories of Lavater,

> the science or knowledge of the correspondence between the external and internal man, the visible superficies and the invisible contents.[3]

What the phrenologists appeared to do was to place this embryonic body of knowledge on a firm scientific basis. Although they believed that the position of the organs of the brain was set, they also maintained that there were large differences in size between individuals, with the size of each organ being directly related to its importance in that person's character. It was this aspect of phrenology that

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1 G. Combe, 1860, p. 22, emphasis in the original.

2 Cabanis, 1806, p. 304 (published in French in 1804).

3 J.C. Lavater, Essays on physiognomy, 1789, quoted in HMA, p. 521. In Cabanis' words, "[in lunatic asylums and prisons] you may find numerous proofs. . .of those constant relations between the physical and moral constitution of man. From their inspection you may learn, that criminal habits, and aberrations of reason, are always accompanied by certain organical peculiarities, manifested in the external form of the body, in the features, or in the physiognomy" (Cabanis, op.cit., p. 311).

led to its reputation as being primarily concerned with people's characters in terms of their "bumps on the head".

The implications of phrenology for theories of insanity were quickly noted. Spurzheim published a phrenological treatise on insanity in 1817, as did Thomas Forster.[1] However, as Cooter has pointed out, it was not until after lecture tours by Spurzheim and others in the 1820s that the principles of phrenology began to be widely accepted by the medical profession or by the literate public.[2] Much of this acceptance was due to the energetic proselytising of the popular writer George Combe, who, together with some assistance from his brother Andrew, became largely responsible for spreading phrenology in this country.[3] George Combe's The Constitution of Man first published in 1828, had reached nine editions by 1860.[4] Andrew Combe published a long and detailed phrenological treatise on insanity in 1831[5] and this work was influential in making the possibilities of using phrenology in the treatment of the insane both well-known and respectable. The following year the 22-year-old Forbes Winslow published a short book on the connections between phrenological knowledge and the understanding of insanity,[6] and although this was before Winslow had any sort of reputation (he was later to become the President of the Medico-Psychological Association), the publication of this work is indicative of the interest that phrenology was creating among the younger members of the profession.

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1 Spurzheim, 1817; Forster 1817.

2 Cooter, 1976, pp. 7-9.

3 G. Combe, 1850; Gibbon, 1878.

4 G. Combe, 1860. See also his 1824 and 1836.

5 A. Combe, 1831.

6 Winslow, 1832.

John Conolly, then a lecturer in medicine at London University, published his Indications of Insanity in 1830 as a textbook for his students. While this work was not meant as a phrenological treatise, it shows the obvious influence on Conolly's mind of phrenological ideas.[1] After leaving London, Conolly moved to Warwick where he was the founder and president (in 1834) of the Warwick and Leamington Phrenological Society.[2] That other famous moral therapist, William Ellis, helped found a phrenological society while he was superintendent at Wakefield Asylum,[3] and in 1836 he wrote to George Combe that

> I candidly own, that until I became acquainted with Phrenology, I had no solid basis upon which I could ground any treatment for the cure of the disease of insanity.[4]

The perceived importance of phrenology can be documented for many other notable physicians connected with the treatment of the insane. W.A.F. Browne was a lecturer on phrenology before and after his appointment at Montrose Asylum,[5] and Matthew Allen (proprietor of High Beech private asylum) was a lecturer in phrenology as early as 1817.[6]

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1 Republished in facsimile as Conolly, 1964. See especially pp. 79-81, 261.

2 See Hunter and Macalpine's introduction to ibid., p. 13.

3 Cooter, 1976, p. 5.

4 Quoted in HMA, p. 872. For the Combes' impressions of Ellis, see G. Combe, 1850, pp. 230-1. George Combe's own appreciation of the virtues of the phrenological treatment of the insane can be seen in his comment that "The great lesson is taught here [Hanwell Asylum] that by honouring humanity even in its lowest forms and conditions (in the pauper-idiot, and insane) it may be improved, and that it may be rendered comparatively cleanly, orderly, quiet, tractable, and useful" (diary entry for 9th May 1846, in Gibbon, 1878, vol. 2, p. 214).

5 Cooter, loc.cit., note 17. See also the Annual Reports of Crichton Royal Institution for the continuing use by Browne of phrenological concepts. Andrew Combe had intended to apply for the post of superintendent at Montrose but stood down when he realised that Browne was also interested in it (G. Combe, op.cit., p. 229).

6 M. Allen, 1837, p. ix; Barnet, 1965.

After detailing the extent to which phrenology was accepted by leading physicians, Cooter rightly points out that

> Altogether these alienists make up a list as impressive as it is substantial. It numbers ten of the medical superintendents of the twenty-three public asylums in England and Scotland in 1844 and among them all those which were considered most advanced in management and humanity. It includes too the proprietors, managers, surgeons and apothecaries of some of the more highly regarded borough and private asylums of the time.[1]

What was it about phrenology that made it so appealing to these reformers? The first point that must be made is that there was nothing intrinsically progressive or reformist about the phrenological doctrine *per se*. As Shapin has pointed out,[2] one of the major tenets of phrenology—that the faculties of the mind are innate—was used by British phrenologists to show the possibility of change. They argued that environmental influences could move one faculty to increased or decreased activity, as well as offset the effect of a deranged faculty with the influence of a healthy one. But the idea of the innateness of mental functions could just as easily be used to justify the *status quo*. This was exactly what happened on the Continent, where phrenology retained its conservative associations.[3]

One attraction of phrenology as understood by the medical profession

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[1] Cooter, 1976, pp. 6-7. It may be noted in parenthesis that Cooter uses the term "alienist" as though it was a contemporary term replacing the older "mad-doctor". On the date he gives as a reference for it (1889) it certainly did fulfil that function, but the OED dates it no earlier than 1864 and there is no use of the term in any of the texts examined for the purposes of the present research. There was a curious hiatus after "mad-doctor" went into disrepute during which physicians, apothecaries, etc., who dealt with the insane, had no generic title. This may perhaps be attributed to the lack of confidence of practitioners in their speciality (due to its bad reputation) existing at the same time as an urgent desire to be seen as ordinary and respectable members of the medical profession.

[2] Shapin, 1975, pp. 232-3.

[3] Temkin, 1947, pp. 287ff.

was that it made mental derangements apparently more tractable. By dividing mind into a number of functions, the derangement of mind could similarly be appreciated as the manifestation of many minor dysfunctions. John Conolly, for instance, defined insanity as

> the impairment of any one or more of the faculties of the mind, accompanied with, or inducing, a defect in the comparing faculty.[1]

This understanding of insanity as due to the derangement or faulty functioning of one or some of a large number of material organs gave the physicians plenty of scope for vivid accounts of what had gone wrong with their patients. Insanity was attributed to the over-activity of individual or combinations of two or three particular organs. In some of Matthew Allen's published case notes he attempted to provide full phrenological descriptions of his patients; for example,

> Pride, benevolence, hope, combativeness and amativeness full; caution, conscientiousness, and veneration partially defective.[2]

William Ellis also provided such descriptions of his patients as

> On examining her head I found Destructiveness Secretiveness Combativeness Firmness & Self Esteem all large. Intellectual faculties, Benevolence & Veneration & Tune very large.[3]

The therapeutic indications of this understanding of insanity were twofold. One was based on the simple acceptance of the principle that if the deranged organ had a precise physical location, then it could be treated with precise physical therapies. One physician apparently had

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1 Conolly, 1964, p. 300 (first published 1830).

2 M. Allen, 1831, p. 204.

3 Letter to unknown recipient, 31st December 1835, in HMA, p. 820.

much success by applying leeches directly on to the affected cerebral organ.[1] This sort of approach was an exception: the moral therapists on the whole were not great enthusiasts for physical therapies. Phrenology for most of them was important because it provided an intellectual basis for psychological remedies; it confirmed that the state of the various organs could be changed through an approach to the mental function corresponding to them. This other indication of phrenology, that the insane were susceptible to individual psychological therapies, which in turn depended upon the physician appreciating his patients as individuals with infinitely variable problems, provides the main connection between phrenology and moral treatment. It is also often recognised as a lasting legacy of phrenology which had a real effect, separate to the now discredited intellectual content of phrenological knowledge. Hunter and Macalpine, for instance, have written,

> It is a remarkable fact that phrenology which—as Ellis exemplifies—was so great a stimulus to psychology and added so much to moral treatment and the management of the insane, achieved all this almost despite and not because of its fundamental untenable tenets of innumerable propensities read from bumps on the head. How then did it achieve its great and progressive influence in this field? Surely because the the application of the doctrine made physicians take an individual interest in patients and their personalities. By providing an "-ology" it satisfied man's intellectual need to shelter under a system and follow a prescribed line.[2]

The main inadequacy of this type of interpretation is that, although it attempts to subject the intellectual content of phrenology to a critical analysis, it passes without comment the equally problematic notion of "individual interest". As has been shown, Pinel and the Tukes'

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1 John Epps, reported by Winslow, 1832, p. 27.

2 HMA, p. 873.

"individual interest" in their patients was closely circumscribed by their particular values. Phrenology represents an attempt to justify moral treatment with a different type of theory to Samuel Tuke's religious doctrines, but it was no less imbued with the values of its practitioners. This can be seen quite easily in the type of "individual interest" that the moral therapists gave their patients as a result of a phrenological assessment of their character.

In spite of all the assertions of noticing an over-endowment of one faculty or a derangement of another, the moral therapists rarely advocated any form of personal psychotherapy. As far as a general psychological approach was concerned, the contribution of phrenology can be seen in two ways. One was in the intellectual support it gave to what were quite unexceptional commonsense type observations. In his Treatise on. . .Insanity William Ellis proclaimed that he "should strongly recommend the study of phrenology,"[1] but instead of giving detailed instructions on how to do this, he made such remarks as

> A single glance will show, to a person in the habit of observing, whether the formation of the head indicates a naturally bold and passionate, or a timid and retiring man.[2]

It is this kind of remark that gives support to Hunter and Macalpine's interpretation of the value of phrenology. But diagnosis is one thing, treatment another, and it is with the latter that can be seen a more interesting and profound use of phrenology.

Phrenology was more than just a wild theory, a rationalization, or

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1 W.C. Ellis, 1838, p. 255.

2 Ibid., p. 256. See Shapin, 1975, p. 237 for a discussion of how this simple empiricism was phrenology's strength in making it a popular science which could be understood by all.

an essentially unimportant intellectual basis for starting societies in which like-minded social reformers could demonstrate their solidarity.[1] It was a body of knowledge by which social practice was interpreted, assessed and reformulated as the basis for fresh knowledge. It was taken seriously by the moral therapists and as such we must accept it as part of the dialectic of history. The subsequent history of moral treatment, as of the entire treatment of the insane, was heavily determined by what phrenology established as normative practice. It is because of this that it must be allowed a far deeper appreciation than the usual cavalier "interpretations".

Phrenology did not just provide a "system", an apparently scientific front behind which the moral therapists could masquerade their interests as objective knowledge. It did do this, but it also provided the intellectual basis by which a variety of ad hoc suggestions about moral treatment could be petrified into distinct forms of knowledge.

One of the "benefits" of phrenology was its supposedly scientific validation of the belief that the insane could be educated far more than was generally believed possible. The idea that anyone could benefit more from education than was normally supposed was not in itself a new idea. It had been expressed as early as the 1790s by educationalists like the Edgeworths.[2] And in 1810 the erstwhile revolutionary, John Thelwall,

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1 This latter thesis is one put forward by McLaren, 1974.

2 See for instance their comment that "It is not from want of capacity that so many children are deficient in arithmetical skill and it is absurd to say 'such a child has no genius for arithmetic, such a child cannot be made to comprehend anything about numbers'. These assertions prove nothing, but that the persons who make them are ignorant of the art of teaching" (R. L. and M. Edgeworth, Practical Education, 2nd edition (1801), quoted in Simon, 1960, p. 47).

in a treatise on speech defects, wrote that

> the development of the organic faculties, is so far dependant [sic] upon mental impression, and educational culture, that few persons are at all aware of the extent of improvability in the respective organs, or of the power that there is in one organ, of supplying the deficiencies, and performing the functions of another.[1]

It is this principle that the phrenologists developed and made the basis of their therapeutic optimism. A commitment to this principle signified a commitment not only to the education of those who were "normal" but asserted the possibility of improving everybody. What did it matter if the working classes were, as individuals, virtually mentally subnormal? They could be improved through education. According to John Conolly in 1830,

> The faculties of uneducated people, and particularly of the lower order, who are neither instructed by precept nor observation, are so little used, as to be incapable of many kinds of mental exercise. . .Even their senses are so unskillfully employed and unimproved that we cannot always depend on what they believe they have seen with their eyes, or heard with their ears.[2]

These are strong words, but Conolly did not draw from them a pessimistic conclusion. Instead of dismissing the poor and the mad as capable only of limited improvement, he saw, mediated through his phrenological beliefs, something of the full possibilities that education could provide.

Of all the moral therapists, Conolly took the formal education of pauper lunatics the most seriously. In 1842, when he was superintendent of Hanwell Asylum, he had classes started in reading, writing and arithmetic, and drawing and singing. The classes were suppressed by order of the visiting magistrates who objected on grounds of economy--that there was no point in spending money on the mental improvement of paupers who

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1 Thelwall, 1810, p. 77. See also pp. 58-9.

2 Conolly, 1964, p. 99.

were only going to work at menial tasks if they were ever discharged. Classes were started again in 1847 and 1848, but again were not allowed to continue. Something of the point that Conolly saw in education appears in his comment that

> As the lessons proceeded, it was found that more command was obtained by the patients over their powers of attention, and that they read with more confidence.[1]

This sort of statement is very similar to those that other moral therapists made on the value of work. By engaging in purposive activity, whether it was pushing a wheelbarrow or learning to write, everybody could increase his or her self-respect and grow to something more than he or she had been before. In Conolly's words,

> whoever will determine to employ the faculties of his mind diligently, and especially his attention, will discover that he can understand more, and effect more than he at one time believed possible to do. Whatever talents are possessed, it is a positive duty to exercise them.[2]

It is no distortion to see moral treatment itself, in yet another of its fragments, as simply a form of education. The patients were taught, sometimes formally but more often not, a variety of precepts and skills by which they could develop those aspects of their personality that were not damaged. W.A.F. Browne pointed out how this principle would work, even in relation to such minor aspects of asylum life as the lending of library books:

> the ordinary rules of moral treatment must be rigidly observed, and every reader [in the asylum library] supplied, not according to his wishes, but his wants, not merely in relation to recreation, but in relation to his

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[1] Conolly, 1968, p. 129. See also his 1973, pp. 249-52, 275; and J. Barlow, 1849, pp. 108-19 for further commentary on education at Hanwell.

[2] Conolly, 1964, pp. 74-5.

recovery. . .Patients have been cured by being re-educated.[1] This active education of the patients appears, at face value, to have been a more radical proposal than giving the patients work to do. Certainly the fact that it was never more than a short-lived experiment was not Conolly's fault. It was the dismissal of the schoolmaster in 1852 for reasons of economy that led Conolly to finally resign his remaining position at Hanwell.[2]

What is more to the point here is the philosophy underlying asylum education. As Conolly himself pointed out, education of the insane was qualitatively no different from education of the poor or other disadvantaged groups. All were capable of learning far beyond previous expectations. But what was the point of this learning: why should man's faculties be developed in particular ways? It was one thing to suggest that a lunatic dominated by an obsession with religious guilt should be encouraged to develop his faculty of self-esteem, but the phrenologists took education much further than the mere cancelling out of a bad function with a good one (the "balancing of the passions" that Pinel had introduced). Why was education so popular with the phrenologists?

First of all it must be said that education based on phrenological principles may only superficially be presented as resting on the same intellectual and radical tradition as that established by writers like the Edgeworths and Thelwall. The full picture is more complex: education of the insane may have involved a radical departure from the usual concept

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1 Montrose Lunatic Asylum, Annual Report, 1837.

2 Hunter and Macalpine, introduction to Conolly, 1973, p. xxxiv. Conolly was at this time only visiting physician, having resigned his post of medical superintendent because of a policy disagreement in 1844.

of therapy, but it could no longer have the same radical connotations it might have had in the 1790s.

At that time the aim of the ruling class was the maintenance of order in ways that differed as little as possible from the methods sanctioned by centuries of tradition. The significance of educationalists like the Edgeworths is that they represented a radical alternative to the more typical "inculcation of morals" type of education popular at that time. The following view of education by Hannah More was far more common among the ruling class than the rationalist enthusiasm of Thelwall:

> My plan of instruction is extremely simple and limited. . . they learn on weekdays, such coarse work as may fit them for servants. I allow of no writing for the poor. My object is not to make them fanatics, but to train up the lower classes in habits of industry and piety.[1]

By the 1830s the face of Britain had changed dramatically and along with it the opinions of the ruling class. The owners of capital and their ideological representatives realised that education could be used in a far more active way, to create a maintenance of order in what appeared to them as a very unstable society. The ideological justifications that were used to maintain order in the villages were neither appropriate nor accepted in the industrial towns. Formal education provided the means by which to instil fresh values in the minds of the working class.[2]

What happened was that the idea of personal growth, which represented a radical idealism in the 1790s, was adapted by bourgeois

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[1] Quoted in Simon, 1960, p. 133. For a methodical summary of the main approaches to education at this time see Silver, 1965, chap. 1.

[2] On the social control function of education in this context see R. Johnson, 1970; Shapin and Barnes, 1977.

ideologists to fit into the specific requirements of the reproduction of the social relations of capital. The point is easily illustrated by a book that Conolly was responsible for producing in 1831.[1] This work, entitled The Working Man's Companion, announced quite unambiguously a conception of mental health as a product of individual effort tied to the creation of capital. One vivid example that Conolly provided for the "working-man" to model himself upon was of a "poor but industrious lad" who got a wholesale tea merchant to sell him a pound of tea on credit.[2] The boy then sold the tea to his neighbours at 1½d. per ounce more than he paid for it (6d. instead of 4½d., a mark-up of 33%!). The trainee capitalist kept on doing this until he had enough capital to buy a shop. The moral that Conolly drew from this story was not that there was so much poverty in England because the poor were constantly being exploited by capitalists, but that only by the creation of capital was it possible to provide sufficient work. The aim of all workers according to Conolly, must be, like that of the boy selling tea, to create capital.[3]

The point that was repeatedly emphasized in this work was that it

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1 [Conolly], 1831. On the attribution of this work to Conolly, see C. Knight, 1864-1865, vol. 3, p. 159. It is not known how much if any of this work was actually written by Conolly, but he had total editorial responsibility for it.

2 [Conolly], op.cit., pp. 103-5.

3 It was not uncommon for enthusiasts of moral treatment to compare its effects directly to the accumulation of capital. Nathaniel Bingham, for instance, defined the power of moral treatment as "founded on the well-ascertained fact, that persons labouring under various degrees of incapacity may have what remains of their understanding improved by cultivation, just as. . .a tradesman increases a small capital by good management" (Bingham, 1841, p. 62).

was not the end result that mattered but the means by which it was achieved. Saving money, for instance, was good; not because it produced a material advantage such as comfort in old age, but because, according to this publication, it had a moral worth of its own:

> every working man or woman, whatever may be his or her condition, and whether the savings made are great or small, does, without any doubt, become a better man, or better woman, than any of those can be, however rich, who lay by nothing.[1]

It was not the rationalist utopianism of unlimited improvement that was being argued here. The objectives were narrowly defined and all too easily recognisable. As Conolly put it, writing of a successful carpenter, "So both he and his wife agreed, that the best fortune for their children would be a good education, and regular habits of industry".[2]

With that sentiment we are back full circle to the issues raised in Chapter Three. Education and individual improvement were only recognised as worthwhile as long as they contributed to "habits of industry"; as long as they manufactured, to put it bluntly, a conditioned working class.

The long-term result of this approach to education has been perhaps even more insidious. By emphasizing the rewards that can be achieved by

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1 [Conolly], 1831, p. 26.

2 Ibid., p. 44. In Conolly's defence it must be said that his early idealism mellowed as he appreciated the real social constraints on many of his patients. Instead of continuing to proclaim the virtues of individual effort as a solution to all problems, he came to recognise in the later 1840s that much could be done to improve conditions by social means. In a lecture he gave at the Royal College of Physicians in 1849 he criticised the lack of social conscience in the medical profession: "successive examples of disease occur, and successive epidemics destroy and pass away", he said, "and we do not apply ourselves to the true wisdom of so amending the lot of labour as that it may shield each honest family from the pestilence which always first assails the wretched and the unprotected" (Conolly, 1849, vol 2, p. 446).

each individual as a result of his or her personal effort, this segment of bourgeois ideology has done much to prevent the formation of a consciousness by the working class of itself as a class, with interests separate to those of serving capital.

A recent study of a particular adult education enterprise at this time has pointed out its function as an attempt

> to build an alliance or a community of interest between the bourgeoisie and the upper section of the working classes, the emerging labour aristocracy. In contrast to crude attempts at coercion or suppression, liberalizing strategies involved policies of "cultural aggression" which by bribe or indoctrination would ensure that the "natural leaders" of the working classes identified with and affiliated to those above them rather than those below.[1]

Conolly was heavily involved with the Society for the Diffusion of Useful knowledge and with the Mechanics' Institutes, two institutions that aimed very much to appeal to a "labour aristocracy". Conolly believed, like all moral therapists, in the need of the individual to liberate himself from whatever difficulties he found himself in. In the context of what was happening in English towns in the 1830s and '40s, this type of education can only be seen as a means to destroy the potential of the working class to act as a class for itself. This subject leads outside the scope of this thesis, but it must be mentioned because it is one of the pervading aspects of what may be called the "doctrine of individualism". As long as each individual is encouraged to believe that his way out of poverty and deprivation must be at the expense of his fellows, then there is little chance of developing a mental health which is more than a reflection of capitalist social relationships.[2]

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1 Shapin and Barnes, 1977, p. 40. Another discussion of this aspect of the Mechanics' Institutes appears in Royle, 1971. On the acceptance of middle-class ideals by the nineteenth century labour aristocracy see also Perkin, 1972, pp. 305-8.

2 In this connection it is worth mentioning what that other famous

Even within the context of early industrial capitalism there were other paths to social improvement which were being discussed and which did not rely quite so heavily on individualist ideology. The various models discussed in Chapter Three indicate something of the range of ideas; from the extreme individualist logic of the single-celled Panopticon to the moral community of the Home Colony. Robert Owen's ideas, for instance, cannot simply be labelled "socialist", but he did have a more socialist attitude towards "community" than did the phrenologists, who saw the environment primarily in terms of a greenhouse in which individual talents could be nurtured.[1] The strength of phrenology in this context was that it appeared to explain all the social problems of the time—poverty, ignorance, crime, insanity—as well as to provide a solution to their control and eventual abolition. It seemed to explain why some individuals were happy and rich and others miserable and poor. It confirmed, at a theoretical level, than an individual's interests were best served by applying reformative programmes and sanctions to his personal behaviour. In this sense the moral treatment of the insane may be compared to a system of education.

But phrenology did more than that. It appeared to provide a scientific basis on which to classify the categories of insanity itself. It was at this time that the formal medical categories of insanity

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moral therapist, W.A.F. Browne, wrote in 1849, the year after the greatest-ever demonstrations of power by the European working class: "To become a Communist is not necessarily to become a madman; but when persons of education and fortune reduce such a theory to practice, when with their new creed comes a revolution in all their habits. . .the true origin of the mental change may be suspected" (Crichton Royal Institution, 10th Annual Report, 1849, p. 11).

[1] This point is elaborated in De Giustino, 1975, pp. 139-45.

underwent a major transformation: this was not directly connected with moral treatment but it was governed by the same rationalising process that made moral treatment appear as a meaningful activity, and as such a discussion of it will help to clarify the significance of moral treatment. Phrenology was not the only intellectual force of importance in this process but the other physicians of insanity did not markedly disagree with the phrenologists about this subject. Whatever the differences between the various theories on the nature of mind, all the physicians (who bothered to write about it) agreed on two principles when it came to classifying insanity: the location of the problem in the characteristics of the individual presenting the symptoms, and the need to subject the deviant properties of insanity to more efficient technical control.

The emphasis on the first of these principles can be seen in such remarks as Winslow's that "Insanity is frequently only an exaggeration of the natural character of the person afflicted".[1] What he meant by this is that, for instance, the organ of acquisitiveness, perhaps already highly developed in a particular individual, could be allowed to become over-excited and thus cause insanity. The historical significance of this idea can be seen by recalling the medieval and renaissance concepts of madness.

For the period up to at least the mid-seventeenth century, madness was not considered as being qualitatively distinct from normal behaviour. The distinctions that were made were more quantitative, emphasizing for instance that there was "no difference between anger and madness, but continuance; for raging anger is a short madnesse. . .".[2] Similarly,

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1 Winslow, 1832, p. 22.

2 Joseph Hall, writing in 1625, quoted in Bamborough, 1952, p. 17.

with drunkenness,

> Rede all bokes and thou shalt neuer fynde
> That dronkennes and wysdome may togyther be
> For where is dronkennes, there madnes is by kynde
> Gydynge the hauer to all enormyte.[1]

In other words, all men could be equally moved by the passions, or affected by the moon, or struck by disease. Man in general had a certain responsibility to try and control his sensitive appetite but, in line with religious doctrine, it was accepted that men in particular could not avoid sinning. And while both sin and madness were to be avoided if possible, there was an established machinery to absolve the individual from any particular act of deviance. The responsibility for the control of moral deviance rested ultimately with God's representatives in the Roman Catholic Church here on earth.

As this essentially feudal notion of responsibility crumbled with the social relations of production which had given it some relevance, so the ideologists of the ascending ruling class attempted to introduce into the concepts of deviance something more appropriate to the reproduction of the social relations they wanted to maintain. Madness changed from being an attribute of the individual act of deviance to an aspect of the mental constitution of the person who exhibited it. The development of concepts like "character" indicate this growing emphasis on individual endowments and responsibility to control them rather than on the attributes held by all mankind which were primarily the problem of the feudal authorities.

As we have seen, this change had a liberating power as well as a

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[1] Brandt, 1874, vol. 1, p. 97. (This was a reprint of A. Barclay's 1509 translation of Brandt's Ship of Fools of 1494.) On this subject see also the many examples in Doob, 1970, chap. 2.

narrowing one: it opened the door for the recognition of individual achievement and effort. But its corollary, at least as far as most mad-doctors were concerned, was the belief that insanity was a problem not so much of the human condition but of the individual who exhibited the disease.[1] The medical theorists of the eighteenth century attempted to incorporate greater awareness of this in their nosologies of disease, but most of these appear to owe far more to their creators' academic interests in presenting formal and intellectually satisfying systems.[2] They bore little relation to the types of insanity that many mad-doctors noticed in their daily practice. Especially for the physicians who wanted to apply Ellis' dictum that "in the moral treatment of insanity it is of great importance to ascertain the ruling passion of the patient",[3] the old divisions of mania and melancholia were too general and too vague. Pinel noticed this, as did his pupil Esquirol, who did much to theorise Pinel's practical intentions. Esquirol pointed out that if the passions could be used both to cause and to cure insanity, then it made sense to categorise varieties of insanity corresponding to the particular exciting cause. Quite often the derangement of mind appeared not to be general, destroying all its faculties, but partial, affecting those faculties relating to the cause. To these partial insanities Esquirol gave the name "monomania".

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1 One indication of this is the number of psychiatric studies of Hamlet that appeared in the nineteenth century, and which interpreted his behaviour in terms of mental pathology. Conolly, Browne, and Combe all wrote such accounts, and Bucknill wrote a book on The Mad Folk of Shakespeare.

2 See for instance Cullen, 1784, vol 4, pp. 125-35; Arnold, 1782, vol.1, pp. 1-74.

3 W.C. Ellis, 1838, p. 220.

> Monomania, characterized by a passion either gay or sad, exciting or depressing, and producing a fixed and permanent delirium, attended also by desires, and determinations depending upon the character of the prevailing passion, is naturally divided into monomania properly so called, which is indicated by a partial delirium, and a gay or exciting passion; and into monomania which is signalized by a partial delirium, attended by a sad or depressing passion.[1]

Esquirol's work was very influential in England and the concept of monomania was generally accepted as marking an improvement in classificatory principles. Esquirol's rather narrow emphasis on the role of the passions was extended to apply to all of the faculties of the mind. One of the clearest definitions of monomania in this country was provided by J.C. Prichard, author of an influential textbook on insanity, though not a phrenologist. In his words,

> Monomania, or partial insanity, in which the understanding is partially disordered or under the influence of some particular illusion, referring to one subject, and involving one train of ideas, while the intellectual powers appear, when exercised on other subjects, to be in great measure unimpaired.[2]

As Cooter has shown,[3] the concept of monomania was seized upon by the phrenologists; it seemed to provide a perfect justification for their belief that the mind consisted of discrete functions. The phrenologists also emphasized that the existence of a multi-faceted mind gave credence to their assertion that the brain could be similarly divided into numerous discrete functions. To appreciate the full significance of this point it is necessary to recap briefly the changes in the relationship between moral treatment and the concept of mind as they have been presented so far.

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1 Esquirol, 1965. p. 203 (from his essay on "Lypemania" first published in 1820).

2 Prichard, 1835, p. 6. A similar definition was used by Sir Alexander Morison in his lectures on insanity (Morison, 1828, p. 55).

3 Cooter, 1976, pp. 136ff.

The word "moral" was, as has been shown, originally derived from "moral affections" or "moral sentiments"; that part of the mind which dealt with affectivity and feeling, and originally derived from the medieval concept of man's sensitive appetite. This was essentially the sense in which the word was used by Pinel and Esquirol. In terms of this meaning, Esquirol's definition of monomania provided a perfectly consistent vehicle for showing the effect of moral causes and the moral treatment of insanity. By extension, the word "moral" continued to be used for all the causes and therapies of insanity which worked by acting on the mind, as in the monomania of Prichard and Morison. A separation between body and mind was not implied by this model—indeed such a connection was implicit in it, as it had been in the humoural understanding of psychophysiology from which it was derived.

But this was only one of the sources from which the English use of "moral" treatment took its meaning. The other was the ethical use of the term signifying the ability to distinguish right and wrong, and this of course was the dominant meaning of "moral" as used at the Retreat. Tuke's understanding of moral treatment did not deny a relationship between mind and body, but neither did it contribute towards demonstrating the existence of such a relationship. For Samuel Tuke, "moral" was a suitable adjective to apply to the workings of the mind because, according to the Quakers, by exercising our mind <u>in certain ways</u> we show our moral purpose in the world as laid down by God. This ethical overtone would also have appealed to William Ellis, a devout Methodist with a strong religious concept of his place in the world. For Ellis, as for the Tukes, we may say that religion was the mediating force through which their belief in a particular social order appeared to them as a moral order, and their belief in this moral order was given expression by them

in the social order of their asylums.[1] But, while this was one strand in the meaning of "moral treatment", it was not one that was particularly appropriate to the interests of the other moral therapists.

The bourgois class did not want to deny the existence of God, but it did want to show the purely material basis of man. In its everyday existence it was transforming the world in a more fundamental way than had ever been done before: not surprisingly it began to reflect this power in its consciousness of itself. One example of this was in the increasing secularisation of the concept of "Reason" itself. "Reason" had been gradually secularised in the eighteenth century, although groups like the Quakers and the Evangelicals still gave it a mystical quality and looked upon it as something which would remain forever beyond man's understanding. It was simply <u>there</u>, something by which man had to regulate his life. What Gall and the phrenologists did was to reject the existence of such vital principles in the world, and to assert that reason was merely the function of man's abilities. Reason thus became no longer something given, but something that man had to make; no longer an <u>a priori</u> feature of human nature, but "the result of a happy development of all anterior-superior parts of the brain".[2] Gall evaded the accusation of materialism by saying that these faculties which gave man the ability to develop reason were specific to man and given by God. It was not the first time that this type of theory had been used, but phrenology did accept its own materialist implications far more

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1 For an indication of the commitment Ellis made to Methodism see the biography of him by his granddaughter ([H.W. Ellis], 1868); and on the moral force of Methodism at this time, see Thompson, 1968, chap. 11.

2 Gall in 1819, quoted in Temkin, 1947, p. 284.

than, for instance, Hartley's doctrine of the association of ideas.[1] Insofar as it did, it can be seen as indicative of a growing self-confidence by the bourgeois class of their ability to make their own future, although not yet confident enough to discard the notion of a prime mover who put them there to do just that.[2]

This ambiguous attitude towards their own authority can also be discerned in the discussions that took place on free will. The phrenologists asserted that man does have freedom of will, that "God in giving the power, does not inflict the necessity",[3] and that

> liberty consists in the possibility of doing or not doing anything, and in the faculty of knowing the motives and of determining one's-self according to them.[4]

Whatever the individualist implications of this statement, it does

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1 Although Hartley provided a psychophysiological model of human nature in which the existence of mind was firmly placed, he also wrote into his theory "a scholium making it against the rules to deduce the materiality of the soul from his physical model of the mind" (Bynum, 1974, p. 320, referring to Hartley, 1749, vol. 1, p. 33). It must be stressed that there was nothing instrinsic in phrenology which caused it to become a scientistic theory of human nature. The phrenologists could, like David Hartley before them, have emphasized the moral connections between God and man. Instead, some writers drew the radical conclusion that phrenology "strikes at the very source of religion, and is a new and invincible proof of the good foundation of the science called Atheism or Materialism. . ." (Richard Carlile in 1826, quoted in McLaren, 1974, p. 92).

2 This explanation is not markedly different to that appearing in Scull, 1975a, pp. 250-5; or in Bynum, op.cit.. Where my account does differ is in the emphasis I lay on the significant factors. Bynum emphasizes the epistemological barriers to the emergence of a psychophysiological account of insanity, and Scull emphasizes the professional imperialism of the asylum doctors which led them to look for one. While not denying that these factors existed, I have attempted here to locate them within the structural features of a society which in effect gave the physicians little option but to do precisely what they did.

3 Spurzheim, 1815, p. 500.

4 Ibid., p. 505.

assert the essentially humanistic basis of all value. As one physician enquired, even if it were discovered that man had an organ of destructiveness,

> does this doctrine [of phrenology] diminish the responsibility for the crime of cruelty or murder, or the necessity for controlling that bad disposition?[1]

The answer given was always "no": man did have the ability and the responsibility to exercise his freedom of will over his various faculties. But what the phrenologists did not appear to notice was that this "freedom" was always lost the moment it was gained. Whatever the philosophical assertions, in practice the prescription of moral laws extended as tightly over the exercise of freedom of will as it did over the propensities this freedom of will was supposed to control.[2]

Discussions of morality by phrenologists, while always asserting the need for man to act responsibly, also located very firmly the boundaries of that responsibility in specific functions of the mind. The implications of this for the nascent science of psychiatry were to be profound because they appeared to demolish at a stroke the ambiguities surrounding the word "moral".

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1 J. Johnson, 1836, p. 74.

2 This point has of course been made above in relation to the practical therapies of work and education. All that is added here is the epistemological argument on which the practice was based. For an example of a phrenological treatise written specifically about the relation of the doctrine to morality, see Epps, 1834. More generally, it is worth mentioning that there is a very interesting parallel here with the Marxist concept of "praxis" which is of course the theoretical concept on which this whole thesis rests. Praxis recognizes that "It is by transcending the given toward the field of possibles and by realizing one possibility from among all the others that the individual objectifies himself and contributes to making History" (Sartre, 1968, p. 93). The difference between these two concepts of human nature is not at this moment a theoretical one, but lies in the extent to which they accept in practice the ability of morality to be determined by conscious men themselves. Phrenology imposed a traditional and well-worn series of moral precepts on to its theoretical recognition that such precepts could be decided by man himself; and historical materialism has in practice no better a reputation, whatever its theoretical commitment to class morality.

The immediate semantic history of the term has just been traced; it referred to both mind and to morality, but not explicity to medicine's recognised area of authority, the body. What phrenology did was to take the two meanings of "moral" and place them clearly within the organs of the body. As with "Reason", morality was to be divested of its metaphysical associations and redefined as a function of man's normative behaviour.

A large part of Andrew Combe's treatise on insanity can be seen as an attempt to make this point clear. One way in which he did this was through his discussion of the moral causes of insanity. He indicated that he was quite aware that he had translated "moral" into "functional" and justified his action on the grounds that

> The term moral cause has a reference to disease in the mind itself, and was used by those who subscribed to this hypothesis. The term functional has a reference to disorder in the action of the organs of the mind, and is therefore more proper for our purpose.[1]

This was a momentous step, for it marks the foundation of one of the bases of modern psychiatry—the existence of functional disorders such as schizophrenia. We are starting now to enter the same language that we use today, implying the same apparently scientific assumptions as to how things "really" are.[2] With phrenology, a metaphysics of the mind

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[1] A. Combe, 1831, p. 149. Combe exaggerated the contemporary use of "moral" to refer to diseases of the mind. Very few doctors held that hypothesis. The most that was usually accepted was that it was possible to consider moral causes and moral therapies without enquiring what their effect, if any, would be on the workings of the body.

[2] Nor is it only psychiatry that "benefitted" from this change. In a paper entitled "The history and derivation of the word 'function' as a systematic term in psychology", the author, K.M. Dallenbach, concluded that "phrenology is the matrix from which our term is derived" (quoted in Cooter, 1976, p. 3).

was formally abolished from the definition of insanity. Andrew Combe recognised this quite clearly, as have psychiatrists ever since.

> Had insanity been recognized to be a symptom of cerebral disease, the insane would never have been rejected and excluded from our sympathies as the detested of Heaven, nor would they ever have been tortured by the lash or the chain, or exposed to public derision. . . .The moment we know that madness is an effect of disease in the material organs with which the Creator has connected the principle of mind, and that to this infliction alone are to be ascribed the waywardness, violence, and impetuosity, which often characterize that state, our feelings towards the unhappy patient, and our attempts at cure, will be very different indeed from what they would be, were we still ignorant of its true nature.[1]

Combe meant by this that the naturalistic understanding of disease eliminated the possibility of the physician condemning the insane, just as it eliminated the possibility of condemning a sufferer from consumption. As shown in the Introduction, this opinion is held by many influential psychiatrists today.

This argument is no doubt emotionally satisfying to those physicians who hold it, but it begins to appear rather strange once the content of the new functional disorders are spelled out in any detail. As will be seen, the moral (ethical) connotations of mind were not abolished when mind was given material substance; they merely underwent a transformation in keeping with the interests of those who held the new doctrine. This can be clearly seen in the content of the monomanias that were being discovered.[2]

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1 A. Combe, 1831, pp. 77-8.

2 The following passage is perhaps not meant to be taken entirely literally, but it does show something of the climate of opinion: "There must be a kind of rough understanding as to the forms of lunacy which can't be tolerated. We will not interfere with the spendthrift, who is flinging his patrimony away upon swindlers, harlots, and blacklegs, until he has denuded himself of his possessions and incurred debt. We have nothing to say to his brother madman, the miser, who pinches his belly to swell the balance at his banker's--being 73 years of age, and without family,--but, if he refuse to pay taxes, society will not accept his monomania as pleadable in bar" (anonymous letter to The Times, 22nd July 1853, quoted in Skultans, 1975, p. 172).

Some of the human behaviour which had a long history of being regarded as sinful and against the law of God was now being incorporated into specific disease entities. Sir Alexander Morison, in a collection of physiognomical drawings for the use of students,[1] provided a series of descriptions of the monomanias he considered to be the most important. There were monomanias "with vicious propensities", "with propensity to steal", and "with unnatural propensities" (homosexuality). Morison considered that a patient exhibiting any of the monomanias could be considered as normal "until the propensity overcame him". He gave a clear example of how this might happen in the case of monomania "with propensity to drunkenness". The patient was a married woman of 40, with a large family.

> She is a good wife and mother until seized with this propensity; then she leaves her house, pawns her goods, and commits acts of insanity; after some months confinement, she is able to resume her duties.[2]

The treatment that Morison recommended was not couched in phrenological terms because he was not a phrenologist, but in practical terms it was no different to that which a phrenologist would have proposed:

> medical means [are necessary] to restore the digestive organs to a state of healthy action, and moral means must be resorted to, in order to fortify the power of the will, and to lessen the desire of self-gratification.[3]

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1 Morison, 1838. Morison was a Society physician, at one stage of his career the Physician Extraordinary to the Prince of Wales, and also the visiting physician to a number of asylums, including Hanwell and Bethlem. Morison began giving lectures on mental disease in 1823, but this was to only six people, and although his textbooks went into many editions, his lecture courses were never very popular.

2 Ibid., p. 171.

3 Ibid., p. 172.

It hardly needs saying that concepts of morality saturate this diagnosis of monomania, no less than in the medieval equations of drunkenness with sin. The difference is not that moral concerns were eliminated, but that the infringement of moral law was now tied to functional disorder of the individual.[1] For instance, another monomania which began to appear about this time as a distinguishable entity was "Cleptomania" or "insanity. . .in a tendency to steal". Its causes were to be sought, not in the nature of man in general, but in the nature of the particular men or women who appeared as the moral deviants.

> If we analyse this affection, when it amounts to insanity, we shall find that it may depend upon either a desire to elude the vigilance of the proprietor of the goods at the moment of making the attempt, or upon a passion to accumulate all sorts of things without the least regard to their subsequent utility. In other words, to use the language of the phrenologists, it may depend upon a morbid condition of the organ of secretiveness or of acquisitiveness.[2]

Another example of highly individual behaviour, but one which is universally regulated by moral sanctions, is sex. Textbooks on insanity literally began to fill with new diseases as the medical profession realised that it was now apparently competent to proclaim on this contentious area of human existence. With the development of the concept of monomania, homosexuality, for instance, became a clearly-defined

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[1] An interesting variant of this was the changed designation of those believed to be under the power of devils. Supernatural explanations were rejected by the nineteenth century physicians, but many of their patients continued to believe in the old superstitions. The solution was to provide another monomania. As G.M. Burrows explained, "Lunatics are often possessed with an extraordinary dread of witchcraft, or of supernatural beings or demons, and will fancy themselves under their baneful influence. Hence this state of delusion has been designated daemonomania" (Burrows, 1828, p. 274).

[2] J.F. Duncan, Popular errors on the subject of Insanity examined and exposed, 1853, quoted in HMA, p. 1008.

disease syndrome, described at length by Morison and others. Not that every specific deviance had its own monomania. Two could be joined together, or as one writer put it, "When religious monomaniacs are addicted to sodomy—a very frequent complication—the case is incurable". And more than that, according to this writer, "the case is still more hopeless, when they select idiots for the indulgence of their vices".[1]

Similarly, masturbation began to appear at this time as closely connected with causing insanity, although it was to be some time before it was "recognised" as a disease syndrome in its own right.[2] For William Ellis, "by far the most frequent cause of fatuity" was masturbation;[3] and Esquirol and Combe were two other moral therapists who proclaimed at length their conviction that masturbation was a direct cause of insanity. The physical basis for all these sexual diseases, according to the phrenologists, was in the organ of amativeness. This was believed to be a fairly large organ of the brain, and consequently likely to cause a lot of trouble if it became overexcited. This faculty has obvious connections with aspects of the medieval concept of the faculties of the soul. The phrenologists brought it up to date and, while still asserting the universal nature of its existence, were able to describe it in the following terms:

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1 Millingen, 1840, p. 37.

2 On the "disease" of masturbation see Engelhardt, 1974; and on the history of its connection with theories of insanity, Hare, 1962. Neither of these accounts shows much appreciation of the social implications of their subject. For this see Szasz, 1973, chap. 11, which, in spite of its author's obsession with demonstrating "psychiatric imperialism", provides a stimulating discussion of the issues involved.

3 W. C. Ellis, 1838, p. 336.

> Uses: It produces love between the sexes: Marriage springs from Amativeness, Philoprogenitiveness, and Adhesiveness, acting in combination.
> Abuses: Promiscuous intercourse with the opposite sex; seduction; marriage with near relations; marriage while labouring under any general debility or serious disease; marriage without possessing the means of maintaining and educating a family.[1]

And this was supposed to be a faculty "common to Man with Lower Animals"—these Victorian values were not even equally applicable to men and women, let alone to other animals.

With hindsight it is easy to see that the phrenologists smothered their supposedly naturalistic observations with specific moral prescriptions. In the classification of insanity this appeared to transform morality into a branch of pathology. For instance, most of the above causes of insanity, from masturbation to drunkenness, were not recognised as having a moral base at all. Their actions were held to be solely in terms of the physical effect they had on the human brain.

Andrew Combe gave an example of a man who became insane "in the very act of coition" with an "abandoned woman". How the woman's abandonment led to the man's brain being disordered beyond repair was not explained. But on dissection "the hemispheres of the cerebellum (Organ of Amativeness) were highly inflamed. . ."[2] Similarly, William Ellis believed that it was the irritation and physiological excitement caused by unnatural sex and alcohol that led to their being the major causes of insanity.[3] An example of the distinction that was made between moral and physical causes is shown in Table 8. This is a fairly typical list

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1 G. Combe, 1850, p. 549.

2 A. Combe, 1831, p. 162.

3 See W.C. Ellis, 1838, pp. 336-7; and 1834, passim.

Table 8

Moral and physical causes of insanity ascertained in 249 of the male patients admitted to Colney Hatch Asylum in 1851[1]

Moral		Physical	
Domestic Grief, Affliction and Disappointment	7	Intemperance and Debauchery	57
Unfaithfulness, Unkindness or Intemperance of Wife	6	Bad Company	1
Loss of Situation and Dread of Poverty	7	Masturbation	5
Want of Employment, and sufferings therefrom	6	Fatigue and Over-exertion	3
Reverse of Fortune, Loss of Property, &c.	12	Over-study	6
Loss of Wife or Children	3	Injury to Head	14
Disappointed Affection	3	Disease of Brain	2
Unhappiness at Home	1	Delirium Tremens	1
Erroneous Views in Religion	3	Fever—Typhus, Yellow, Erysipelas, Small-pox	4
Sudden Shocks, Fright, &c.	29	Epilepsy	14
Jealousy	3	Paralysis	6
Pride	3	Chorea	2
Non-success in Business	1	Injury to Retina	2
Responsibility and over-anxiety	1	Disease of Lungs	3
Sudden Loss of Several Cows	1	" " Liver	1
Regret for a Theft	1	Old Age	4
Suicide of a Brother	1	Congenital Deficiency	16
Over-excitement at the Great Exhibition	1		140
	89		

Hereditary Predisposition was assigned in a further 20 cases.

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for the time, with the moral causes limited to those working superficially on the mind through the agency of the passions and through

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1 Source: Hunter and Macalpine, 1974, p. 195.

shocks to its various functions. As can be seen, by far the largest single cause of all cases of insanity was the supposedly physical one of "Intemperance and Debauchery".[1] But, the physicians always maintained, they were merely observing what they saw in front of them and were not invoking any values of their own.[2]

The physicians did not forget the traditional manifestations of insanity such as hallucinations, thought disorder, maniacal fury, or despondency; these new monomanias appeared more as additions to the collection of symptoms with which physicians had to deal, although they did necessarily lead to some redefinitions of the older classifications. One of the "largest" of the new diseases that were carved out of the old classifications was that of "moral insanity" or the disease of the "moral feelings exclusively".[3] It is often said that this is a precursor of our present-day concept of psychopathy although, as Hunter

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1 There was very little change in the half century following this date. The 51st Report of the Commissioners in Lunacy (1897b, Appendix A, Table XXV) gives the yearly average for the period 1891 to 1895 and locates the primary cause of insanity as "hereditary influence ascertained", closely followed by the physical cause of "intemperance in drink". Major moral causes were given as "domestic troubles" and other "worry".

2 It is interesting in this connection that opium addiction or "abuse" was never recognised in the nineteenth century as associated with insanity, unlike the experience of this century when the medical profession has seen fit to draw such conclusions. Two reasons for this omission could be (a) that the medical profession could hardly proscribe something it made so much use of itself; and (b) that opiate use was not as disruptive to family and industrial order as the use of alcohol. The use of opiates in the hinteenth century is discussed by Lomax (1973). One reason she gives for opium not being prohibited is that the British government was aware of the difficulty of interfering with domestic opium use while it encouraged its production in China. It was not until 1908 that opium was placed on the list of restricted poisons.

3 Prichard, 1835, p. 5, writing about Pinel's recognition of this type of case.

and Macalpine have pointed out, the use of the term "moral insanity" by its recognised author, J.C. Prichard, involved much more than we mean by "psychopathy".[1] Moral insanity was not described as a monomania; it was more a term which covered a whole class of derangements of the mind, those

> consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination.[2]

Or, in more practical terms,

> the disordered condition of the mind displays itself in a want of self government, in continual excitement, an unusual expression of strong feelings, in thoughtless and extravagant conduct. . .[3]

The essential feature of moral insanity was that the person who had it did not need to exhibit any illusions or hallucinations. He merely had to show, in the eyes of his physicians, that he was not able to judge right and wrong.

In spite of Prichard's reputation as the author of the concept, the term "moral insanity" was defined in detail by another medical writer before Prichard presented his account.[4] This other physician,

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1 HMA, pp. 836-8.

2 Prichard, 1835, p. 6.

3 Ibid., p. 384.

4 Mayo, 1834. According to the Appendix to this work, Mayo appears to have first put forward his views in the London Review in 1829. An even earlier recognition of this disease of the "action of the moral faculty" was made by the American physician, Benjamin Rush, in 1793. (Rush, 1793. This paper was first read to the American Philosophical Society in 1786. For Rush on moral insanity see also his 1962, chap. 19.)

Thomas Mayo, suggested that moral insanity had always existed, but had until then been seen as a symptom of some other derangement of the mind. Mayo insisted that it was not that

> insanity in many cases unseats the moral principle. . . [but that] the patient is insane, because, in him the moral principle is in a vitiated or imperfect state.[1]

Mayo drew strong conclusions from this new rationalisation of the definition of insanity. It gave the physician a new responsibility in looking after society's deviants. "At present", he maintained,

> it is a most painful consideration, that we are compelled to wait until an opportunity is given of correcting a moral defect by its ripening into the commission of a crime.[2]

Instead of appealing to these individuals' "supposed sense of right", which they do not have; what the physician must do, with full institutional support, is force them to "appreciate the cogency of an obligation, which leaves them no choice".[3]

The concept of moral insanity is an interesting one because it raises a number of questions about the changing appreciation of human nature. By locating the source of the disorder in the functions of the mind it reiterated the point made by phrenology that the boundaries of man's responsibility were dependent on the purely natural properties of his constitution. In so doing, it appeared to take away the moral injunctions that would previously have been imposed on people who were without the ability to appreciate them. In other words, it was more humane because it worked with an understanding of human nature based

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1 Mayo, 1834, p. 22.

2 Ibid., p. 33.

3 Ibid., p. 35.

on naturalistic observation and not on one which relied on a system of metaphysics. Such at least was the ideological camouflage in which the concept of moral insanity was wrapped.[1]

Enough has already been said to indicate why this should be considered as an inadequate justification for what was being done. The deeper implications of this reformulation of human nature, the question of not only how, but why, it took the form it did, will be examined in the Coda to this thesis. For the present, it is enough to note that in the early period of industrial capitalism, the categories of insanity underwent a rationalisation that paralleled that occurring in the field of treatment.

Theoretical models of insanity were necessary to get the insane admitted to specialist institutions in the first place. The trouble was that from the point of view of the practical concerns of those actually treating the insane, the methods of classification which were very good for getting the patients into the asylum, or for recognising them as insane once they were there,[2] were not much help in leading to their cure and discharge. What was needed in this latter case was a

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1 These extremely schematic comments on moral insanity do very little justice to what was to become a major ground of contention amongst nineteenth century alienists and large sections of the lay public. The best discussion of the social and intellectual significance of moral insanity is to be found in the as yet unpublished essay by Roger Smith (1977, chap. 9).

2 This point must be emphasized. The above discussion may have given the impression that people were admitted to the asylums "suffering" only from masturbation, or kleptomania. From examples of cases given, and from general discussions in medical textbooks, it seems more likely that admissions depended on more traditional displays of insanity (hallucinations, inability to cope, etc.), but that once the patient had settled into the asylum routine the physicians noticed those attributes they considered the most important. And in an age obsessed with establishing a moral control over its deviants, the infringements of the code of personal morality became the most obvious ones.

system of organising the patients, not around a code of morality they were supposed to have broken, but around norms of behaviour they had to relearn. The distinction is an important one because it is at the core of the difference between what we call mental health and mental illness. The conformity to or deviance from behavioural norms is the practical basis of any such distinction, but it is only in the case of justifying the removal of the deviant from the community that recourse has to be made to theoretical models of illness or "badness". As the sociologists of deviance have pointed out,[1] this theoretical work both legitimises the removal of the deviant and strengthens the moral community from which the deviant is being ejected. Not surprisingly, in a period when the bourgeois class was attempting to establish an ideological hegemony to complement its new-found political and economic power, the boundaries of moral community were constantly being displayed.

But once the deviant was captured and his infractions noted, the administrators of the institutions for the control of deviance had a more practical task on their hands. They needed to return their charges to the community as resocialised examples of normality. The main focus of their work was a practical one, and not the theoretical one of demonstrating the existence of disease. Concepts of morality still saturated the process, but they were now incorporated into the logic of convalescence, a different one to that which justified the description of the unfortunate individual as insane.

The classification of these convalescent programmes begins

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1 See for instance Pearson, 1975, pp. 103-4.

with the very existence of the asylum itself. The commonsense assumption that all the mentally disordered are better off in a specialist institution is one that we are only today seeing gradually dismantled: it was in the period being examined here that this assumption was established as a normative aspect of therapy. Virtually every treatise or textbook on insanity included a long section presenting the reasons why the insane should be dealt with outside of their homes and in specialist asylums.[1] A number of reasons were given, ranging from stressing the bad influence of the patients' home environments to emphasizing the specialist knowledge and experience of the physician. What all the reasons had in common was their reliance on the assumption that the recovery of the patient depended on an active process of resocialisation. The insane person was not to be haphazardly dosed with piece-meal remedies, he had to be subjected to a thorough-going process of reform. The asylum was to be the site of that process, and the classification of the patients within the institution was to be a further means to the same end.

The early specialist asylums were, in effect, the eighteenth-century subscription hospitals, so it is not surprising to find there the basis of what was to become the "classification of convalescence". In this, as with so much else in moral treatment, the work of John Ferriar at Manchester Lunatic Hospital is seminal. It was pointed out in Chapter One how much Ferriar had wished

> that a room be appropriated in our hospital, to convalescents, and that the privilege of admission to it might be made the reward of regular behaviour among the patients.[2]

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1 For examples see Burrows, 1820; Prichard, 1835.

2 Ferriar, 1792-1798, vol. 2, pp. 111-2.

Ferriar's aim, as was shown in Chapter One, was to provide some form of assistance to enable his patients to exercise discipline over themselves. He and a number of other eighteenth century physicians had noticed that the conditions of the large hospitals and madhouses actively worked against the possibility of the patient exercising any degree of self-control. The patients were often distinguished by nothing except their ability to pay, with long-term and apparently incurable patients mixed with the recently ill. As Ferriar noticed, these recently ill were often made worse by being mixed in this way. He suggested a means of isolating the different levels of insanity so that those who still had a chance of controlling themselves could be encouraged to do so.

One of those who took note of this suggestion was William Stark, architect of Glasgow Asylum. As shown in Table 4 (p. 216), Stark divided the patients into "frantic", "incurable", and "convalescent" groups (as well as by sex and "rank"). The main difference between this and a more traditional hospital such as Bethlem was the introduction of this new category of "convalescent". It was to become a central feature of every asylum, a half-way stage between disease and health. In some of the progressive asylums, such as Wakefield, the convalescent part of the asylum became so dominant as to disappear as a category. It appeared as the main part of the asylum, with the few exceptional patients who needed firmer control relegated to the "refractory" cells at the extremities of the building (see Figures 8 and 9). Wakefield was unusual in that it allowed such a small area for patients who were not improving: the confidence shown at that asylum in its ability to rehabilitate its patients never extended

throughout the asylum movement.[1]

What did permeate the whole movement, though, was the principle of classifying the patients according to their personal behaviour. The criterion was not whether they experienced hallucinations or other traditional symptoms of insanity, but whether they could reproduce, at least on a superficial level, the behavioural norms of the asylum administrators. It did not matter what the patients were thinking as long as they conformed to the rules. For instance, J.B. Steward, physician to Droitwich Lunatic Asylum and owner of Southall Park Asylum after William Ellis, classified his patients according to the following system: First of all they were split into two groups, "Quiet" and "Noisy". Both groups were divided again into "Cleanly" and "Dirty", and these groups into "Not Dangerous" and "Dangerous", and finally into "Mischievous" and "Destructive".[2]

Another example can be found in Matthew Allen's private madhouse which consisted of two separate buildings, and in which he divided his patients according to their approximation to normal behaviour. In his advertisement of the facilities he was offering in the two buildings he concluded,

> It may be added by this system of classification I possess a powerful moral restraint. They [the patients] are moved from one house and from one part to another according to their conduct.[3]

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1 But see Spurzheim's plan for an asylum in his 1817, plate 3. He turned over nearly the whole of the building to the convalescent, except for a space for the "dirty, noisy and dangerous" patients who would be isolated from the rest.

2 Steward, 1845, p. 77.

3 M. Allen, 1829, [p. 3].

At Lincoln Asylum in 1828 a new plan of segregating patients was proposed, whereby they would be classified as "Convalescent, Ordinary, Insensible, Noisy or Frantic". Only in the "Ordinary" section, the central area of rehabilitation, would the patients be further separated into "Ranks". Further,

> the Upper Rank patients are brought from the Back to the Front; and the degrees of rank are more rigidly observed as the patients approach to convalescence, and as they consequently become more sensible of such distinctions.[1]

In contrast to these fairly rigid classificatory systems, John Conolly appears to have had a very flexible approach to the classification of his patients, reclassifying them as often and as much as was necessary. An aspect of this was his insistence that single bedrooms should be provided for patients, rather than the large dormitories which have always been attractive to economy-minded administrators. Conolly also pointed out the medical rationale that supposedly underlay all these systems of classification. According to him,

> So long as one lunatic associates with another lunatic, supposing the cases to be curable, so long must the chances of restoration to sanity be very materially diminished. Convalescents should not even associate with convalescents, except under the strict watching of persons of sound mind: they can hardly assist, and they may retard, the recovery of one another.[2]

The idea expressed here is simple enough: only through his own efforts may a lunatic be restored to health, his fellow patients acting as a form of contamination of this endeavour. This assumption was not directly dependent on phrenological theory, although the strong emphasis of phrenology on individual improvement would obviously have given

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1 Charlesworth, 1828, Appendix C.

2 Conolly, 1964, p. 29.

intellectual support to any system of convalescence which relied on the doctrine of individualism. And whatever the hindsight with which we dismiss phrenology as unscientific, this strong individualist emphasis has remained a core feature of most psychiatric practice up to the present day.

And yet, in spite of Conolly's emphasis on the need for frequent moving of patients, in this as in all the other fragments of moral treatment the principle of classification was gradually institutionalised into a rigid formula which allowed for very little modification according to individual needs. Something of the direction in which the change was going can be seen from the 1844 Report of the Metropolitan Commissioners in Lunacy. The Commissioners defined classification as

> the distribution of patients with reference to their mental disorders, and in associating those persons whose intercourse is likely to be mutually beneficial, and in separating others who are in a state that renders their society a source of mutual irritation and annoyance. The distribution of lunatics, on this principle, is found to have a most beneficial influence in promoting their recovery.[1]

Already a significant change can be seen in the rationale employed as a basis for classification. Although the aim was still to facilitate recovery, the distribution was now held to be not so much in terms of approximation to "regular behaviour" (Ferriar) but "with reference to their mental disorders". In practice, it involved the same system of discrimination and rewards, but in theory it demonstrated a commitment to the general shift from a moral to a medical language. Even so, the language was still a long way from making

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1 Report of Metropolitan Commissioners in Lunacy, 1844, p. 122.

use of such euphemisms for moral normality as today's "self-actualisation". The Commissioners found that Lancashire County Asylum had the "most complete" system of classification of any asylum. Its ten wards were divided on the following principles:[1]

1. Dementia cases, plus "active, orderly, and quiet cases, who have been some time in the house, and are capable of rendering assistance to the cases of Dementia",
2. Recent cases, plus "active. . ." etc. as above,
3. Non-violent, non-suicidal, and non-escapees,
4. Convalescents,
5. "Refractory and excited cases",
6. "Suicidal cases, associated with cheerful and watchful cases",
7. Refractory and violent epileptics,
8. Non-violent epileptics,
9. Aged quiet cases,
10. Infirmary.

What is interesting about this classification, apart from its obvious implications for later practice, is the way that "active, orderly and quiet" patients are used to help maintain order in the asylum. But, as the Commissioners admit, such a well-defined classification system was exceptional. Far more common was the type of system they found at Gloucester Asylum. There the patients were divided into:

1. Quiet and nearly convalescent,
2. Epileptics,
3. "Fatuous",

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1 Report of the Metropolitan Commissioners in Lunacy, 1844, pp. 126-7.

4. Dirty and noisy,

5. "The working class", comprising some convalescent and some incurables who could be induced to work regularly.

This classification was still based predominantly on the social and moral characteristics of the patients, but it was the underlying belief that these characterististics referred to manifestations of the state of mental disorder itself that gave these divisions their medical, and increasingly rigid, character. This insistence on classifying the patients quickly became entrenched in asylum practice, so much so that already by 1857, a writer in the Quarterly Review was criticising it for preventing precisely that which it had been devised to achieve. "The vice of classification", wrote the reviewer,

> is that it separates the population of an asylum into so many mental castes, which in some measure prevents that easy transition from lunacy to sanity, which it is desirable to maintain.[1]

What did remain in the ideology of classification, whatever its degeneration into rigid forms of control, was the belief that the movement from one classificatory section to another depended on the ability of the individual lunatic to restrain his own insane propensities. As will be seen in the next chapter, it was the growing pessimistic view that individuals really could not change themselves very much that led to the decline of moral treatment. But the emphasis on the "doctrine of individualism" remained, as indeed it still does in psychotherapy today.

There is nothing surprising about this. Just as the medieval notion of insanity as a variety of normal, if extreme, behaviour only disappeared as the means of production came to depend on more standardised

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[1] Anon, 1857, p. 367.

techniques and the need to exploit a narrow range of normal behaviours; so it is likely that an individualist appreciation of deviance control will only disappear when the means of production are organised on a more collectivist basis than they are now. Some indication of this can be seen from the following example, in which the rehabilitation of the insane is tied to a very different set of social interests to those discussed so far.

In the Peoples' Republic of China, the economy is run on a self-consciously collectivist basis: individual achievement is denigrated unless it is seen to be in the service of the community. Similarly, the creation of mental health in psychiatric hospitals is achieved in the same way, with the patients regaining their health by taking part in the same sort of activities that would be encouraged outside. The overriding principle is a pragmatic one of utilising whatever forces can be marshalled, from drugs to acupuncture, from group therapy to intensive after-care.[1] The aspect of this therapeutic programme that is of particular interest in the present context is that convalescent patients are not isolated from the more insane. The opposite is true, in fact: there is an explicit policy (at least in the Peking and Shanghai Hospitals) of pairing the sicker patients with those who are nearly recovered.[2] Each ward is organised into a number of "collective fighting groups" which include the medical and auxiliary staff as well as as the patients. The aim is to fight the insanity collectively, with each individual benefitting from the experience of his comrades.

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1 On psychiatry in China see Kagan, 1973; Ratnavale, 1973; V.W. and R. Sidel, 1974, chap. 7; and my 1975.

2 On this see especially V.W. and R. Sidel, op.cit..

Rather than feeling that the convalescent patients can be contaminated by the more deranged, the overriding belief is that the convalescent patients have the experience (of getting better) which can be of help to those patients who have not yet overcome their illness, as well as simply being able to provide emotional and moral support to their less able comrades. As with the theories of the moral therapists, each individual is held to have some part of his mind which is not damaged; but rather than encourage him to develop this healthy part in isolation, the whole aim of therapy is one of mutual help and participation within a collectivist conception of mental health. This example is not provided to suggest that all treatment of mental illness in China is like this, or even that China is necessarily a socialist country. But it does demonstrate the possibility of alternative modes of convalescence, given the fact that those who are responsible for the administration of the psychiatric services can be convinced of the need for an alternative practice.

Returning again to the treatment of the insane in nineteenth-century Britain, it must be concluded that social philosophies of normality existed at every level from the moment a patient was admitted to an asylum to the time that he left it. There is nothing to be decried in this--it is only by placing such activities as the treatment of the insane on a rationalist basis that it is possible for men to eliminate the superstitions that affected these endeavours when men were less conscious of their own abilities. This is an aspect of moral treatment that critics of capitalism, such as Michel Foucault, tend to ignore. The new regime may have imposed an almost totalitarian control on the range of possibilities that the insane could use to rehabilitate themselves--but at least this new philosophy offered hope to many who otherwise would merely have been confined at minimum expense. This latter motivation

has of course never disappeared: few people in any age are willing to devote time or money (or be taxed) for such groups as the insane. But in the early period of industrial capitalism, when a lot of people were concerned with establishing their version of moral order, the treatment of the insane was often optimistic, imaginative, and at the least, a real improvement on what went on before. In the words of the 1827 Select Committee Report, enquiring into the extent of actual practice of moral treatment,

> In the moral treatment of the Patients, is it considered an object of importance to encourage their own efforts of self-restraint in every possible way, by exciting and cherishing in them feelings of self-respect, by treating them with delicacy, more especially in avoiding any improper exposure of their cases before strangers in their own presence; and generally by maintaining towards them a treatment uniformly judicious and kind, sympathizing with them, and at the same time diverting their minds from painful and injurious associations?[1]

Given the evidence of the last two chapters, we are now in a position to claim that something of an answer has been given to this question. That this "self-restraint" should have been produced by methods which reiterated the general values of the parent society should not surprise us. Moral treatment, like capitalism itself, gave to men the chance to create their own lives, but it did so in ways which were heavily dependent on the material need to reproduce the capitalist social relations. At the time there seemed no real alternative to any of those who concerned themselves with the question of improving the treatment of the insane. It is only because we live today within a different praxis which generates a different set of values that we are able to evaluate moral treatment as a significant but limited improvement on what went before.

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1. 1827 SC, Report, p. 11.

This concludes the examination of the epistemologies that allowed moral treatment to appear as a meaningful and progressive activity. In this chapter, more than any of the others, it has been possible to see some of the ways in which that which began with moral treatment is still with us today, just as the reproduction of the social relations required for the maintenance of capitalism is still with us. At the same time there have been many changes in the last century and a half in the treatment of the insane, as in the exploitation of the means of production. To follow these changes would lead outside the subject matter of this thesis--the moral treatment of the insane--because as the nature of capitalism changed, so moral treatment effectively disappeared. Many of its images have remained to provide psychiatric practice with a legendary past, but its practices, as described here, were to be slowly forgotten. It is to the final stages of this amnesia that we may now turn.

CHAPTER FIVE

The Transformation of Moral Treatment: Its diffusion and dispersion after the 1830s.

At the present time, when people go into an asylum, they see everything cleanly, orderly, decent, and quiet, and a great number of persons in this later generation cannot believe that there was ever anything terrible in the management of insanity.

--Lord Shaftesbury, 1859

In a colossal refuge for the insane, a patient may be said to lose his individuality, and to become a member of a machine so put together as to move with precise regularity and inevitable routine; - a triumph of skill adapted to show how such unpromising material as crazy men and women may be drilled into order and guided by rule, but not an apparatus calculated to restore their pristine condition and their independent self-governing existence.

--J.T. Arlidge, 1859

Most of the work described in the last two chapters took place in the twenty or so years following the publication of the Description of the Retreat. During that period, moral treatment never became the dominant mode of treatment for all the insane, but it was recognised as the only important approach by those who were concerned with improving the treatment of the insane. As we have seen, much of the impetus for moral treatment rested with very few people: William Ellis at Wakefield and Hanwell Asylums, W.A.F. Browne at Montrose and Crichton Royal, and John Conolly at Hanwell were perhaps the three most influential moral therapists. The point has been made many times in these pages that moral treatment meant many things to many people, but it was these three physicians who did most to raise the possibility of change in the treatment of the insane, whatever the particular ways in which they and others tried to direct it.

There was one other well-known moral therapist who has not yet been mentioned because he attempted to develop moral treatment into something more than it had previously been taken to signify. The man was Robert Gardiner Hill, and his innovation became known as "the abolition of mechanical restraint". To what extent Hill, or anyone else, ever achieved this "abolition" is a debatable point and will be examined later in this chapter. But whatever the particular interpretation we make of the words "non-restraint", there is no doubt that in the late 1830s and early 1840s, when "non-restraint" was first being proposed, the whole idea of such an extension of moral treatment was highly contentious. Because of this, many physicians connected with the treatment of the insane felt they had to take a stand for or against the new proposals. From our point of view the controversy thus provides a window through which we may examine the changing attitudes to the principles of

moral treatment.

1. The Non-restraint Controversy

Robert Gardiner Hill was born in 1811, 27 years after Samuel Tuke and 31 years after William Ellis. He therefore represented a whole new generation who had grown up with moral treatment of the insane as an established ideology. This is not to say that many of the insane in the 1830s were not still chained or ignored, but that the work which had been done, far from appearing as recent innovation, was seen as a long-established practice which itself needed reforming. To a large extent this description applies to John Conolly as well because, although Conolly was 17 years older than Hill, he did not become an asylum superintendent until 1839, or four years after Hill was appointed as the superintendent to Lincoln Asylum. It was in those four years that Hill attempted

> to complete that which Pinel began. I assert. . .that in a properly constructed building, with a sufficient number of attendants, restraint is never necessary, never justifiable, and always injurious, in all cases of lunacy whatever.[1]

What was it that had led him to this dramatic conclusion?

First of all, it must be remembered that the extent to which mechanical restraint was practised always depended upon the social status of the patient. The physician at Bethlem in 1815, Thomas Monro, probably relied on chains as much as anyone to restrain his public charges, but for his private patients he had a very different approach, as the following dialogue between himself and George Rose, a member of the 1815 Select Committee on madhouses, makes clear:

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1 R.G. Hill, [1839], p. 21, emphasis in the original.

> George Rose: Why is not the restraint by chains and fetters, in your private [mad] house?
> Thomas Monro: There is such a number of servants, there is no sort of occasion; I have forty odd patients, and as many servants.
> Rose: What are your objections to chains and fetters as a mode of restraint?
> Monro: They are fit only for pauper Lunatics; if a gentleman was put into irons, he would not like it. . . . it is a thing so totally abhorrent to my feelings, that I never considered it necessary to put a gentleman into irons.[1]

All that was really innovative about non-restraint was that it attempted to extend this philosophy to all the insane.

Lincoln Asylum was not a county asylum—it was originally funded by subscriptions and donations—but in most other respects it was similar to many of the small public asylums. It was opened in 1820 for up to 50 pauper and private patients. In 1834 it was enlarged to accommodate over 100 patients, but it never went through the massive expansion experienced by many asylums. In 1844 it had 103 patients, of whom 30 were privately financed.[2] Also, unlike some other asylums, it had always attempted to provide a strong medical service to its patients. Three visiting physicians were appointed on a monthly rotation basis when the asylum opened, and one of them, Dr E.P. Charlesworth, took sufficient interest in his job to publish a book on the treatment of the insane.[3] Charlesworth was responsible for getting rid of many of the instruments of restraint at Lincoln, although he did believe initially in keeping some of the male patients in manacles "to protect the weak and

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1 Minutes of Evidence, 1815 SC, 1st Report, pp. 95-6.

2 Report of the Metropolitan Commissioners in Lunacy, 1844, Appendix B.

3 Charlesworth, 1828.

quiet from the outrages of the strong".[1]

There had been three superintendents at Lincoln Asylum before Hill was appointed; all, like Hill, trained as surgeons, although none of the others had ever had a reputation for reform. Prior to his appointment to Lincoln Asylum, Hill had been a medical officer at the Lincoln General Dispensary. When Samuel Hadwen, the then superintendent at the asylum, was forced to resign in 1835, Hill's colleagues in the Dispensary nominated him for the vacant position. Hill was then only 24 years old, and his period of superintendence lasted a mere five years before he in turn was forced to resign.[2] It was in that five years, though, that Hill took the moral treatment of the insane a significant step beyond what it had previously been taken to mean.

In a passage written much later, Hill described his first impressions on entering Lincoln Asylum.

> The first thing that struck me on my introduction to the Asylum was a poor fellow with poultices on his wrists, and an attendant standing by him to prevent him eating them. The wrists were poulticed in consequence of injuries produced by the use of handcuffs.[3]

Here, thought Hill, was a case of restraint making the patient's condition worse rather helping to prevent insane behaviour. This was of course what Pinel and the Tukes had observed a long time previously, and it was what had led to the attempt to control patients by "moral" and not physical means. But up to this time none of the other moral therapists had

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1 Physician's report for 1823, in Appendix A to R.G. Hill, [1839].

2 For biographical details of Hill's career see Frank, 1967; Walk, 1970.

3 R.G. Hill, 1857, quoted in HMA, p. 887.

believed it possible to eliminate entirely the need for straitjackets, leather belts, or other more rigorous instruments of restraint. At Hanwell Asylum, for instance, during Ellis' superintendence there were 600 instruments of restraint. What Hill did was gradually to reduce the number of instances of restraint, a practice begun by Charlesworth, but which Hill carried to its ultimate conclusion. Table 9 shows the dramatic

Table 9

Instances of Restraint at Lincoln Asylum, 1829-1838[1]

Year	Total Number of Patients	Number of Patients Restrained	Number of Instances of Restraint	Number of Hours Passed under Restraint
1829	72	39	1727	20,424
1830	92	54	2364	27,113¾
1831	70	40	1004	10,830
1832	81	55	1401	15,671½
1833	87	44	1109	12,003½
1834	109	45	647	6,597
1835	108	28	323	2,874
1836	115	12	39	334
1837	130	2	3	28
1838	148	0	0	0

drop in restraint that Hill effected. It is some indication of Charlesworth's and the superintendent Hadwen's interest in the subject that figures were kept at all. But it was not until Hill was made superintendent that all instances of restraint were stopped.

The means by which this abolition of restraint was achieved did not involve anything beyond that which has already been discussed as constituting moral treatment. Nor did Hill use different concepts or language to describe his methods. He summed up his approach in a lecture

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1 Source: R.G. Hill, [1839]; also in HMA, p. 892.

to the Lincoln Mechanics' Institute, given there on the 21st June 1838 and subsequently published.[1] In familiar words, Hill described his method. "Moral treatment", he maintained, "with a view to induce habits of self-control, is all and everything."[2] The means by which this could be achieved, according to Hill,

> may be summed up in a few words, viz - classification - watchfulness - vigilant and unceasing attendance by day and by night - kindness, occupation, and attention to health, cleanliness, and comfort, and the total absence of every description of other occupation of the attendants.[3]

On "watchfulness" Hill reiterated Bentham's point about the need for absolute surveillance:

> It is essential. . .that the patient should be aware that he is observed though not suspected of wrong: and aware also that the person who observes him is powerful enough to control him.[4]

According to Hill, surveillance of this kind lessened the likelihood of suicide, incontinence, and accidents. He argued that as long as the attendants were plentiful enough, the patients would soon exhaust themselves, whereas restraint merely exacerbated the likelihood of conflict. He argued further that the consequences of this position were increased patient satisfaction and an increased recovery rate.[5]

This "invisible" restraint of strong young attendants was of course

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1 As R.G. Hill, [1839]; and as part of his 1857.

2 R.G. Hill, [1839], p. 45.

3 Ibid., pp. 37-8, emphasis in the original.

4 Ibid., p. 45, emphasis in the original.

5 R.G. Hill, letter to The Lancet, 1839-40, 1, 22nd February 1840, pp. 796-7.

more expensive than traditional forms of restraint, and Hill admitted that he could not employ as many attendants as he would have liked to have done. To back up what attendants he did have, Hill turned to that other essential of moral treatment—classification. He divided his patients into three ranks and then into three classes—convalescent, moderate, and frantic. Movement between these divisions was swift and frequent, depending on the patients' daily conduct.

> In this Asylum when a patient misconducts himself, he is immediately removed to the Refractory Patients Gallery where he remains until he has pledged himself that his future conduct shall be more orderly.[1]

Hill did not place as much emphasis on the value of work as some moral therapists. Its value, he maintained, lay not in its socialising aspect of creating "habits of industry", but in the exercise it would provide and "the enjoyment of the sweet music of spring".[2] Unlike Ellis, he believed that "no patient should be compelled to work in any way".[3]

So Hill did not develop any new methods. What he did do was to suggest that moral treatment itself was far more powerful than previous moral therapists had realised. The question of whether Hill did actually abolish restraint depends very much on how the word "restraint" is defined. While Hill may have refused to use straitjackets, straps, etc., there are at least two ways in which it could be said that he did use physical restraint. In the first place, the confinement of patients at all was a form of restraint: it took away their liberty as ordinary mem-

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1 R.G. Hill, [1839], p. 49.

2 Ibid., p. 46.

3 Ibid., emphasis in the original. See also the extract from the 13th Annual Report, quoted by Hill in ibid., p. 103.

bers of society and subjected them to the rule of the asylum.[1] Once in the asylum, any control at all of patients implied some form of coercion, otherwise a large number of them would have just walked out. And secondly, Hill and all the other moral therapists always relied on further means of confinement—the seclusion room, the "Refractory Patients Gallery", etc.—to coerce their patients into normal behaviour. Also, of course, whatever the state of abolition of physical restraint, there was certainly no claim made by the moral therapists that they were abolishing mental restraint. This was made quite explicit by Conolly in 1839:

> The example of the Lincoln asylum, in which no patient has been put in restraint for nearly three years, came also powerfully in aid of an attempt to govern the asylum at Hanwell by mental restraint rather than by physical.[2]

What the abolitionists did claim was that they were getting rid of mechanical restraints,[3] and it was this that caused so much controversy.[4]

Amongst the few who from the first agreed wholeheartedly with what Hill had done was John Conolly. In 1839, Conolly already had many years

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1 This point was made in an editorial in The Lancet, 1840-1, 1, 5th December 1840, pp. 377-8.

2 Conolly's first report from Hanwell, in Conolly, 1973, p. 192.

3 Viz. the titles of R.G. Hill, 1857; Conolly, 1973. Hill and Conolly both made a distinction between "restraint" and "seclusion". At one stage Hill defended his regime against attacks on it by his predecessor, Samuel Hadwen, on the grounds that Hadwen "gives sham tables of late restraint, dishonestly manufacturing them from seclusions" (R.G. Hill, letter to The Lancet, 1840-1, 1, 31st October 1840, p. 198). Conolly provided a detailed explanation of what he meant by seclusion in his annual report for Hanwell for 1840, reprinted in Conolly, 1973, pp. 207-15.

4 I am concerned here with the reaction to the new principle, not with Hill's outspoken claim to be the discoverer of the new system. Hill spent a large part of the later years of his life publicising his claim (see for instance R.G. Hill, 1857; 1870), but he never received what he considered to be his just recognition. On this controversy and its significance see K. Jones, 1972, pp. 117-9; Scull, 1974, pp. 313-4.

of reforming work behind him, but it was in May of that year that he was appointed to the position of medical superintendent at Hanwell. By 1st June, when he took up his duties, he had visited Lincoln Asylum and had decided to follow Hill's lead and abolish all restraints.[1]

Hanwell, of course, had a very different history to that of Lincoln Asylum. It was built as a direct result of the findings of the 1827 Select Committee on madhouses in Middlesex. That enquiry had demonstrated the existence of large numbers of pauper lunatics in conditions of neglect in the county, and so a public asylum had been erected for them. From the start, Hanwell had embodied a number of principles of moral treatment. Its design (Figure 14) was based on the "H"-shape which had been used at Wakefield and which incorporated the principle of "espionage" used at Glasgow and Wakefield.[2] The appointment of the first superintendent was made under heavy competition, but the job was given to William Ellis with his wife as matron. The asylum was opened in 1831 with accommodation for 300 patients (the majority recommended by the Act of 1808). Ellis' regime there has already been described, a rigorous programme of rehabilitation formed mainly around his imperative that as many of the patients as possible should work. In 1838 for instance (Ellis' last year of superintendence), of the 610 patients, 454 were constantly employed.

Ellis resigned in 1838 to move into private practice, and his successor was a Dr. J.G. Millingen. Conooly had applied for the position

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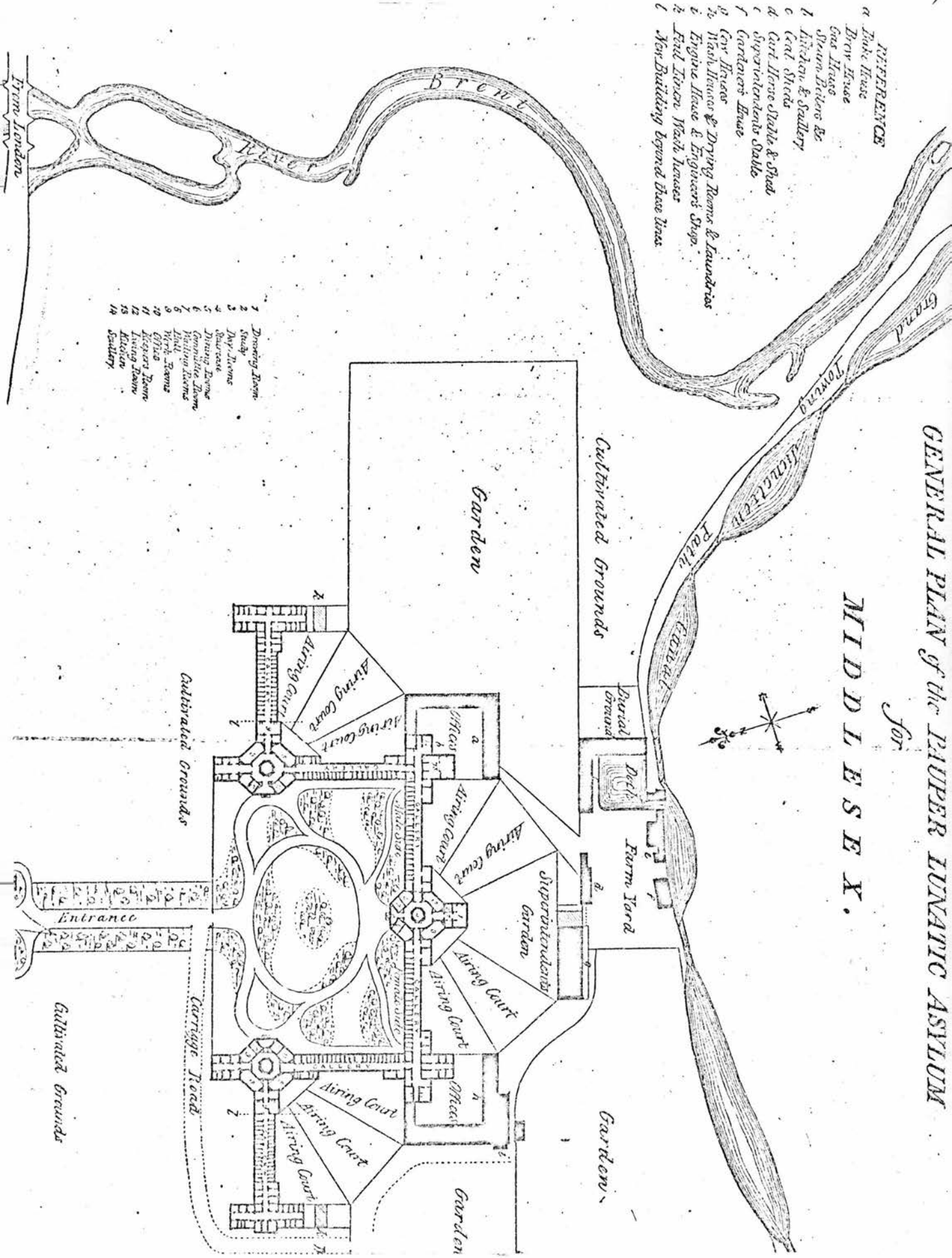
1 Conolly, 1973, p. 178.

2 Unlike Lincoln Asylum, which had been built on more conventional lines but which Charlesworth did attempt to modify in order to facilitate classification. For a plan of Lincoln Asylum, see Charlesworth, 1828, facing p. i.

Figure 14

Plan of Hanwell Asylum



Source: W.C. Ellis (1838), facing title page.

but was unsuccessful. He said later that he had been told by the Chairman of the Asylum Committee "that my exclusion was occasioned by my politics".[1] In the event, Millingen's career ar Hanwell was short-lived: according to the new Chairman of the Asylum Committee (the old one having died),

> upon his appointment he had endeavoured to introduce a system of military discipline among the officers of the asylum. . .He had also introduced a harsher system of treatment as regarded the patients; the restraints were multiplied and the confusion increased.[2]

Millingen was forced to resign and Conolly was appointed as the new superintendent in May of 1839. At that time there were over 800 patients, many under restraint. In order to find out what the abolition of restraint would entail, Conolly had an inventory made of all the instruments of restraint. He found

> scattered through the wards, to be used for the most part at the discretion of the attendants. . .of restraint chairs, forty-nine; of restraint-sleeves of ticking or leather, seventy-eight; of leg-locks and handcuffs, three hundred and fifty-two; of long leather straps, for various extemporaneous application, fifty-one; besides ten leather muffs. . .two extra-strong iron chain leg-locks; and two dreadful screw-gags. . .[3]

And this in the asylum with the best reputation in the country for its moral treatment!

Conolly was soon able to report a dramatic drop in instances of restraint.

> After the first of July [1839], when I required a daily

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1 Conolly, quoted in Hunter and Macalpine's introduction to Conolly, 1968, p. 20.

2 C.A. Tulk, quoted in ibid., p. 21.

3 Conolly, quoted in ibid., p. 24. For illustrations of the types of restraint see ibid., figures 1 and 2. See also Conolly, 1973, pp. 189-90.

> return to be made to me of the number of patients restrained, there were never more than 18 so treated in one day - a number which would seem reasonably small, out of 800 patients, but for the facts that after the thirty-first of July the number so confined never exceeded eight; and after the twelfth of August never exceeded one; and after the twentieth of September no restraints were employed at all.[1]

The implications were profound. It was one thing for an unknown surgeon to abolish restraints in a small provincial and partly private asylum, but for a well-known physician to do the same in the main metropolitan asylum, the largest in the country, where all the patients were paupers and where most had already spent many years in workhouse cells and under regular restraint: this was an event that could not be ignored. Samuel Tuke visited Hanwell in 1840, and he summed up the opinion of many when he said,

> Who can visit or contemplate the establishment at Hanwell, containing eight hundred insane persons, governed without any personal restraint, without admiration and surprise?[2]

Tuke had of course already experienced a lifetime of working for reform himself, and although he may have been surprised, he could hardly have disagreed with this new extension of liberty to the insane. There were, however, a number of other people working in the field of the treatment of the insane who had made gestures to moral treatment in the past but who were not at all committed to extensive reforms. With this announcement of the apparent feasibility of total abolition of restraint for all lunatics, it became less easy for anyone to ignore moral treatment. At this time many asylums—let alone the workhouses and the private madhouses—still chained some of their patients. A common argument was that moral treatment was useful for some, but that other patients were so

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1 Conolly, 1973, p. 179.

2 S. Tuke, 1841, p. xxxv.

violent, so degenerate in their habits, that there was nothing that could be done for them except to control them with whatever was necessary for their own and other patients' safety. Not surprisingly, this attitude was soon given an articulate voice at Hanwell itself.

The first person to speak out publicly against Conolly was the Reverend H.S. Trimmer, the Chaplain at Hanwell. He complained to the visiting justices in January of 1840 that the non-restraint system was not working and had led to far worse consequences than had existed before.[1] One of the allegations against Conolly was that in November, 1839 he had ordered a shower bath for a patient named Dorothy Evans for striking the matron and knocking her hat off. In the bath, the patient screamed to be released and said that she would die. Conolly allegedly said that Evans could only come out if "she would beg the Matron's pardon". She did not and was kept in the bath "until she was absolutely in a state of Syncope". Letters were published in The Times both defending and attacking Trimmer's allegations. The Middlesex Magistrates Court held an official enquiry on 16th February 1840, but because of insufficient evidence it adjourned without putting anything to a vote.[2] This was not, however, the end of the opposition to total non-restraint.

At about the same time an editorial appeared in The Lancet which discussed the 1839 Annual Report of the West Riding of Yorkshire Lunatic Asylum.[3] This article was to lead to a long debate in the pages of

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1 This example was privately recorded by Morison (1840, p. 17). Morison, it will be seen, was not an impartial witness.

2 Copies of the letters and a transcript of a shorthand account are in Morison, op.cit.. The shorthand writer was employed by Trimmer so it is possible that some of Conolly's evidence has been left out or distorted.

3 The Lancet, 1839-40, 1, 8th February 1840, pp. 732-3.

The Lancet and elsewhere, a debate that eventually led to legislative action. The Report had been written by C.C. Corsellis, who was both Ellis' successor and a man who had attempted to maintain an active tradition of moral treatment. Corsellis had spoken out in favour of some restraint, but only on certain grounds. First of all, he advocated the restraint of as few of the patients as possible (only six out of 368 were under restraint at the time of his writing). Secondly, Corsellis argued, as long as restraint is used only when the symptoms demand, it will be found that the patients will often ask for it themselves:

> many instances have. . .been known of patients who, feeling a return of excitement, have themselves requested to be again restrained; a proof that when they could exercise a judgement, they were sensible how beneficial restraint had been to them.[1]

In other words, physical restraint could itself be used as a form of moral treatment. The point was also made by Hadwen in relation to a patient who had to be repeatedly secluded:

> Had the moral power of proper restraint been resorted to at first, the habits would not have formed which now set us at defiance.[2]

Hadwen, however, was under no illusions as to the function of the asylum. It was one thing for reformers to proclaim an unbounded optimism in human nature, but what was the asylum really for?

> Proper instruments of restraint, judiciously and humanely employed, are not ignominious manacles and fetters, as the vain claimants of a pseudo-humanity love to represent,

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1 Corsellis, quoted in The Lancet, 1839-40, 1, 8th February 1840, p. 733.

2 Hadwen, letter to The Lancet, 1839-40, 2, 12th September 1840, p. 906, emphasis in the original. And again, "Nor are [instruments of restraint] simply physical agents; in the hands of the rational and experienced practitioner, they form one of his best and most important remedies; used with discrimination and judgement, a suitable instrument of this description is a moral agent of incalculable benefit" (ibid., p. 907).

> any more than an asylum is an ignominious place of detention; for what is an asylum but a house of restraint, and keepers but persons of restraint?[1]

Here was a point of view diametrically opposed to that of Hill. It accepted the traditional view that restraint was necessarily involved in the treatment of the insane: why then, it argued, deny it? An aspect of this viewpoint which the non-abolitionists also emphasized was that constant surveillance of patients was in itself a likely cause of irritation to the patients, and could lead to exciting their passions far more than a neutral mechanical restraint. Corsellis quoted with approval the nineteenth Annual Report of Dundee Asylum:

> Is it better to enslave the mind, than enchain the body? May there not be greater benevolence and sympathy in subjecting the members of the body to salutary restraint, than in the exercise of a moral discipline, which will ever appear to human feeling burdensome and oppressive?[2]

Corsellis was raising a fundamental issue of principle here. Just how much self-control was it necessary or desirable to inculcate in the insane, and was this the primary function of therapy? Corsellis' question was very similar to those raised by Haslam and other thoughtful physicians over a generation previously, when moral treatment had first started to appear. In comparison to this essentially conservative approach, the ideologists of non-restraint were believers in the great bourgeois dream—that every man can be his own master. They taught this philosophy in the Mechanics' Institutes to the artisans and

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1 The Lancet, 1839-40, 2, 12th September 1840, p. 907. Hill replied to this letter (The Lancet, 1840-1, 1, 31st October 1840, pp. 197-9) accusing Hadwen of exaggeration, lies, and misrepresentation.

2 The Lancet, 1839-40, 1, 21st March 1840, p. 963. A longer quotation from this Report appears in the Medico-Chirurgical Review for October 1839, p. 593.

mechanics, and they taught it to the insane in the asylums. They themselves had succeeded through hard work and perserverence and saw no reason why, as a general principle, a similar approach should not be used to solve all problems involving the maintenance of social order.

As we have seen, this driving force of the enthusiasts for total non-restraint was not a humane desire to liberalise the treatment of the insane. It was a firm belief in a particular doctrine which they attempted to express in all conditions. The same as with the original moral therapists, to initiate a change of this magnitude required a great deal of moral courage and a strong belief in the rightness of what they were doing. The other side of this enthusiasm for a principle was often an under-appreciation of individual cases and an intolerance for all other points of view. For instance, the issue that Corsellis had raised about patients developing initiative by asking to be restrained was condemned by Hill, who wrote,

> As for lunatics asking to be restrained, I will say, that they should not be indulged in their whim, but trained to self-control. The perverted tastes and instincts of lunatics are notorious; I would almost say, that their instinct was often towards what would injure them.[1]

Corsellis' reply to this was a comment which showed that he was probably more attuned to the subjective needs of individual patients than was Hill with his obsessional commitment to the doctrine of individualism. In Corsellis' words,

> the preference, even of a lunatic, in a matter affecting his own personal feeling, should be respected. . .he is not likely to choose that which is most painful to himself.[2]

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[1] Letter to The Lancet, 1839-40, 2, 11th April 1840, p. 94, emphasis added.

[2] Letter to The Lancet, 1839-40, 2, 9th May 1840, p. 246.

Corsellis had had many years experience as an asylum superintendent (he had been Director at Wakefield since 1831) and no doubt considered that his sentiments were based on firm knowledge. But the espousal of total non-restraint was essentially an ideological and not a practical question: its assertion involved a recognition of the explicit ethos of capitalism as applied to the individual. To have opposed it outright would have been to oppose all that was held to be progressive and valuable in human relations.

What its opponents had to do was to appeal to other sources of meaning in order to suggest that the total abolition of restraint was inappropriate as a means of treating the insane. Again, given the context of cultural and professional pluralism, this was not very difficult. There were the arguments already presented, that some form of restraint or seclusion had always existed, and that physical restraint could itself be used as the basis for moral restraint. There was also the appeal that could be made to the physician as symbol of wisdom, an appeal that rested on a long tradition in the treatment of the insane, as well as on a strong belief in early Victorian society that the upper class had a responsibility towards the "lower orders". Restraint was only used, according to this argument, because the restrainer understood better than the restrained what he (the latter) would wish to do if he was fully able. Thus Arthur Stilwell, described in an obituary notice as "The English Pinel or the English Esquirol",[1] was able to write,

> I would have it [mild restraint] used, as in the delirium of fever, to prevent persons committing acts which in their lucid moments they would regret.[2]

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1 The Lancet, 1840-1, 1, 23rd January 1841, p. 631.

2 Letter to The Lancet, 1840-1, 1, 5th December 1840, p. 371.

If Stilwell's reputation is deserved, he used mechanical restraint in the absolute minimum number of cases. But the medical profession as a whole did not have a very good reputation in the treatment of the insane. It was physicians after all who were responsible for all the madhouses and asylums which offered little more than crude confinement and in which physical restraint could be said to have no therapeutic role.

Eventually the debate moved outside the somewhat incestuous pages of The Lancet and into the realms of those who were in a position to affect national policy. At a meeting of the Middlesex magistrates on 29th October 1840, Sir Peter Laurie, the President of Bethlem, declared himself against total non-restraint on the grounds that the alternative to non-restraint must be seclusion or solitary confinement, a practice which he believed could cause madness in itself. In reply, C.A. Tulk, Chairman of the Hanwell Asylum Committee, pointed out that solitary confinement was regularly practised at Bethlem.[1] The majority of the magistrates were in favour of Conolly's methods but declared that the whole matter must go before Parliament.[2] This it eventually did and resulted in an Act passed in 1842.[3] The main purpose of this Act was

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1 Elsewhere Tulk described the details of a case of solitary confinement he had seen at Bethlem. The patient had been kept for three weeks in total isolation and darkness. When he refused to eat he was put in a strait waistcoat, strapped into a coercion chair, and a stomach pump was used on him (The Lancet, 1840-1, 1, 21st November 1840, pp. 296-7).

2 This meeting was reported in The Times (30th October 1840) and in The Lancet (1840-1, 1, 7th November 1840, pp. 238-9). For further editorial comment on non-restraint in The Lancet see 1840-1, 1, 5th November 1840, pp. 377-8. For further correspondence on the subject see loc.cit., 28th November 1840, pp. 339-41 (Hill); 7th November 1840, pp. 230-2 (Cookson); 13th January 1841, p. 681 (Browne); 21st November 1840, pp. 298-9 ("Philanthropus"); and 24th October 1840 (Anon).

3 5 and 6 Vict., chap. 87.

to extend and make more rigorous the existing provision for inspection of madhouses and asylums. The Act was instituted for only three years in the first instance, mainly because those responsible for its introduction realised that a thorough inspection of the facilities available would point out the need for further and more comprehensive legislation.[1] In the event, that was exactly what happened. The Metropolitan Commissioners in Lunacy (the body responsible for inspection) issued their Report in 1844, complete with a separate 246-page statistical appendix.[2] And the following year most of the Commissioners' recommendations were written into two major and definitive Acts.[3]

Returning for the moment to the controversy over non-restraint, the 1842 Act required the Commissioners to report on all aspects of moral treatment in the institutions they visited, including non-restraint, classification, and occupation. They did their job thoroughly and there was a long section in the 1844 Report on non-restraint.[4] The Commissioners took a cautious attitude towards non-restraint, mainly on the grounds that ideological fervour was one thing but difference in practice another. In their words,

> Those who profess the entire disuse of restraint, employ manual force and seclusion as parts of their methods of management, maintaining that such measures are consistent with a system of non-restraint. It is said by these

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1 K. Jones, 1972, pp. 132-3.

2 Report and Statistical Appendix of the Metropolitan Commissioners in Lunacy, 1844. On the background to this Report see HMA, pp. 923-6, and for a discussion of the main proposals see K. Jones, op.cit., pp. 135-44.

3 Lunatics Act (8 and 9 Vict., chap. 100) and the Lunatic Asylums and Pauper Lunatics Act (8 and 9 Vict., chap. 126).

4 Report of the Metropolitan Commissioners in Lunacy, 1844, pp. 137-59. The arguments for and against non-restraint are summarised on pp. 156-8; and also in D.H. Tuke, 1882, pp. 216ff.

> persons that when any of the limbs. . .are confined by the strait-jacket, the belt, or by straps or gloves, he is under restraint. But in cases where he is held by the hands of attendants, or when he is for any excitement or violence forced by manual strength into a small chamber or cell, and left there, it is said that restraint is not employed, and the method adopted in these cases, is called "the non-restraint system".[1]

They continued, not unreasonably,

> It seems to us that these measures are only particular modes of restraint, the relative advantages of which must depend altogether on the results.[2]

The Commissioners were in favour of as little restraint as possible, as long as there was some provision for violent and suicidal patients. This provision, they seemed to accept, could be best achieved by means of the solitary confinement of those who needed it. They pointed out that this practice was already beginning to supersede mechanical restraint:

> Seclusion, or solitary confinement is now getting into general use in the treatment of the insane, and great numbers of the superintendents of public, and of the proprietors of private asylums throughout the country are fitting up and bringing into use solitary cells, and padded rooms for violent and unmanageable Lunatics.[3]

The Commissioners remarked that seclusion appeared to be effective "in cases of paroxysms and of high excitement" but added the warning,

> We are convinced, however, that it ought to be used only for short periods, and that it should not be permitted as a means of managing and treating those persons who are permanently violent and dangerous.[4]

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1 Report of the Metropolitan Commissioners in Lunacy, 1844, pp. 137-8.

2 Ibid.

3 Ibid., p. 146.

4 Ibid.. The problem presented by permanently dangerous lunatics (that is, the criminally insane) was largely being dealt with throughout this period (1815 to 1863) by the specialist wards provided at Bethlem. It was not until 1863, when Broadmoor was opened, that a "final solution" was believed to exist for violent lunatics.

The solitary confinement of the insane thus received official approval. It was many years after Bentham's original suggestions for a Panopticon, and the principle of seclusion was used nowhere near as extensively as Bentham had envisaged. But Bentham's original bourgeois vision—that each man must ultimately control himself—was finally written into official policy. As with so many other aspects of moral treatment, what had begun as the product of individual initiative by isolated reformers was now being given formal recognition and approval by the representatives of the bourgeois state. Solitary confinement, classification, employment, self-restraint: all the disparate fragments of moral treatment appeared to have been taken up and announced as official policy. Had the dream come true—was there really "moral treatment for all"? We are now in a position to attempt an answer to this question.

2. Moral Treatment for All?

It was with the statutory recognition of the proposals of the Metropolitan Commissioners in Lunacy, the 1845 Lunatic Asylums Act, that public responsibility for the insane was written into the statute book. More specifically, this Act forced all county authorities to make provision in county asylums for pauper lunatics. Lord Ashley, Chairman of the Commissioners in Lunacy and the major figure behind the 1845 legislation, summed up the aim underlying his efforts:

> Our present business. . .is to affirm that poor lunatics ought to be maintained at the public charge. I entertain . . .a very decided opinion that none of any class should be received for profit; but all, I hope will agree, that paupers, at any rate, should not be the subjects of financial speculation.[1]

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1. Parliamentary speech in 1845, quoted in Parry-Jones, 1972, p. 20.

Table 10

Distribution of patients in public and private asylums in 1844, 1859, 1879 and 1891[1]

Type of institution	1844	1859[a]	1879[b]	1891[c]
Paupers				
County and borough asylums	4,244	15,291	42,543	59,122
Other public asylums	464	210	117	241
Private licensed houses	2,774	2,139	1,040	1,449
Privately cared for as "single" patients	—	5,798	6,230	5,813
Workhouses	9,339	7,963	11,697	11,259
Totals	16,821	31,401	61,627	77,884
Private Patients				
County and borough asylums	245	227	476	977
Other public asylums	1,146	1,669	3,060	3,724
Private licensed houses	2,399	2,661	3,531	3,059
Privately cared for as "single" patients	282	122	472	440
Totals	4,072	4,679	7,539	8,200

[a] 682 criminal lunatics excluded

[b] 719 criminal lunatics excluded

[c] 711 criminal lunatics excluded

The ideological appeal of this concern for the poor was an attractive one: converted into bricks and mortar its contribution was less impressive. As can be seen from Table 10, the proportion of pauper lunatics in private accommodation was not a large one.

The private houses continued to fulfil a useful function for non-pauper lunatics until the end of the century. But as far as the paupers were concerned, those whose insanity was synonymous with their poverty, it was the county asylums that from mid-century were recognised to be the only suitable source of care. Table 10 shows that the movement out

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[1] Source: Report of the Metropolitan Commissioners in Lunacy, 1844; Special Report of the Commissioners in Lunacy, 1897a.

of the workhouses was not rapid and, given the fact that many workhouses had their own lunatic wards and that it was cheaper to keep a lunatic there than in a purpose-built asylum, this is not surprising. In spite of a commitment to fairly simple principles, the history of provision for the insane in the second half of the nineteenth century was no more straightforward than it was in the first. From the standpoint of the history of moral treatment, all that really needs to be said is that the county asylum remained the main site for the treatment of the insane. The major changes in therapeutic ideology continued to emerge from within the county asylums, and insofar as the mental hospitals of today still occupy the same buildings, they still do.

Just as moral treatment was nurtured and grew in the county asylums, so it met its demise in the same institutions. Its disappearance, or more exactly, transformation, was a slow and gradual process which occupied most of the second half of the nineteenth century. No attempt will be made here to follow all the features of that transformation: to do so would require another study as long as that already completed. What can be provided here is an examination of some of the trends that were already becoming apparent in the 1840s and 1850s. These were the trends, like "management" in the 1780s, that began as innovations in the treatment of the insane and were to be petrified into rules, commonsense assumptions as to the best way that things ought to be. And just as "management" contained many of the fragments out of which the creative force of moral treatment was to be constituted, so did these trends contain the fragments of the remains of moral treatment.

First of all, what happened to the major moral therapists whose careers have been followed in these pages? Hill only lasted four years at Lincoln Asylum before disappearing into obscurity as a private mad-

house owner; obscurity, that is, except for his repeated attempts to secure for himself the title of "founder" of the non-restraint system.[1] Ellis died in 1839, a year after having left Hanwell, also to become the proprietor of a private asylum. Samuel Tuke remained as treasurer of the Retreat until ill health forced him to retire in 1852. The daily administration was the responsibility of a number of superintendents--men and women who appear to have conformed to the original philosophy of the founders of the Retreat without themselves being radical in the sense that the early moral therapists were. Certainly, total non-restraint was to arrive later at the Retreat than at most other institutions with a progressive reputation.[2]

Of all the moral therapists, it was John Conolly who remained the most critical of his society, and the most imaginative of the practitioners. He disclosed one of the sources of his idealism in a letter written late in his life:

> Condillac's "Essai sur l'Origine des Connaisances Humaines" is now on my table, - the very volume put into my hands forty years ago, and which I seem to remember every word: perhaps to it I owe the direction of my mental life.[3]

It is not know what aspect of Condillac's work most impressed Conolly, but the following quotation from Condillac, which expresses both rationalist and individualist sentiments, would seem to sum up much of Conolly's approach to the treatment of the insane.

> Instructed by experience in the means of relieving or in forestalling its wants, it will reflect on the choice it must make. It will examine the advantages and disadvantages of objects which until then it has either

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1 See above p. 344, note 4.

2 On this see Conolly's comments in his 1973, pp. 314-8.

3 Letter to M. Battel, quoted in J. Clark, 1869, p. 4.

> avoided or sought. . . .It will feel the advantage of being ruled by experience; and accustoming itself to make use of its knowledge will learn to resist its desires and even overcome them. Interested in avoiding pain it will emancipate itself from the sway of its passions, extend the power of reason over its will, and become free.[1]

This quotation has already been cited in Chapter One. It was seen there how the progressivist optimism of Condillac's sensationalist doctrine was not generally taken up by the mad-doctors in the eighteenth century; it was altogether too radical a proposal for the medical profession. A hundred years later the whole face of Britain had changed, including the structure of the medical profession and the treatment of the insane.

And yet—although, as we have seen, there was a commitment by all the bourgeois ideologists to individual self-improvement and development—were the insane any freer, any more able to construct their own lives in the sanctuary of the asylum? Conolly never rejected the values of his society, but of all the moral therapists he did the most to enable his patients to grow as individuals within the system that constrained them all. One suggestion he made was for a "half-way house", a step between the asylum and home.

> We require an institution, subsidiary to the asylums of the poor, to which those cured or decidedly convalescent and curable might be removed, and where they could be supplied with work, receiving board and lodging, and some small payment in money for a time, until they could find work and a home for themselves.[2]

In a sense this was no more than an extension of the idea first mooted

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1 Condillac, 1930, p. 200 (first published in 1754). By "it" Condillac was referring to a hypothetical statue in order to make the point that man is not imbued with a metaphysical essence but is no more than the sum of his senses and the use he makes of them.

2 Conolly, 1846, vol. 1, p. 404.

by Ferriar; that the convalescents should be segregated in order to increase their chances of recovery. But it took individual therapy one step further and it is still a principle accepted today. Such a suggestion was at the core of what was imaginative in moral treatment; in the context of the 1840s it was fast becoming visionary and irrelevant. Perhaps Conolly was able to retain more of his idealism than other moral therapists because he did not remain in the asylum movement. He continued to retain an interest in the insane but, because of frustration at the constraints placed upon him by the visiting justices, he resigned his position of resident physician at Hanwell after only four years.[1] Rather than compromise his ideals, he moved into private practice. He did remain at Hanwell as visiting physician although, as already noted, he gave that up in disgust in 1852 when the asylum schoolmaster was dismissed for reasons of economy.

Until recently, it was generally understood that Ellis resigned from Hanwell purely because he too wanted to move into private practice.[2] However, Hunter and Macalpine have now discovered that there was another, more fundamental, reason. As they point out, Ellis was appointed as resident medical superintendent, steward, and treasurer.

> The post was created on the principle that the welfare of the whole establishment should rest on him, and the fact that he alone was responsible for management would in turn assure its welfare.[3]

It was this location of overall responsibility in one man that enabled Ellis to develop moral treatment beyond a few isolated maxims. It was

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1 Hunter and Macalpine, introduction to Conolly, 1973, pp. xvii-xix.

2 See for instance the account given in Hunter and Macalpine's introduction to Conolly, 1968, pp. 18-20.

3 Hunter and Macalpine, introduction to Conolly, 1973, p. xvii.

this that gave Wakefield and Hanwell Asylums their appearance of moral communities, centres in which moral treatment could be allowed to permeate every aspect of asylum life. But, as Hunter and Macalpine continue, "It worked in 1831 when the asylum opened for 300 patients. It did not when there were 800".[1] In 1837 the visiting justices decided "to appoint [separate positions of] House Steward, Treasurer, and accountant". Ellis' authority was restricted to the "sufficiently arduous office of a Physician. This change", the justices admitted much later, "led to his and Lady Ellis' resignation".[2] Conolly's appointment at Hanwell was confined to that of resident physician and, as noted above, he was never allowed to run the asylum as he wished.[3] Once the system of non-restraint, to which both he and the visiting justices were committed, had been introduced, Conolly continually found himself in conflict with the insistence of the justices that everything be made subordinate to economy. It is surely no coincidence that Hill, Ellis, and Conolly all resigned from their asylum positions following deep-seated disagreements with the lay administrators.

A number of conclusions can be drawn from this regarding the real centres of power in the asylum movement. Scull[4] makes much of the medical "capture" of insanity, but it was an appropriation heavily circumscribed by what the non-medical administrators would allow.

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1 Hunter and Macalpine, introduction to Conolly, 1973, p. xvii.

2 77th Report of the Visiting Justices, 1846, quoted in ibid., note 42.

3 Hunter and Macalpine point out that he could not even transfer patients from one ward to another without the sanction of the Committee (ibid.).

4 Scull, 1974; 1975a; 1976.

Indeed it is very likely that if the medical profession had really been allowed to develop moral treatment as it liked, the history of the insane in the second half of the nineteenth century (and up to today) would have been very different. Whatever the intention of individual physicians, they were repeatedly blocked by the practical problems that confronted them. It is true that the physicians always asserted their right to control the treatment of the insane although, as already shown above, this was not such a new development as Scull implies. It is also true that with the increasing secularisation of the concept of mind, the physicians had the strongest professional claim to consider the study of disorders of the mind as their legitimate province. But the conditions under which the asylum physicians were forced to work were not chosen by them; indeed the whole structure of the psychiatric profession was formed under conditions forced on them by pressures over which they had no control.[1]

Scull argues that

> To all intents and purposes. . .the medical profession had secured the exclusive right to treat the insane by mid-century. . .[because] the medical profession's control

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[1] The present Royal College of Psychiatrists began with a "Meeting of Medical Gentlemen attached to Lunatic Asylums' in 1841. A permanent organisation was constituted in the same year with the name "Association of Medical Officers of Hospitals for the Insane" (which later changed its name to the "Medico-Psychological Association"). Its official journal was started in 1853 with the title of The Asylum Journal (later to become The Asylum Journal of Mental Science). Scull makes much of this, quoting Freidson on the fact that any "profession bases its claim for its position on the possession of a skill so esoteric or complex that non-members of the profession cannot perform the work safely or satisfactorily and cannot even evaluate the work properly" (E. Freidson, Profession of Medicine, 1970, quoted in Scull, 1974, pp. 497-8). It could be argued that the medical profession has always done this and all The Asylum Journal represents is precisely what its name implies--an attempt to produce knowledge about insanity within the specific context of the public asylum. (On the origin of the Medico-Psychological Association see Walk, 1961.)

> of asylums, the only legitimate institutions for the treatment of insanity, effectively shut out all potential competitors.[1]

To assert this is to ignore the social pressures which limited the right of the medical profession to treat the insane in any institution other than the county asylums. It also ignores the social pressures which turned so many people into pauper lunatics. Rather than seeing the medical profession as being in control of the whole operation, there is a strong case for describing the physicians as manipulated by the social administrators in order to give an air of respectability, of scientific enquiry, into what they knew was merely a custodial solution to a social problem.[2] It is hardly surprising that within such constraints the psychiatric profession attempted to develop as much autonomy as possible, but that is hardly a basis for saying that they took over the control of the insane.

The national inspectorate, the overall authority for all the institutions for the insane, was made up mainly of non-medical personnel,[3] as were the visiting justices who decided on asylum policy, numbers, and staffing. Both nationally and locally, the administration

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1 Scull, 1974, p. 515.

2 To suggest this raises of course the question of why science should be called to the aid of deviance control, and not an alternative form of legitimation. It is because Scull does not tackle this question that his interpretation is unable to delve beyond the interests of a particular group of professionals, and thus ignores the factors which determined those interests. My own understanding of why scientific knowledge became more important in the treatment of the insane should be apparent to some extent from the discussion in Chapter Four. A more general discussion of the same issue is provided in the Coda to this thesis.

3 The Metropolitan Commissioners in Lunacy between 1842 and 1845 comprised 15 to 20 officials, of whom only six or seven were physicians. When the inspectorate was permanently reconstituted in 1845 as the Commissioners in Lunacy, it was made up of a full-time staff of five laymen, three legal advisers, and three physicians, the Chairman always being a layman (K. Jones, 1972, pp. 133, 145-6).

of the county asylums was dominated by the social interests of the bourgeois state and not by the professional interests of the "Asylum Officers". Unless this is appreciated, it is impossible to make sense of the transformation of moral treatment.

One of the major factors affecting the possibility of providing a range of imaginative moral treatment was the size of the asylum. It was one thing for Ellis to say that "it is only in a large asylum that moral treatment can be carried to its proper extent",[1] but that was when he was at Wakefield and "large" meant 200 patients. In 1844 the average population of the 15 county asylums was 293,[2] and by 1874 it had risen to 634.[3] And at Hanwell, the model asylum from which so many others took their cue as to what constituted progressive practice, the visiting justices wanted to double the size from one to two thousand beds. They were prevented from this by the Commissioners in Lunacy, and another county asylum for Middlesex was built to relieve the pressure on Hanwell. This asylum was at Colney Hatch and it opened in 1851 with 1000 beds--the largest asylum for the insane ever built. As with Bethlem before it, Colney Hatch attracted a lot of attention because of its size and impressive facade. So numerous were the tourists who visited the new asylum as part of their trip to London to see the Great Exhibition of 1851 that a leaflet was published to guide them through the main points of interest.[4]

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1 W.C. Ellis, 1827, p. 94, emphasis in the original.

2 And with a range from 107 at Dorset to 975 at Hanwell (Return of the Number of Pauper Lunatics. . ., 1844).

3 This was an average for 49 asylums (Report from the Committee on Madhouses in England, 1826, Appendix B1). In 1897 the average was 953 patients for 70 asylums (51st Report of the Commissioners in Lunacy, 1897b, p. 7).

4 A Guide through Colney Hatch Lunatic Asylum, London, 1851 (see Hunter and Macalpine, 1974, p. 29).

Hunter and Macalpine's detailed account of life at Colney Hatch shows clearly how the massive numbers there stifled any form of therapy directed to individual needs. The number of patients increased from 1244 in 1853 to just under 2000 six years later, and to 2584 in 1896.[1] And not only was every spare yard of space filled with extra beds, but as the asylum increasingly took on the aspect of a warehouse of human flesh, the cost of caring for the patients went down. In spite of inflation throughout this period the cost per patient per week at Colney Hatch dropped from 10s.2½d. in 1852 to 8s. 9d. in 1889.[2]

Within this changing context of care in the county asylums it is hardly surprising that the ways in which moral treatment was expressed also changed. Essentially, two things happened to moral treatment after the middle of the nineteenth century: its content became emasculated, and its recognised importance diminished. The two are obviously connected, but for the purposes of analysis may be examined separately.

The emasculation of moral treatment from the dynamic force it was in the hands of Tuke or Conolly into what it became in the large county asylums was to some extent a direct result of the increasing scale on which it was applied. Purely in order to deal with the large numbers then being cared for, the precepts of moral treatment had to be formalized and converted into rules which could be easily applied without regard to individual needs and interests. Of course, this contradicted some of the assumptions on which moral treatment was based, as J.T. Arlidge, for one, pointed out:

To treat insane people aright, they must be treated as

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1 Hunter and Macalpine, 1974, pp. 36, 48. The highest number ever held at Colney Hatch was not reached until 1937, when it stood at 2700 (ibid., p. 50).

2 Ibid., p. 59.

> individuals, and not en masse; they must be individually known, studied, and attended to both morally and medically.[1]

But in spite of isolated attempts like this to draw attention to what was happening, the medical profession had to come to terms with the growing asylum population, with the different conditions under which they had to treat the insane.

One aspect of community life which some asylums attempted to establish was dancing. To allow the patient the opportunity to engage in dancing might seem a progressive and therapeutic step; but at Hanwell, where there was a regular Monday ball, even this aspect of asylum life was subjected to a formalized routine. In 1857, a writer for the Quarterly Review visited Hanwell for one of these Monday functions.

> On the occasion of our visit there were about 200 patients present. . . .A raised orchestra. . .soon struck up a merry polka, and immediately the room was alive with dancers.

But, he continued, after describing the enthusiasm with which the patients involved themselves in the dancing,

> At nine precisely, although in the midst of a dance, a shrill note is blown, and the entire assembly, like so many Cinderellas, breaks up at once and the company hurry off to their dormitories.[2]

There would appear to be some justification for seeing a conflict here between the commitment to humanistic values and the practical concerns of running a large institution with minimum staff. On the other hand, it is too easy for us to forget that these patients were not just lunatics, they were pauper lunatics, and everything about their rehabil-

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1 Arlidge, 1859, pp. 102-3. Arlidge was the physician to a number of private and public asylums in his career.

2 Anon, 1857, pp. 375-6. See also the discussion in Scull, 1974, pp. 423-4, where this quotation is also given.

itation had to be directed towards returning them to their particular role in society. This can be seen very clearly in a letter by J.C. Bucknill, medical superintendent at Devon County Asylum and editor of The Asylum Journal. He was replying to a questionnaire sent out by the Commissioners in Lunacy in 1854 on the subject of non-restraint in all lunatic asylums. Bucknill had the reputation of being in the forefront of progressive practice and he was certainly committed to a policy of liberal humanism. First of all, he contrasted the contemporary approach with the dark ages of pre-non-restraint.

> The lunatic is unable, without assistance, to control his actions, so that he may tend to his own well-being, and to that of society. He is therefore placed under care and treatment, that he may be restored to the power of self-control; under care, that while this power remains impaired, he may be assisted in its exercise. This assistance may come in the shape of a strait waistcoat, or in the fear of one; or it may come in the sense of duty imposed in the operation of a gentle but effective discipline, of honest pride, desire of approbation, or personal regard, or the still nobler sentiments of religion. The first motive, that of fear, belongs to man and the animals, and its exercise is degrading and brutalising; the latter motives are human, and humanising in their influence, and their development is the true touchstone of progress in the moral treatment of mental disease. It was the brutalising influence of fear, and the degrading sense of shame, which constituted the true virus of mechanical restraints.[1]

Two pages later, however, comes the other side of these noble sentiments, what they mean in practice to the inhabitants of the asylum.

> Habits of industry, propriety, and order, are inculcated with so strict a surveillance as to leave to the ill-disposed but little opportunity for the indulgence of vicious propensities. By these means, habits of self-control are gradually established; and frequently in the end, self-respect is so far awakened that it becomes both prudent and just to withdraw surveillance.[2]

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[1] Eighth Report of the Commissioners in Lunacy, 1854, p. 126.

[2] Ibid., p. 128. A similar, almost punitive, attitude is expressed in the discussion on moral treatment that occurs in Bucknill and Tuke's

So nothing basic had really changed at all. "Habits of industry" was still top of the list, the content of insanity was still being described in moralistic terms, and the recipient of care was still being treated as an automaton, to be programmed with so many attributes until in the end he could be trusted to govern himself according to the laws of industrial capitalism. All that had changed was that the formative period in the creation of this ideology was over: these precepts had now become standardised, to be applied with as little attention to individual differences as the eighteenth century "terrific" system had done in its time.

Another fragment of the treatment of the insane that was at one stage much affected by moral treatment was the classification of the insane into various groups. As shown above, this classification reflected a rationalisation of the concept of insanity as well as of the stages of convalescence. To follow the intricacies of the changing systems of classification after the mid-nineteenth century would be a major task, but one point may be noted. As with all other aspects of asylum life, the principles of classification came to reflect the changing needs of the asylum rather than the variety of individual disorders presented in it. Peter Sedgwick has argued that Kraepelinian nosology (which was to be the major form of classification by the end of the century, and from which the concept of schizophrenia is derived) can be seen as an attempt to pin down behaviour occurring on a continuum, into simple easily manageable groups. In Sedgwick's words,

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influential textbook on Psychological Medicine which appeared in 1858: "The influence of example in enforcing obedience to law has a wonderful potency. The lawless youth who has been the terror of his native village, becomes obedient and docile when he enlists, often without suffering any punishment, and solely because he finds himself in the midst of an orderly system. The same influence tells forcibly upon the new inmate of an asylum; he may resist at first, and his mouth may be as hard as that of an unbroken colt; but after a while, and without any harshness, he will answer to the slightest indications of the rein of discipline" (Bucknill and Tuke, 1858, p. 511).

> A dichotomous diagnosis matched the dichotomising treatment decisions characteristic of a bureaucratised psychiatry based on large, impersonal public asylums.[1]

There is no space here to explore the implications of this for nosologies of insanity today[2] but, given the validity of the argument for the social determination of knowledge, it is the type of development that might be expected in the expanding asylums.

Returning to the more strictly "therapeutic" fragments of the changing practice, it must be admitted that they are fairly obvious and have been noted by most observers. Andrew Scull has drawn attention to the repeated attempts by the medical profession to increase their control of the treatment of the insane, even to the extent of coining phrases such as "medico-moral treatment" to indicate that doctors ought to be in charge of all treatment.[3] What this phrase meant was really no more than what other writers were still calling "moral treatment", as can be seen from the Annual Report of Littlemore County Asylum in 1855:

> Medicines are subordinate to that which has been termed Medico-Moral treatment. The removal of the patient from the sources of his habitual excitements, necessitating his trust in the unseen resources of others; the enforcing of rest; the regulating of habits; . . .these and ensuring warmth and food of wholesome and suitably varied quality become medical administrations to a mind diseased.[4]

What is really significant about this is not that the medical profession proclaimed a right to control non-medical treatment, but that whole

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1 Sedgwick, 1975, pp. 193-4.

2 Sedgwick (ibid.) does provide some discussion of this question.

3 Although, as shown earlier, this tradition was established by at least the time of Cabanis at the end of the eighteenth century. Scull seems to think that it was something which the profession did not really begin to hold until the middle of the nineteenth century. For examples of this type of assertion see Scull, 1974, p. 529.

4 Quoted in ibid., p. 510.

areas of treatment were eliminated by this type of redefinition of moral treatment. By 1892, D.H. Tuke had so emasculated his father's (i.e. Samuel Tuke's) original concept that he was able to write, in a Dictionary of Psychological Medicine, of "general or moral treatment"[1] to denote rest in bed, occupation, exercise, amusements, seclusion, and mechanical restraint. These aspects of moral treatment were certainly likely to work on the mind rather than on the body, but they no longer involved an appeal to individual attributes, passions, desires, etc. as Pinel's and Samuel Tuke's versions of moral treatment had done. It is this which is the most noteworthy of the later manifestations of moral treatment--the almost complete rejection of appeals to individual minds. While this is entirely understandable given the social control functions of the county asylums, it must be seen as largely responsible for the poverty of psychological medicine in this country until an attempt was made to incorporate into it that other "mental science" of psychoanalysis.

The separation of moral treatment into "social" and "psychological" fragments has been resisted so far because to do so would be to impose distinctions that were not made at the time. At this stage of the account, however, it is useful to examine the ways in which the earlier, broader, concept of moral treatment had begun to break down as it was applied in different situations. Most of the present account has been concerned with what happened in the county asylums because they have constituted the stage on which moral treatment made its major appearance. But alongside this interpretation of moral treatment as predominantly a form of social control, it must not be forgotten that the

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1 D.H. Tuke, 1892a, vol. 2, p. 1314.

original moral therapists did raise the possibility of treating individuals as individuals, with problems arising from their own praxis. As Esquirol had said,

> Each melancholic should be treated on principles resulting from a thorough acquaintance with the tendency of his mind, his character and habits.[1]

This "psychotherapeutic" fragment of moral treatment may also be seen as constituting, in an embryonic form, the same approach to insanity that was later to be developed by Freud and the psychoanalytic movement. The "psychotherapeutic moral therapists" did not occupy a large or a significant role in the moral treatment movement, but their work does illustrate another fragment of the ideology, and one that by its very insignificance emphasises the emasculation of moral treatment that was taking place.

One physician whose work would seem to justify his inclusion in this group is Sir Alexander Morison, a man for whom non-restraint was "a gross and palpable absurdity, the wild scheme of a philanthropic visionary, unscientific and impossible".[2] But if Morison was against non-restraint, he was not against at least one version of moral treatment. Something of his approach can be seen from the fact that he used the phrase "the mental or moral treatment"[3] of the insane to indicate

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[1] Esquirol, 1965, p. 228 (first published 1820). It is possible to trace this "mentalist" approach to therapy back even further, to the "philosophy of mind" school of Reid and Gregory, although, as already noted, this was never recognised as an important source of therapeutic knowledge. For an example of that approach see Gregory, 1770, pp. 22-4.

[2] Quoted in R.G. Hill, 1857, p. 37. This was in reply to the visiting justices at Hanwell in respect of the specific practice of non-restraint at that asylum. Morison had been the visiting physician at Hanwell from 1832 and had never agreed with Conolly's approach to the treatment of the insane.

[3] Morison, 1828, p. 7.

the non-medical aspects of therapy. But his point was more than just that the physician had to work with his patients' minds; what Morison stressed was the need to understand the individual praxis which had led to the insanity. As he put it,

> In order to conduct the mental treatment with efficacy, the most important object is to obtain full information of the patient's previous history, and particularly of the mental cause giving rise to, or at least intimately connected with, the production of the disorder. . . . Possessed of such knowledge, we are the better able to appreciate the phenomena of his delirium, the association of his ideas in general, and the tendency of those ideas on which his mind chiefly dwells, thereby foreseeing and preventing mental irritation, removing or diminishing uneasy sensations, and lessening the frequency of fits of fury or of despondency.[1]

As with Ellis' "ascertain the ruling passion" idea, this approach to the treatment of the insane involved an individual assessment of each patient; an assessment which in Morison's phrases clearly pointed the way to twentieth century psychotherapy.[2]

Another physician who showed a sensitive appreciation of the psychotherapeutic functions of moral treatment was George Man Burrows, a private asylum owner who earlier in his life had been responsible for some reforms of the medical profession.[3] According to Burrows, moral treatment "is an art, in fact, that cannot be taught. . .the qualifi-

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[1] Morison, 1828, p. 8.

[2] Although, as was shown in Chapter Four, Morison's use of concepts like "monomania" showed little concern for a deep analysis of his patients' minds. It is also noteworthy that Morison used the phrase "association of ideas". As shown in Chapter One, this doctrine raised the possibility of a psychological approach to insanity in the eighteenth century, but it was not taken up at that time.

[3] Burrows was connected with the reform movement which culminated in the Apothecaries Act of 1815 (see Holloway, 1966, especially pp. 122-5). Burrows' career began as a surgeon's apprentice, but he gradually moved up through the profession, becoming MD (St Andrews) in 1824 and FRCP in 1839 (DNB).

cations are intuitive, not acquired".[1] For Burrows, moral treatment was an art of therapeutics in which the therapist used caution, natural aptitude, and a number of learned skills in order to guide a convalescent back to health. He emphasized the importance of knowing the right amount of trust, encouragement, or censorship to be extended to the patient at the appropriate moment. Apart from the "intuitive" knowledge a good moral therapist was supposed to have, Burrows did list four general principles to be followed:[2] 1) never exercise the mind of an insane person on the subject about which he is delirious; 2) never openly oppose the morbid ideas of the insane; 3) aim to excite "fresh moral emotions, revive the dormant faculties";[3] and 4) never make a promise to a lunatic, but if made, never break one. These principles do not differ much from the precepts laid down by Pinel, but what is significant about Burrows' contribution to the moral treatment debate is that he limits his review of moral treatment entirely to these psychological factors. Unlike most other authors who saw it as merely one aspect of moral treatment, for Burrows moral treatment was only the relationship between the therapist and his patient.[4] There is no mention at all of self-restraint, that main obsession of most moral

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1 Burrows, 1828, p. 667. This work was a large treatise on insanity and aroused considerable contemporary interest (see HMA, pp. 777-8).

2 Burrows, loc.cit., pp. 667-79.

3 Ibid., p. 668.

4 Another physician who conceived of moral treatment in this way was Thomas Mayo, the President of the Royal College of Physicians from 1857 to 1862. Chapter 8 of his 1838 is on "mental treatment" of insanity, on the need to take note of the patients' changing mental states and to adjust treatment accordingly.

therapists.[1]

It has been argued that an emphasis on self-restraint was one of the major signs of the emasculation of moral treatment in the mid-century period. The other was a gradual realisation that perhaps moral treatment was not as important as had originally been thought, and it is to this that we may now finally turn.

The direction in which county asylum administrators were beginning to turn their thoughts can be seen from the comments of the Commissioners in Lunacy in 1847. At the end of a report devoted to an analysis of the results of a questionnaire sent to asylum superintendents, the Commissioners conclude that

> there is reason to apprehend that the attention of medical men has been of late years too exclusively devoted to what is termed Moral Treatment, to the neglect, in some instances, of the resources of medicine. They appear occasionally to have lost sight of the fact that Insanity never exists without a physical cause, namely some disturbance of the functions of the brain.[2]

The Commissioners themselves had lost sight of another fact (or they may never have known it): it was only 10 to 15 years previously that the science of phrenology had "solved" this very problem. The phrenologists had argued that it was precisely because insanity was due to disordered brain functions that moral treatment (which attempted to develop other, undamaged, functions) was such an appropriate and

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1 It is interesting that Morison, together with Burrows, Haslam, and a number of other physicians, formed a "Society for Improving the Condition of the Insane" in 1842 in active opposition to the non-restraint movement. Haslam gave a paper to the Society in 1843 (printed in Sommers, 1850, pp. 1-5) in which he argued that "restraint and coercion" acted as positive measures in getting the insane to develop a consciousness of their own insanity.

2 Report of the Commissioners in Lunacy, 1847, p. 229. The Commissioners defined moral treatment as "all those means which, by operating on the feelings and habits, exert a salutary influence and tend to restore them to a sound and natural state" (ibid., p. 222). They included in this definition the abolition of "mechanical coercion", employment, a bright environment and a resident chaplain.

effective method of therapy. In this context it is instructive to look at the writings of W.A.F. Browne, a physician whose medical involvement with the treatment of the insane lasted from the mid-1830s to 1870.

At the beginning of his career, Browne had been responsible for the almost utopian message on the treatment of the insane, What Asylums were, are, and ought to be. This was published in 1837, the heyday of phrenology and the same time that R.G. Hill was abolishing all restraints at Lincoln. In this work, Browne affirmed that

> They [the patients] literally work in order to please themselves, and having once experienced the possibility of doing this, and of earning peace, self-applause, and the approbation of all around, . . .a difficulty is found in restraining their eagerness, and moderating their exertions.[1]

Nine years later Browne had modified his early enthusiasm a little. He then maintained that "while disposed to attribute great, infinitely greater, efficacy to moral than to medical treatment",[2] he felt it necessary to emphasize that attention to bodily health must be a major function of an asylum superintendent's responsibility.

By 1864 however, Browne had completely rejected most of his earlier enthusiasm. In a lecture given to a class of students in medical psychology, Browne admitted that

> Benevolence and sympathy suggested and developed, and in my opinion, unfurtunately enhanced the employment of moral means, either to the exclusion or to the undue disparagement of physical means, of cure and alleviation. I confess to have aided at one time in this revolution; which cannot be regarded in any better light than as treason to the principles of our profession.[3]

In this lecture Browne agreed that many therapies (such as the shock of

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1 Browne, 1837, p. 230.

2 Crichton Royal Institution, Annual Report, 1846, p. 20 (signed by Browne).

3 Reprinted as Browne, 1864, p. 311.

a shower bath) have a moral and medical character in that they worked on the mind and on the brain.[1] All that appears to have changed in Browne's thinking was the evaporation of his earlier optimism that all patients could improve themselves through moral treatment. What he felt it necessary to emphasize in 1864 was not that men have more ability than they are usually given credit for (the message of his 1837 lectures), but that many of the insane are not capable of much improvement at all. "In many senses", he maintained,

> an asylum should be a grand moral school and reformatory, as well as an hospital [because]. . .the blight of alienation. . .falls heaviest and most poisonously upon those of imperfect character, of ungoverned passions, and degraded propensities. . .[Asylums] should teach and elevate, but their lessons should speak of early habits, former pursuits, natural proclivities.[2]

And so on. Nowhere in this whole essay is there any sign of Browne's earlier rationalist optimism. By 1864, for Browne and for most of the profession, we are justified in accepting Scull's comment that moral treatment had become "simply a system of discipline".[3]

There is little doubt, then, about what happened to moral treatment. What still remains to be answered is precisely why all the earlier optimism evaporated quite so quickly, even within the lifetimes of those who were largely responsible for it in the first place. Before looking for causes, one point must be emphasized: only a very small proportion of asylum superintendents were enthusiastic moral therapists. In 1844,

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1 Browne had always shown an awareness of the joint effect of many therapies. In 1841, for instance, he had pointed out that "the efficacy of even a drug may, and often does, depend as much upon the feelings of repugnance or confidence with which it is swallowed, as upon the intrinsic properties" (Crichton Royal Institution, Annual Report, 1841).

2 Browne, 1864, pp. 314-5, 313.

3 Scull, 1974, p. 664.

for instance, out of all the public asylums, the Metropolitan Commissioners found only seven in which they considered that non-restraint was being practiced.[1] The "outstanding" moral therapists can be counted on the fingers of one hand, and even they had little long-term effect on the asylums where they were employed. Even Hanwell, at which both Ellis and Conolly had devoted so much effort, had, by 1855, degenerated into

> a very inferior, and in many respects an ill-built, ill adapted, and an indifferently managed asylum. . .where lunatics are herded by the thousand, fed and clothed as paupers, but not treated as patients.[2]

But for reasons that have been stated many times in these pages, if moral treatment and non-restraint were principles that few could emulate as imaginatively as their founders, they were also principles that few would care to disown. In other words, although moral treatment remained strong as an ideology until the 1860s or even later, the deterioration in care was not as marked as it appears merely from looking at what happened at Hanwell or at the Crichton Royal Institution. In most asylums the pauper lunatics never received much more than custody or confinement at any time. The commitments to employment, classification, abolition of mechanical restraints, etc., did gradually filter through the system, but it was not until after the 1845 Act and the establishment of a full-time national inspectorate that any standardisation of principles of care was really achieved. It must be stressed that until that time, in talking of the importance of moral treatment, we are

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1 Lincoln, Hanwell, Lancaster, Suffolk, Gloucester, Northampton, and Haslar (Report of the Metropolitan Commissioners in Lunacy, 1844).

2 J.T. Arlidge, writing in 1856, quoted in Hunter and Macalpine's introduction to Conolly, 1973, p. xxxiv.

talking of an ideology which few would have denied, but few put into practice.

It has already been argued in this chapter that the reasons for the changes in care must be located outside the asylum, in the changing attitudes of the authorities who directed social policy rather than in the attitudes of the profession who had to carry out the requirements of that policy. Some of the most perceptive comments on this have been made recently by Vieda Skultans.[1] Skultans argues that the decline in the belief in moral treatment must be seen in terms of the decline of the need for the middle class to acquire new members. Until the middle of the century (she maintains as late as 1870), the middle class went through a period of growth in its material possessions and in its confidence in itself. It had a physical need to recruit active and willing members but it also had a need to establish a moral legitmacy--to demonstrate that what it was doing was essentially right. In the context of the treatment of the insane, moral treatment became important because, theoretically, it confirmed the doctrine of individualism and the democratic basis of change and, practically, because it showed that bourgeois means of improvement worked on the weakest of material.

In the earliest period of moral treatment (1790 to 1830), when the middle class was not yet in a position of economic or political dominance, it emphasized opportunity, untapped resources, an enthusiastic belief in the ability of man to make himself. In many respects this reflected the biographies of many bourgeois ideologists themselves, who saw these features as the basis of their own success. This ideology also reflected the physical need of the growing middle class to recruit

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[1] Skultans, 1975, introduction, especially pp. 21-5. The following discussion receives its inspiration from her comments although it disagrees in many details with the significance of the various phases of capitalist growth.

new members, to build its strength from all sections of society at a time when that society was going through a period of unprecedented change.

The second period of moral treatment (1830 to 1860) coincided with the time when the bourgeois class in Britain was consolidating its economic power into the realms of political and ideological power. It no longer needed to emphasize its openness to all comers, or to new ideas; it was able to harden its attitude towards those outside it. The behavioural norms had been established--it was up to everybody to exercise self-restraint in order to live up to them. After the 1870s this attitude was hardened further. In the treatment of the insane it had the effect of eliminating moral treatment altogether as a meaningful programme of therapeutics. Skultans suggests that this decline in optimism was due to a number of external factors which checked the confidence of the middle class in itself. Foreign competition and economic depressions demonstrated to the British bourgeoisie that its authority was nowhere near as powerful as it would have liked to believe, as did the growing strength of the organised working class. The effect of these factors on bourgeois ideology was to cause it to turn in on itself, to transform its earlier optimism into a profound pessimism as to the possibilities for further growth. While there is undoubtedly some truth in this, it must not be forgotten that the last quarter of the nineteenth century was part of Britain's heyday as an imperialist power. The bourgeois class was still very optimistic about its opportunities for itself: the pessimism is one that was directly mainly at those whom this now-dominant class did not want to recruit.

The natives of the newly colonised territories, the paupers, the morally defective, the insane: these and others were groups that the

ideologists of imperialist Britain recognised as important, but only because they were believed to constitute a threat to the order of Victorian society. Insanity began to appear, not as a minor problem affecting individuals, but as something which permeated the whole of society like a cancerous growth. Andrew Wynter, a popular medical writer of the 1870s, wrote of the hordes who "suffer from a paralysis of the moral sense", who are untruthful, have degraded thoughts, etc.

> They have long belonged to the Borderland of Insanity, in the opinion of those who know them best; but it is only the last supreme act which, in the eyes of the world, takes them over the frontier into the domain of the insane. There are thousands who, lacking the opportunity or the power of will, never indeed do cross the frontier, but remain and swell the vast army of undiscovered lunatics which leavens unsuspectedly the sane population.[1]

Against this vision of unlimited lunatics and moral deviants constantly replenishing the asylum beds, what was the point of individual therapy? It could neither cure individual patients nor turn back the tide of degeneracy which the bourgeoisie saw all around it.

Another feature of this siege mentality was the growing belief in heredity as a cause of deviance. Many of the unfortunates were supposed to be in the state they were in because of their own nasty behaviour, but for many more it was their genetic inheritance that branded them forever as members of the "Borderland of Insanity". Another famous physician of the insane, Henry Maudsley, wrote at length on the effects of the hereditary feature of insanity. He explicitly rejected the earlier optimism of the moral therapists:

> A true reformation would be a re-forming of the individual nature; and how can that which has been forming through generations be re-formed within the term of a single life?

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1 Wynter, 1875, p. 51. There was believed to be such a large increase in the numbers of the insane that a government committee was set up to enquire into its causes (Special Report of the Commissioners in Lunacy, 1897a).

> Can the Ethiopian change his colour, or the leopard his spots?[1]

No, he answered, it cannot, and thus there was little point in moral treatment or in any other therapy which was based on an attempt to change individuals through individual methods. Some people, groups, races, classes, are necessarily inferior. By all means care for them humanely, but to try and change their nature--that would be a waste of time.

A waste of time, that is, as long as the methods were only applied to individuals. The latter part of the nineteenth century was the time which saw the birth and expansion of interest in eugenics, a reform movement which believed that social improvement was possible, but only through selective breeding: a form of deviance management which took the initiative for change away from individual entrepreneurs and put it firmly in the hands of "the professional middle class".[2] And in the United States of America, Rosenberg has shown how a similar change there towards emphasizing the degenerative aspects of heredity led to "scientific racism".[3] Enthusiasm for change did not diminish in the latter part of the nineteenth century, but the direction of that change was increasingly being translated through a body of knowledge which left moral treatment with no meaningful role to play. The needs of capitalism had moved on.

In providing a conclusion for the account of moral treatment

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1 Maudsley, 1873, p. 131, emphasis in the original. See also the family tree he provided on p. 134 of the same work to show how murder and robbery in the first generation led to suicide and imbecility in the second and to mania in the third.

2 MacKenzie, 1976, p. 521.

3 Rosenberg, 1976, chap. 1.

presented in these pages, it may be said that it appeared as a success because, amongst other things, it reflected a commitment to individualism and to rational self-reflection; it appeared to confirm the value of those attitudes to a class for whom they were believed to be the basis of their own success. This was the "expressive" function of moral treatment, its value as an ideology which proclaimed in the world of beliefs, moralities, and epistemologies the praxis of a class of entrepreneurial capitalists. Sometimes this praxis was expressed reflexively, illustrating the self-image of the middle class; and sometimes it was expressed as a series of normative statements about the world--comprising other classes and social interests--whose other images had to be conquered in the realm of ideas.

But moral treatment was more than an ideology. It was also a coherent, rationally constructed, attempt to produce and reproduce the aspects of that world in which its protagonists believed. It was constructed as an instrument to petrify the social relations of early industrial capitalism. As I have tried to show in these pages, these social relations were rich and varied. Ultimately, it was always the ownership of the means of production which determined the possibilities of change, but within those limits there were a variety of individual approaches. I have tried to illustrate something of this richness here, without denying either the boundaries of meaning within which the moral therapists had to work, or the essential creativity of their task.

Whether moral treatment was "successful" in curing the insane is another matter and outside the concerns of this thesis. But the ideological success of moral treatment (or of rationalist optimism in individual self-improvement) was one with a historically specific role.

Once the bourgeoisie had achieved its greatest strength its material and ideological needs changed. From a position of attack it moved to one of defence, and "success" in this latter period was no longer to be defined in terms of who could be recruited to the class, but of who needed to be kept out. And in terms of these new interests it may be said that moral treatment did not demonstrate that it had failed, merely that it was no longer appropriate as a means of dealing with those who could not, or would not, conform.

The last word may be left with someone who, like William Tuke before him, saw himself as an emissary for God in a world of evil. But whereas Tuke pointed to the possibilities of man in the 1790s, when the bourgeoisie was just becoming aware of its capabilities, General William Booth of the Salvation Army was writing a century later when the greatest potential for change was emerging from within a different class. And just as Tuke had reflected the interests of the bourgeoisie at his time in history, so did Booth in his. "There are men", wrote Booth in 1890,

> so incorrigibly lazy that no inducement that you can offer will tempt them to work; so eaten up by vice that virtue is abhorrent to them, and so inveterately dishonest that theft is to them a master passion. When a human being has reached that stage, there is only one course that can be rationally pursued. Sorrowfully, but remorselessly, it must be recognised that he has become lunatic, morally demented, incapable of self-government, and that upon him, therefore, must be passed the sentence of permanent seclusion from a world in which he is not fit to be at large. . . .Between them and the wide world there should be reared an impassable barrier, which once passed should be recrossed no more for ever.[1]

That we still today make use of the asylums at Hanwell and Colney Hatch says a lot for the success of Booth and others in erecting that

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[1] From Booth's In Darkest England, 1890, quoted in Skultans, 1975, pp. 24-5.

"impassable barrier". But at the same time that these ideologists of capital were attempting to write off whole sections of the population, other intellectuals were aligning themselves with the interests of the working class. That story takes us a long way from the history of moral treatment. But the point at which it begins can perhaps be measured from the time of men like Booth. With their attempt to confine forever those they could not change, they proclaim to us all the final end of the reign of moral treatment.

CODA

Praxis and the reification of human nature.

The Conclusion is that imprisonment cannot be fully understood by those who do not understand freedom.

--Bernard Shaw

This part of the thesis is described as a Coda and not a Conclusion for a number of reasons. It is not a "conclusion" because it is implicit in the approach used throughout this thesis that description is its own interpretation. My argument is that in writing history it is not possible impartially to present evidence and then draw conclusions from what has been discovered in the process of research; it is rather that a conclusion as to what is important is made every time a "piece" of history is selected from the past and transferred as "evidence" to the researcher's notebook. And further, this process is repeated every time the researcher gathers a number of "pieces of evidence" together and presents them as part of his reconstruction of history. A separate conclusion is redundant to this work because, insofar as a conclusion is ever possible in historical research, it is incorporated into every page of the description itself.

A conclusion can be used, on the other hand, to present in a different, perhaps more theoretical way, some of the points that have already been made in the text. The term "Coda", while implying the end of a piece of work, also implies an extension of the ideas which have received a systematic expression in the main body of the work. It is a term used in music to denote a passage added after the natural completion of the final movement, in which some of the main ideas are presented in a slightly different form, in order to create a more definite and satisfying ending to the work. This makes it an appropriate term in the present context.

In the Introduction I stated a commitment to a phenomenological understanding of human nature, one which sees man as making himself but always within the specific social context in which he finds himself. In the main body of the work it was shown how a particular understanding of

human nature manifested itself in early industrial capitalism. The central focus of the text was at the level of everyday practice, what people thought and did about the specific problems involved in caring for the insane. It was argued that this contributes not only to our understanding of the history of the treatment of the insane but also of how capitalism reproduces itself through its constituent members. It may now be asked, what are the implications of the above for a general theory of human nature, especially insofar as it affects our understanding of the potential for consciousness within the historical epoch of industrial capitalism? One position with which the above account may appear to be in sympathy is that held by the French sociologist Roger Bastide and, to some extent, by Michel Foucault.[1]

Bastide's argument is that the treatment of insanity in capitalist society is essentially a repressive activity, an exercise in social control in which certain elements of consciousness are forever concealed. Purely in terms of the language employed by the moral therapists, this would seem to be a valid interpretation. Moral treatment was, after all, the control of the moral affections, of aspects of human consciousness which representatives of the ruling class had decided were anti-social and unnecessary. Both Bastide and Foucault appear to see this as a narrowing of the range of the reasonable, with possibilities of criticism, creativity, or consciousness exiled to the realm of unreason. Bastide argues that attempts to evade the reign of bourgeois consciousness, as through the artistic movements of dada and surrealism, are themselves merely part of the dominant (and rational) system of commercial production.[2]

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[1] Bastide, 1972, especially pages 186-200; Foucault, 1971, conclusion.

[2] The surrealists made much of their "automatic writing" in which they

The only way out is through madness, "a resistant enclave of affectivity, myth, and pure subjectivity within the dominant system".[1] Foucault takes this even further and holds up the existence of madness as a mirror on the world. The particular examples that Foucault uses to typify madness are hardly typical by any standards and yet it is possible to see in them implications for a general theory of consciousness. He points to the creative work of Nietzsche, Van Gogh, and Antonin Artaud, and argues that although "where there is a work of art, there is no madness", it is possible to conflate the two and produce something which the sane cannot ignore. It is precisely "through madness", Foucault argues, that

> a work that seems to drown in the world, to reveal there its [that is, the work of art's] non-sense, and to transfigure itself with the features of pathology alone, actually engages within itself the world's time, masters it, and leads it; by the madness which interrupts it, a work of art opens a void, a moment of silence, a question without answer, provokes a breach without reconciliation where the world is forced to question itself.[2]

Or, in the words of a man who spent many years in insane asylums, Antonin Artaud,

> And you, lucid madmen, consumptives, cancer ridden, chronic meningitics, you are the misunderstood. . . .In the name of what superior light. . .can they understand us, we who are at the very root of knowledge and of clarity. . . . We, whom pain makes journey into our souls in search of a calm place to cling to, in search of stability in evil,

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believed their unconscious mind was allowed to be directly responsible for artistic creation. But, as Sanchez Vazquez has remarked, "Consciousness asserts its existence both through its decision to automate the psyche, since it alone can determine the rate of progress towards that automatism, and also throughout the process and its result. The very radicalism of the Surrealist project. . .demonstrates that it is impossible to exclude consciousness from the practical, artistic process" (Sanchez Vazquez, 1977, p. 229).

1 Bastide, 1972, p. 199.

2 Foucault, 1971, p. 288.

> as the others search for it in good--we aren't mad, we're marvellous doctors, we know the necessary dose for the soul, for sensibility, for the marrow, for thought.[1]

The argument will be familiar to the readers of R.D. Laing or David Cooper, or of a number of other critics of bourgeois rationality.[2]

It may be added that, whether or not we accept the pleading of individual "lunatics" and of their defenders, there is nothing in the definition of psychiatry as examined in this thesis which denies that certain expressions of affectivity have been excluded from bourgeois consciousness. It is not clear however quite what role this affectivity could play if it was subjected to any form of non-exploitative but social control. Artaud was always very outspoken in his

> protest against any interference with the free development of delirium. . . .We simply affirm that their [the insane's] concept of reality is absolutely legitimate, as are all the acts resulting from it. . . .All individual acts are anti-social.[3]

Is this conflict between the individual and the social, between the rational and the irrational, a necessary one--or is it one which is specific to certain forms of society? Although this was not the central point of the above account of moral treatment, the account did provide some leads as to the answer to this question. These leads may now be

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1 "General security--the liquidation of opium" (circa 1925), in Artaud, 1965, pp. 61-2.

2 The literature here is far too vast to cover in a footnote. It stretches from the early "Romantics" (Blake and Shelley) to modern propagandists of the same message such as Theodore Roszak. A related position is that expressed in the "critical theory" of the Frankfurt School, a sociology which sees the increasing rationalism of the world as the reliance on an order which necessarily excludes fundamental human freedoms.

3 "Letter to the Medical Directors of Lunatic Asylums" (circa 1925), in Artaud, 1968, p. 182.

drawn together and some tentative suggestions made as to the type of answer that would satisfy it.

It was argued in the Introduction to this thesis that consciousness is not a fixed attribute of human nature, but something created, like the hand, out of human labour. Man creates himself in the world as he appropriates the world that confronts him and turns it into his world. This process is known by the term "objectification". Man, the subject of history, becomes for himself the object of history--his own destiny and his own product.[1] The role of consciousness in this process is a crucial one, but like the human nature it creates, it often appears contradictory and confused. This is especially so in the period of capitalist production because of the particular way in which production has to be carried on in order to maintain the distinction (on which capitalism rests) between capital and labour. In the above account of the history of moral treatment it was shown repeatedly how moral treatment was itself a consciously-created product of men's needs, yet was never acknowledged as such: its meaning was always held to be located in the moral or scientific laws within which the moral therapists believed they were constrained. Moral treatment was created in a society dominated by the production of commodities, by the fetishistic belief that such a material order was natural and not dependent on the working out of men's interests. Moral treatment embodied those contradictions and attempted to reproduce them in the area of the treatment of the insane. As practice, the effect of moral treatment must be assessed in comparison with other modes of treating the insane. But as ideology, moral treatment appeared to demonstrate the existence of laws which

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[1] This theme is dealt with at length by Sartre in his 1968 and 1976.

could improve the maintenance of the social relations of capitalism.

So much as already been argued many times in these pages. An attempt has been made to demystify the fetishism of commodities as it applied to the treatment of the insane. But how are we to go beyond that, to build a demystified view of human nature or social improvement? As far as historical materialism is concerned, the direction from which this question must be answered is clear. The creation of value is not derived from metaphysics, from a particular social system, from capital, or from individual members of society. It derives, as was stated in the Introduction, from the labour power of the vast majority of the population. From this viewpoint it is possible to cut through many of the mystifications of bourgeois logic and to point to real improvements in the social conditions of a society.

The changes within capitalist society that can be said to mark an improvement (within the context of the present discussion) are those which modify the fetishism of commodities and thereby demonstrate that society is the product of its constituent members. Thus Marx described the Ten Hours Bill, which reduced the number of hours that factory operatives had to work, as

> the victory of a principle; it was the first time that in broad daylight the political economy of the middle class succumbed to the political economy of the working class.[1]

Marx was under no illusions. He knew that even in working ten hours a day the working class was being exploited and prevented from receiving anything like the full reward for its labour. But this was the direction in which improvement had to occur--the introduction of material changes which were in the interests of the working class because they

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[1] Inaugural address of the Working Men's International Association, 1864, in K. Marx and Engels, 1958, vol. 1, p. 383.

reduced the amount of exploitation and they showed the existing ruling class that it no longer held undisputed power.

Improvements of this nature were never made merely to establish a principle. Marx was always very clear about the specific material benefits that he expected from any piece of reform. The reduction in the working day, for instance, was seen by Marx as a fundamental necessity in order to give to the working class the possibility for future growth: that is, not only "to restore the health and physical energies of the working class", but also "to secure for them the possibility of intellectual development, sociable intercourse, social and political action".[1] The comment could also have been made in relation to the provision of minimum facilities for the insane. Whatever the inadequacies of the asylums, or of moral treatment, as long as the intentions of therapy were to restore the insane to a minimum basis of normal functioning, they must be seen as better than that which went before, in which the role of the lunatic in society was symbolic and not related in any way to his or her individual needs.

So also in education. Marx and later Marxists have recognised that whatever the force of the bourgeois educational system in reinforcing the doctrine of individualism, it has also provided the working class with basic skills, skills which the working class will itself need to teach when it comes to power.[2] What has to be remembered, though, is that this "minimum consciousness" soon becomes class consciousness;

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1 "Instructions for the delegates to the Geneva Congress of the Working Men's International Association", 1867, quoted in Simon, 1977, p. 197. Simon's whole article is connected with this subject of improvement within capitalist social relations. See also Mishra, 1975.

2 See Simon, op.cit., p. 200. This point is not accepted by all Marxists. Simon is a vocal exponent of the viewpoint put here, but for a strongly argued defence of the position that bourgeois education is necessarily solely coercive see Althusser, 1971.

that it is really only in opposition to what they do not want that the interests of the bourgeois and working classes can be said to have anything in common. In terms of the treatment of the insane, they do not want the mentally ill to be looked upon as subhuman, nor as symbolic of universal metaphysical truths. They want all men to be "objectified" into the fabric of society, but it is in the means by which this is achieved that the different types of societies reveal themselves for what they are.

One feature of the social reforms and welfare measures (including moral treatment) dominated by commodity fetishism is that they create the consciousness in their reformers' and recipients' minds that change occurs at an individual level. These measures confirm in their praxis that the basic unit of society is the individual, and that the basic means of improvement is through competition between individuals. A fundamental feature of the reforms dominated by the interests of the working class is that they create a consciousness in their members' minds that the basic means of improvement is their co-operation as members of a class. The work of the Brazilian educator, Paulo Freire, who was mentioned in passing in the Introduction, is of significance here. In his discussion of the different kinds of consciousness that different societies propagate, Freire introduced a concept which helps to explain the implications of the above discussion for the points raised by Foucault and Bastide. Freire uses the phrase "culture of silence" to describe the relationship between a dominating metropolitan country and the third-world country it exploits.[1] According to Freire, in this type of situation there is no possibility of a dialogue emerging between

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[1] Freire, 1972, especially pp. 57-9.

the two sets of interests. The situation is defined by the interests of the dominating society, who effectively silence the voice of the other and communicate with it only in terms of the concepts, values, etc., of the dominant society.

> The dependent society is by definition a silent society. Its voice is not an authentic voice, but merely an echo of the voice of the metropolis--in every way, the metropolis speaks, the dependent society listens.[1]

Friere is writing here particularly of Brazil, a country of which he has much personal experience. But the same "culture of silence" syndrome applies to the relationships between many countries--and of course, although this is not Freire's concern, between the oppositional groups within any one country. It is here that Freire's concept of the "culture of silence" appears to have much in common with Foucault's understanding of the silence that exists about the meaning of insanity in our society today. According to Foucault,

> The language of psychiatry which is a monologue of reason <u>about</u> madness, has been established only on the basis of such a silence.[2]

In both cases the dominant class or group has silenced the voice of the dominated group, and substituted its own language, concepts, logic--in short, its own reason--as the medium of communication. It is in the way out of this stranglehold that the solutions offered by Foucault and Freire differ. Foucault appears to believe that the actual content of madness--repressed, yet the authentic voice of a sentient individual--has some sort of possible function as a means of breaking the domination of the "culture of silence". Freire, on the other hand, also writing of unhappy, alienated individuals, sees no way out except

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1 Freire, 1972, p. 59.

2 Foucault, 1971, pp. xii-xiii, emphasis in the original.

through their collective action. In his words,

> Men are made free in communion with others through a situation we have to change. We have to make our freedom together with others--"We" not "I".[1]

If we apply this dictum to the insane the implication must be that they do have something to say vis-à-vis the sane, but it is a something which derives its meaning from their common experience. In a sense this is just another way of expressing the main argument of the substantive part of this thesis: that the "voice" of the pauper lunatic in early nineteenth century Britain is the voice of the oppressed and exploited working class.

The "structural seeing" with which the therapists at the Retreat were able to communicate with their patients derived from their common material interests as Quakers and as members of a particular social class. These interests were specific and sufficiently strongly held by the therapists and their patients for the insanity to be controlled by their joint action, their class-specific "communion". Outside of the Retreat and a few private madhouses, the community of interests diverged. Instead of providing therapy which raised their patients' consciousness, the aim of the reformers became one of instilling habits which would merely confirm the insane as subservient, as members of a dependent class.

The implications of this for a socialist psychiatry are now, if

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[1] Freire, 1976a, p. 226. This was a point made by Marx both in relation to the ultimate freedom from the realm of necessity and as the basis for the immediate improvement of unfree conditions. As he put it in the last volume of Capital, "Freedom. . .can only consist in socialised man, the associated producers, rationally regulating their interchange with Nature, bringing it under their common control instead of being ruled by it as by the blind forces of Nature; and achieving this with the least expenditure of energy and under conditions most favourable to their human nature. . . . The shortening of the working day is its most basic prerequisite" (quoted in Sanchez Vazquez, 1977, p. 335).

not explicit, at least clearer than they were. It would in any case be idealistic to propose a programme for ideological reform in isolation from the material conditions which would make that reform both possible and meaningful. What can be pointed to though is the need for a programme of reform which is based on a real dialogue between helper and helped, and which is always open to modification. This is a concept of improvement which is as applicable to the treatment of the insane or mentally ill as it is to penal or educational reform. A partial recognition of the social construction of society was made by some of the moral therapists, and it has been made by many twentieth century psychiatrists. On this it is relatively easy to build.

More problematic, however, is the ability to maintain the consciousness that society (or therapeutic knowledge) is man-made. Here Marxism has just as bad a record as the bourgeois ideologies. The moral therapists tried to rest their practice on the basis of "moral laws" and "scientific knowledge". Socialist practice, if the existing socialist societies are a fair example, is also very prone to being reified into apparently universal laws of nature. What socialism and mental health have in common is their need to create in man the conscious recognition of his own potential. This can be achieved only if the necessary material steps are taken, <u>and</u> only if man recognises that it is his own practice that will achieve it. Our consciousness may never be total, but it need never be as partial as it is.

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I. Primary source materials

   A. Unpublished institutional archival material

   B. Parliamentary Papers

      1. Reports

      2. Returns

   C. Books, articles, and pamphlets

II. Secondary source materials

I. Primary Source Materials

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